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Research Article

### KNOWLEDGE AND PRACTICE OF PRIMARY CARE PHYSICIANS TO SCREENING AND INTERVENTION OF INTIMATE PARTNER VIOLENCE IN TAIF CITY, KSA

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**Abstract:**

**Introduction:** The Centers for Disease Control and Prevention defines intimate relationship abuse as physical violence, sexual violence, and psychological damage perpetrated by a current or former intimate partner.

**Methodology:** This was a cross-sectional study conducted in Taif city, Saudi Arabia. The study aimed to assess knowledge and practice of IPV among Saudi primary healthcare physicians and investigate the factors affecting IPV screening and management. The Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) is a questionnaire distributed among the physicians. **Results:** A total of 126 physicians were included; over half of them (55.6%) were males. The participants had a mean score of perceived preparation ( $2.8 \pm 1.3$ ), perceived knowledge of ( $2.6 \pm 1.2$ ), and actual knowledge of ( $17.8 \pm 4.8$ ). We demonstrated a significant association between age ( $P=0.006$ ), years since graduation ( $P=0.005$ ), the academic degree ( $P=0.000$ ), and the average number of patients taken care of by the physicians ( $P=0.024$ ) and the actual knowledge score. The average number of patients taken care of by the physicians and practitioners at the worksite who have participated in an IPV training course in the past 6 months are significantly associated with the practice score with ( $P=0.030$ ) and ( $P=0.008$ ), respectively.

**Conclusion:** We found a lack of training on IPV among primary health care physicians in Saudi Arabia. In addition to poor perceived preparation, poor perceived knowledge, and poor actual knowledge about IPV among the participants. Older physicians were found to be more experienced and knowledgeable about IPV than the younger residents. Practicing skills were more positive with the increasing years of experience and the applied training programs.

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**INTRODUCTION:**

"Intimate partner violence" is defined by the Centers for Disease Control and Prevention as physical violence, sexual violence, and psychological harm by a current or former intimate partner.<sup>1</sup>

The abuses divide into two main categories: a) physical abuse, including physical violence, forced sex, sexual contact, and b) non-physical abuse that include threat and controlling behavior; furthermore, violence has many types that effect by violence which divided according to it to self-directed violence, interpersonal violence, and collective violence.<sup>2,3</sup>

Worldwide prevalence in 2010 was, 30.0% of women aged 15 and over had physical and/or sexual intimate partner violence during their lifetime Whereas The prevalence in Saudi Arabia according to two studies did in Riyadh and western region was 20%, 11.9% respectively among women that visited the primary health care.<sup>4,5,6</sup>

The systematic review gives us many tools that we can use to screen the victim of violence in health care settings, which depends on psychometric sound.<sup>7</sup>

World Health Organization had a policy and guidelines to evaluate and assess intimate partner violence against women.<sup>8</sup>

Screening programs that help us detect intimate partner violence among women had a positive effect on a population's whole health.<sup>9</sup>

The United States Preventive Services Task Force USPSTF recommendation and most major medical organizations (including the American Medical Association [AMA], the American Academy of Paediatrics [AAP], the American Academy of Family Physicians, the American College of Obstetricians and Gynaecologists and the American College of Emergency Physicians) recommend to screening the patient as apart of routine caring that provided to the patient at every visit.<sup>10,11,12,13</sup>

The United States Preventive Services Task Force (USPSTF) guideline recommends screening all women aged 14 to 46. While the National Consensus Guidelines (NCG) recommends all adolescents and adult patients have to screen routinely, and their assessment includes both current and past intimate partner violence victimization so the primary care providers screen for current rather than past intimate partner violence among 2 groups: all women aged 14 to 46 years, and women older than 46 only.<sup>14,15</sup>

HITS is one of the screening tools that have a good ability to differentiate abuse victims from family practice patients, so it is useful for screening among family care physicians.<sup>16</sup>

