Wife abuse: a hidden problem. A study among Saudi women attending PHC centres

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تعنيف الزوجة؛ مشكلة مستترة: دراسة بين السيدات السعوديات المراجعات لمراكز الرعاية الصحية الأولية

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الخلاصة: هدفت هذه الدراسة إلى قياس معدَّل الانتشار وشدة وأنماط تعنيف الزوجات لدى السيدات التي سبق لهن الزواج، واللاتي راجعن مراكز الرعاية الصحية الأولية في المدينة المنورة، في المملكة العربية السعودية. وقد قابل الباحثون السيدات في مقابلات ذات خصوصية، في المراكز الصحية، استخدم فيها استبيان تضمن عناصر مستمدة من سلم القياس التكتيكي المعدَّل للنزاعات، ومن سلم قياس الزواج لكنساس، وسلم قياس الكذب في لائحة جرد الشخصية المتعددة المراحل لمينيسوتا. ومن بين 689 سيدة مؤهلة للإدراج ضمن الدراسة، أبلغ 25.7٪ منهن عن تعنيف جسدي، و32.8٪ منهن عن تعنيف عاطفي غير مترافق مع عنف جسدي. ومن بين السيدات اللاتي تعرضن لتعنيف جسدي عانى 36.7٪ من إصابات طفيفة، فيما عانى 63.3٪ منهن من إصابات شديدة. وقد بلغ معدَّل انتشار التعنيف طيلة الحياة بين السيدات 57.7٪، ولكن لم يبلغ سوى 36.7٪ من المجموعة الفرعية من السيدات المعنَّفات عن هذا التعنيف، حيث أبلغن وناقشن هذه القضية مع طبيب الرعاية الصحية الأولية الذي يهتم بهن.

ABSTRACT The aim of this cross-sectional study was to measure the prevalence, severity and type of wife abuse experienced by ever-married women attending primary health centres in Medina, Saudi Arabia. Women were interviewed in private at health centres using a questionnaire which included items from the Modified Conflict Tactic Scale, Kansas Marital Scale and the lie scale of the Minnesota Multiphase Personality Inventory. Of 689 eligible women, 25.7% reported physical abuse and 32.8% emotional abuse without physical violence. Of those physically abused, 36.7% suffered minor and 63.3% severe incidents. The lifetime prevalence of abuse among the women was 57.7%. Only 36.7% of 109 abused women had informed and discussed the issue with their primary care physician.

Violence envers l'épouse : un problème caché. Étude chez des femmes saoudiennes fréquentant des centres de soins de santé primaires

RÉSUMÉ L'objectif de cette étude transversale était de mesurer la prévalence, la gravité et le type des violences subies par des femmes mariées ou ayant été mariées qui fréquentent des centres de soins de santé primaires à Médine (Arabie saoudite). Ces femmes ont été interrogées en privé dans des centres médicaux, sur la base d'un questionnaire contenant des items tirés de la version modifiée de l'échelle des stratégies de gestion des conflits CTS (*Conflict Tactic Scale*), de l'échelle de satisfaction conjugale KMS (*Kansas Marital Scale*) et de l'échelle de mensonge du MMPI (*Minnesota Multiphase Personality Inventory*). Sur 689 femmes remplissant les conditions requises pour l'étude, 25,7 % ont signalé des violences physiques et 32,8 % des violences affectives sans violence physique. Parmi les femmes ayant fait l'objet de violences physiques, 36,7 % avaient subi des incidents mineurs et 63,3 % des incidents graves. La prévalence des violences au cours de l'existence de ces femmes était de 57,7 %. Seuls 36,7 % d'un sous-ensemble des femmes victimes de violences avaient informé le médecin de soins primaires et discuté du problème avec lui.

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Introduction

Violence against women is a significant public health problem worldwide with serious implications for their physical and mental health as well as for their children [*1–3*]. Population-based surveys have shown that the lifetime prevalence of physical abuse by an intimate partner ranges from 10% to 69% in different countries and settings [*4*]. Prevalence rates