HITS (Hurt-Insult-Threaten-Scream) is a domestic violence screening tool developed and tested in a female population at Christ Hospital in Chicago; furthermore, Sensitivity and specificity are 88% and 97%, respectively.<sup>17,18</sup>

The items included in HITS are useful for assessing psychological violence, as well as physical aggression.<sup>19</sup>

HITS consist of four questions which it describes as "how often does your partner: hurt you physically, insult or talk down to you, threaten you with harm, or scream or curse at you?" It represents on the 5-point scale include: never (1 point), rarely (2 points), sometimes (3 points), fairly often (4 points), frequently (5 points) so if the Scoring more than 10 points are positive for IPV.<sup>20</sup>

Another tool that we can use is The Abuse Assessment Screen (AAS) includes 5 questions covering emotional, physical, and sexual abuse, and can be used with pregnant patients, so questions are: (1) have you ever been emotionally or physically abused by your partner or someone important to you, (2) within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone, (3) since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone, (4) within the last year, has anyone forced you to have sexual activities, and (5) are you afraid of your partner or anyone you listed above? If the abuse victim answer by yes, that means we have positive IPV.<sup>21</sup>

After screening the abuse victim, we need to assess safety assessment safety, including five questions: (1) has the physical violence increased over the past six months? (2) Has your partner used a weapon or threatened you with a weapon? (3) Do you believe your partner is capable of killing you? (4) Have you been beaten while pregnant? (5) Is your partner violently and constantly jealous of you? If the patient answers three or more by yes, that means the risk of injury, so we need urgent intervention to protect the victim from harm.<sup>22</sup>

Intervention is important to step to control and save the victims of intimate partner violence, so the steps are starting with non-judgmental, validity, and supportive statement then we put safety plan to

protect the victim, including strategy in relation to the violent person, violent site, and during incident furthermore, we arrange a suitable referral to access resources in the region after that we need treatment associated medical problem with mandatory reporting with proper documentation to the organization the help the victim to restoration the right.<sup>23,24</sup>

A study about Screening and Intervention for Intimate Partner Abuse Practices and Attitudes of Primary Care Physicians found "the practices of primary care physicians in California. An estimated majority (79%; 95% confidence interval [CI], 75%-83%) of these primary care physicians routinely screen injured patients for intimate partner abuse. However, estimated routine screening was less common for new patient visits (10%; 95% CI, 7%-13%), periodic check-up's (9%; 95% CI, 6%-12%), and prenatal care (11%; 95% CI, 7%-15%) no association between physician sex and the rate of screening Commonly reported routine interventions included relaying concern for safety (91%), referral to shelters (79%) and counseling (88%), and documentation in The medical chart (89%). Commonly cited barriers to identification and referral included the patients' fear of retaliation (82%) and police involvement (55%), lack of patient disclosure (78%) and follow-up (52%), and cultural differences (56%).<sup>25</sup>

In a review of 24 studies from 1966 to January 1999 about Screening for Intimate Partner Violence by Health Care Providers, Barriers and Interventions found factor barriers to a health provider to deal with IPV included lack of provider education regarding IPV, lack of time, and lack of effective interventions. Some factors related to the patient such as patient nondisclosure, fear of offending the patient. other studies included in this review were evaluating interventions designed to increase IPV screening by providers revealed that interventions limited to the education of providers had no significant effect on screening or identification rates, so the highest specialty from four specialties in the united states that provided primary health care was an obstetrics-gynaecology specialty, and lowest was an Emergency physician.<sup>26,27</sup>

A study conducted in Flanders, Belgium 2006 about A knowledge, attitudes, and practice survey among obstetrician-gynaecologists on intimate partner violence found obstetrician-gynaecologists believe the effect of screening on counteracting abusive behaviours, so their outcome expectancy is weighed down by their perceived lack of self-efficacy in dealing with IPV, by lack of familiarity with referral

procedures and by their perceived lack of available referral services Finally, physician education was found to be the strongest predictor of a positive attitude towards screening and current screening practices.<sup>28</sup>

In the primary healthcare setting, social workers had a higher self-efficacy and accessibility to the system that needs to help the victim than other workers in the setting. Physicians and female care providers had less likely to blame the victim than social workers male care providers according to a study did in Nigeria 2010 talked about Health Care Providers' Readiness to Screen for Intimate Partner Violence.<sup>29</sup>

According to a systematic review talked about universal screening for intimate partner violence showed universal screening occurs at low rates pediatricians and pediatric care-providing family practice physicians concluded that 12% of respondents routinely screened for IPV at all well-child care visits primary care physicians, 11% of physicians who provide prenatal care routinely screened during the first prenatal visit, while 10% of physicians routinely screened for IPV during new visits and 9% screened during periodic check-ups Overall, relative to family practice settings, screening more frequently occurs in prenatal and gynecological practices and screening rates overall reported in the literature typically range from 1.5% to 39%, depending on setting less than 25% indicated they were asked about IPV by emergency room staff In emergency departments and acute care settings where providers frequently encounter IPV, rates are also reportedly quite low.<sup>30</sup>

A previous study did in United Kingdom 2012 about knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians found Clinicians only had basic knowledge about domestic violence but expressed a positive attitude towards engaging with women experiencing abuse. Many clinicians felt poorly prepared to ask relevant questions about domestic violence or to make appropriate referrals if abuse was disclosed. Forty percent of participants never or seldom asked about abuse when a woman presented with injuries. Eighty percent said that they did not have adequate knowledge of local domestic violence resources. GPs were better prepared and more knowledgeable than practice nurses; they also identified many domestic violence cases. In fact, screening about IPV was more significantly among male physicians than other categories of health providers overall the society of physicians more than nurse population when talked about screening.<sup>31,32</sup>

In a study did in 2016 about Intimate Partner Violence: The Knowledge, Attitudes, Beliefs, and Behaviours of Rural Health Care Providers Found A total of 93 health care providers returned completed surveys. In general, the respondents demonstrated good overall knowledge, judicious attitudes, and beliefs congruent with IPV's available evidence. Of concern were their knowledge and practice gaps regarding the prevalence of IPV, the higher risk of injury faced by women who leave their abusers, women's ability to make appropriate choices about their situations, and what actions to take when someone discloses abuse.<sup>33</sup>

The prevalence in Saudi Arabia, according to two studies did in Riyadh and the western region, was 20%, 11.9% respectively among women that visited the primary health care, so No similar study up to the researcher's knowledge was carried out among primary care physicians in Taif city in this regard.

IPV can lead to acute health outcomes, including acute physical injury and homicide, as well as chronic health burdens; furthermore, Increase Health care costs and decreased productivity related to IPV.

Primary care physicians are the first line to detect IPV and do a proper intervention.

### Hypothesis

Knowledge and practices of intimate partner violence screening and management among primary health care physicians in Taif city are low.

### Research Question

What are about knowledge and practices of intimate partner violence screening and management among primary health care physicians in Taif city, Western region, Saudi Arabia?

## OBJECTIVES AND AIMS

### Overall Aims

To identify the barrier of knowledge and practices of IPV screening and its management among primary health care physicians in Taif city.

### Specific Objective

1. To assess knowledge and practices of intimate partner violence screening and management among primary health care physicians in Taif city, Western region, Saudi Arabia.
2. To assess the factors effect on intimate partner violence screening and management among primary health care physicians in Taif city.

## METHODS:

### Population and Study Sample

#### Study design

A cross-sectional study design was applied.

#### Study area

The study was carried out at Taif city; it is located in the Makkah region of western Saudi Arabia on the eastern slopes of the Sarawat Mountains at an altitude of 1,700 meters above sea level with an area of 1036 km<sup>2</sup>. One of the most important characteristics of Taif is its location, which is characterized by its proximity to Mecca. The population of the province in 1435 is estimated at 993.8 thousand people, 12.79% of the total population of Makkah region.

#### Study setting

Primary healthcare in Taif city it is about 19 center around the city that provide service to the population that stating from prevention to treatment of all disease

#### Study period

The study was conducted in eight weeks period and started on Feb 1, 2019.

#### Study population

Primary health care physicians working in centers belong to the ministry of health in Taif city (19 centers) throughout the study period.

##### ❖ Inclusion Criteria:

- All primary health care physicians working in the ministry of health in Taif city
- Males and females
- All nationalities
- All degrees (resident, specialist, and consultant)

##### ❖ Exclusion Criteria:

- All Physicians are working in hospitals.
- Dentists.
- Physicians who are on vacations or who are absent.
- All Physicians who are not working in the ministry of health.

#### Sample Size and Selection of Sample

All primary health care physicians working in centers belong to a ministry of health who were available at the time of the study and were included in the study (around 126 physicians).

#### Tools

The Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) is a questionnaire developed and validated in the US. It is a 15-minute survey that is a comprehensive and reliable measure

of physician preparedness to manage IPV patients.<sup>34,35</sup>

The PREMIS is a 67-item, comprehensive measure assessing physician readiness to manage intimate partner violence (IPV). The measure was multifaceted and contained four sections: Background (perceived preparation and knowledge), knowledge (actual knowledge), Opinions (attitudes and beliefs), and Practice Issues (physician/office behaviors). According to developers, items were consistent with the theoretical literature on IPV. The measure tool 15-35 minutes to complete and can be administered in paper- and web-based formats. Self-report responses were made through Likert-type scale, true/false, multiple-choice, and open response options. The PREMIS was adapted and validated.

### Procedure

Primary health care physicians in Taif city were invited to complete the PREMIS questionnaire on the online form that applied by google form; the period started from February to the end of March

### Data Analysis Strategies

All collected data were coded before its entry to a personal computer. Data entry and analysis were done by using the Statistical Package of the Social Sciences (SPSS) statistical program version 26. We followed the PREMIS coding and scoring manual. Scores were presented in mean  $\pm$  standard deviation (SD). We used Mann-Whitney U test and Kruskal-Wallis test for nonparametric mean analyses. A P-value of less than 0.05 was considered as a level of significance throughout the study.

### Ethics and Human Subjects Issues

Privacy of physician information and confidentiality was maintained. Permission from the regional Research and Ethical Committee in Taif city was obtained for conducting the study. Permission from the director of primary care centers in Taif was obtained. Permission from the source of the questionnaire was obtained. All the subjects participated voluntarily in the study.

### RESULTS:

**Table (1)** shows the socio-demographic characteristics of 126 primary care physicians. More than half of the total participants (55.6%) were males, and most of them (73.8%) aged from 25-30 years. Most of the respondents (72.2%) spent from 1-5 years since graduation, while only 4% spent more than 15 years after graduation. Nearly 19.8% of the

participants are in the 1<sup>st</sup> year of residency in the family medicine residents' program, 16.7% were in the 2<sup>nd</sup> year, 15.9% in the 3<sup>rd</sup> year, and 17.5% in the 4<sup>th</sup> year. 31.7% of them take care of 20-39 patients per week, and 24.6% usually see 60 or more patients per week. The majority of the participants (89.7%) did not know how many practitioners at the work site have participated in an IPV training course in the past 6 months.

**Table (2)** indicates PREMIS scale scores among participating physicians. Regarding IPV background, they had a mean score of perceived preparation ( $2.8 \pm 1.3$ ) and perceived knowledge of ( $2.6 \pm 1.2$ ). The participants had a mean score of actual knowledge of ( $17.8 \pm 4.8$ ) and minimum and maximum scores of (4 - 28). Concerning the mean scores of participants' opinions, preparation ( $4 \pm 1.2$ ), legal requirements ( $3.3 \pm 1.3$ ), workplace issues ( $3.7 \pm 1.1$ ), self-efficacy ( $3.7 \pm 1$ ), alcohol/ drugs ( $4.2 \pm 0.7$ ), victim understanding ( $4.2 \pm 0.7$ ), victim anatomy ( $4.1 \pm 1$ ), and constraints ( $4.4 \pm 1.2$ ). The participants had a mean score of the practice of ( $20.5 \pm 6.8$ ) and minimum and maximum scores of (6 - 37.2).

**Table (3)** presents the characteristics of the precipitating physicians in association with IPV knowledge and practice scores. We demonstrated a significant association between age ( $P=0.006$ ) and years since graduation ( $P=0.005$ ) and the actual knowledge score. Higher levels of knowledge were reported among the older participants; participants aged from 41-50 had a mean score of ( $25.5 \pm 0.7$ ) and those aging more than 50 years ( $22.3 \pm 2.3$ ). Moreover, greater knowledge levels were recorded among the participants who spent more than 15 years after graduation ( $23.6 \pm 2.4$ ). The academic degree was significantly associated with ( $P=0.000$ ); higher knowledge was found among the participants in the 4<sup>th</sup> year of residency ( $22.2 \pm 4$ ) and consultants ( $23.8 \pm 3.2$ ). The average number of patients taken care of by the physicians was also significantly associated with the knowledge score ( $P=0.024$ ) as higher knowledge was found among the physicians who take care of 40-59 patients per week ( $19.2 \pm 5.5$ ) while poor knowledge was found among the physicians who take care for less than 20 patients per week ( $16.8 \pm 5.2$ ). The average number of patients taken care of by the physicians and practitioners at the worksite who have participated in an IPV training course in the past 6 months are significantly associated with the practice score with ( $P=0.030$ ) and ( $P=0.008$ ), respectively.

*Table (1): Characteristics of the participating physicians, Taif, 2021 (n=126).*

Parameter	No.	Percentage	
Age, y	25-30	93	73.8%
	31-40	28	22.2%
	41-50	2	1.6%
	More than 50	3	2.4%
Gender	Female	56	44.4%
	Male	70	55.6%
Years since graduation	1-5	91	72.2%
	6-10	20	15.9%
	11-15	10	7.9%
	More than 15	5	4.0%
Highest academic degree	FM program resident R1	25	19.8%
	FM program resident R2	21	16.7%
	FM program resident R3	20	15.9%
	FM program resident R4	22	17.5%
	General practice Resident	24	19.0%
	Specialist	10	7.9%
	Consultant	4	3.2%
The average number of patients you care for per week	Less than 20	14	11.1%
	20-39	40	31.7%
	40-59	35	27.8%
	60 or more	31	24.6%
	Not seeing patients	6	4.8%
Practitioners at the work site have participated in an IPV training course in the past 6 months	A few	7	5.6%
	Some	4	3.2%
	Most	2	1.6%
	I do not know	113	89.7%

Table (2): PREMIS scales scores among participating physicians, Taif, 2021 (n=126).

Scale	Mean $\pm$ SD (Min – Max)
<b>Background</b>	
Perceived preparation	2.8 $\pm$ 1.3 (1 - 6.6)
Perceived knowledge	2.6 $\pm$ 1.2 (1 - 6.9)
<b>Actual knowledge</b>	
Actual knowledge	17.8 $\pm$ 4.8 (4 - 28)
<b>Opinions</b>	
Preparation	4 $\pm$ 1.2 (1 - 7)
Legal requirements	3.3 $\pm$ 1.3 (1 - 7)
Workplace issues	3.7 $\pm$ 1.1 (1.2 - 6.8)
Self-efficacy	3.7 $\pm$ 1 (1.3 - 6.3)
Alcohol/drugs	4.2 $\pm$ 0.7 (2.3 - 6.7)
Victim understanding	4.2 $\pm$ 0.7 (2.3 - 5.8)
Victim autonomy	4.1 $\pm$ 1 (1.3 - 6)
Constraints	4.4 $\pm$ 1.2 (1 - 7)
<b>Practice issues</b>	
Practice issues	20.5 $\pm$ 6.8 (6 - 37.2)

Table (3): Characteristics of the participating physicians in association with IPV knowledge and practice scores, Taif, 2021 (n=126).

Parameter	Scale		
	Actual Knowledge (Mean $\pm$ SD)	Practice issues (Mean $\pm$ SD)	
Age, y	25-30	18.1 $\pm$ 4.5	20.4 $\pm$ 7
	31-40	15.7 $\pm$ 5.3	21 $\pm$ 6.8
	41-50	25.5 $\pm$ 0.7	16.7 $\pm$ 4.3
	More than 50	22.3 $\pm$ 2.3	21.3 $\pm$ 4.1
	<i>P-value</i> *	<b>0.006</b>	0.899
Gender	Female	17.9 $\pm$ 4.2	21.1 $\pm$ 5.7
	Male	17.7 $\pm$ 5.3	20 $\pm$ 7.7
	<i>P-value</i> **	0.850	0.367
Years since graduation	1-5	18.1 $\pm$ 4.5	20.4 $\pm$ 6.8
	6-10	16.6 $\pm$ 5.9	21.2 $\pm$ 6.9
	11-15	14.4 $\pm$ 4	20.5 $\pm$ 8.7
	More than 15	23.6 $\pm$ 2.4	19.5 $\pm$ 4.4
	<i>P-value</i> *	<b>0.005</b>	0.989
Highest academic degree	FM program resident R1	16.2 $\pm$ 4.1	21.6 $\pm$ 6.8
	FM program resident R2	15.9 $\pm$ 3.2	16.9 $\pm$ 7
	FM program resident R3	19.9 $\pm$ 2.6	21.4 $\pm$ 7.5
	FM program resident R4	22.2 $\pm$ 4	20.5 $\pm$ 6.1
	General practice Resident	15.2 $\pm$ 5.4	21.3 $\pm$ 6.7
	Specialist	15.6 $\pm$ 3.9	20.5 $\pm$ 6.3
	Consultant	23.8 $\pm$ 3.2	22.9 $\pm$ 7.9
	<i>P-value</i> *	<b>0.000</b>	0.421
The average number of patients you care for per week	Less than 20	16.8 $\pm$ 5.2	20.9 $\pm$ 7.8
	20-39	18.8 $\pm$ 3.9	18 $\pm$ 6.1
	40-59	19.2 $\pm$ 5.5	19.8 $\pm$ 6

	<b>60 or more</b>	15.7 ± 4.7	23.7 ± 7.2
	<b>Not seeing patients</b>	16 ± 2.5	22.6 ± 6.7
	<b><i>P-value*</i></b>	<b>0.024</b>	<b>0.030</b>
<b>Practitioners at the worksite have participated in an IPV training course in the past 6 months</b>	<b>A few</b>	19.4 ± 4.9	26.9 ± 6.6
	<b>Some</b>	20.5 ± 8.5	13.8 ± 5.1
	<b>Most</b>	17 ± 0	23.5 ± 0.7
	<b>I do not know</b>	17.6 ± 4.7	20.3 ± 6.7
	<b><i>P-value*</i></b>	0.654	<b>0.008</b>

\*Kruskal-Wallis test was used.

\*\* Mann-Whitney U test was used.

### DISCUSSION:

IPV is a common social and medical problem. It takes place in all countries regardless of their cultural, economic, social, and religious values. Battered women look for physical and psychological help in healthcare facilities.<sup>36</sup> The personal value system and beliefs of the medical personnel about IPV can play a principal role. This cross-sectional study was conducted to evaluate the knowledge, attitude, and practice of IPV among primary health care physicians in Taif, Saudi Arabia.

There has lately been a worldwide focus on demanding IPV in healthcare environments as patients present with symptoms that could be triggered by such victimization.<sup>37</sup> In this study, the majority of the primary healthcare physicians (87.9%) did not even know about IPV training courses. Another study conducted by *Zaher&Mason evaluates knowledge, attitude, and perception towards IPV among Saudi family residents*. They reported that all of the resident participants did not receive IPV training within the last 6 months or any previous post-graduate or undergraduate training regarding IPV.<sup>38</sup> These findings indicate a lack of training about IPV; we suggest IPV for frontline primary healthcare physicians is required. In Saudi Arabia, a significant collaboration between program supervisors at the Saudi Commission for Health Specialties and leaders and policymakers at the Ministry of Social Affairs and the National Family Safety program is needed.

Regarding IPV background, this study reported a poor perceived preparation of (2.8 ± 1.3) and poor perceived knowledge of (2.6 ± 1.2). The participants had a mean score of actual knowledge (17.8 ± 4.8) and minimum and maximum scores (4 - 28). We found that primary physicians did not perceive themselves as either well-prepared or knowledgeable to talk through IPV with patients. These findings also signify the lack of training and education about IPV

in Saudi Arabia to respond to battered women appropriately.

These results were in line with *Zaher&Mason* who also reported poor perceived preparation of (2.25 ± 1.29) and poor perceived knowledge of (2.08 ± 1.26) and actual knowledge of (18.10 ± 6.70).<sup>38</sup> However, a similar study conducted among Australian university students reported relatively higher results for actual knowledge (60.5%) and perceived knowledge of (34.7%).<sup>39</sup>

The mean score of participants' opinions was low, which was consistent with *Alhalal et al.*<sup>40</sup> and *Papadakaki et al.*<sup>41</sup> Many healthcare providers have cited low self-efficacy as a major obstacle to discussing IPV with patients, as their trust loss causes them to be reluctant to inquire. As a result, women can lose out on recognition and referral chances, putting them at risk of further violence. Paramedics must be willing to speak to patients about IPV because there is evidence that IPV patients are often left at home by paramedics.<sup>42</sup>

This study demonstrated a significant association between age (P=0.006) and years since graduation (P=0.005) and the actual knowledge score. Higher levels of knowledge were reported among the older participants; participants aged from 41-50 had a mean score of (25.5 ± 0.7) and the participants who spent more than 15 years after graduation (23.6 ± 2.4). The academic degree was also significantly associated with (P=0.000); higher knowledge was found among the participants in the 4<sup>th</sup> year of residency (22.2 ± 4) and consultants (23.8 ± 3.2). The physicians' average number of patients taken care of was also significantly associated with the knowledge score (P=0.024) as higher knowledge was found among the physicians who take care of 40-59 patients per week (19.2 ± 5.5).

*Zaher&Mason* also reported that senior family physicians have higher knowledge scores and preparedness regarding IPV.<sup>38</sup> These results could be

explained as the acquired experiential learning through years of practice plays an important role in handling and understanding IPV. Moreover, the low knowledge levels among young residents are probably due to the lack of training and exposure to family violence issues. These results are particularly significant in light of the recent analysis and update of the US Preventive Services Task Force (USPSTF) guideline on screening women for IPV, which states that screening all women of childbearing age for IPV may be helpful.<sup>43,44</sup>

This study found that the average number of patients taken care of by the physicians and practitioners at the worksite who have participated in an IPV training course in the past 6 months are significantly associated with the practice score with (P=0.030) and (P=0.008), respectively. *Alhalal et al.*<sup>40</sup> also reported a significant association between the nurse's age and years of practice and their knowledge and attitudes towards IPV. *AlAzmy et al.*<sup>45</sup> and *Sharma et al.*<sup>46</sup> were also consistent with our findings regarding the indispensable role of training in improving the practicing skills and the association between years of experience and the high level of knowledge and positive attitudes.

### CONCLUSION:

This study found a lack of training of IPV among primary health care physicians in Saudi Arabia. In addition to poor perceived preparation, poor perceived knowledge, and poor actual knowledge about IPV among the participants. Older physicians were found to be more experienced and knowledgeable about IPV than the younger residents. Practicing skills were found to be more positive with the increasing years of experience and the applied training programs. Educational campaigns and programs about IPV are highly required among Saudi physicians. Education should target building confidence in discussing IPV with patients and provide practicing skills opportunities with professional and expert educators.

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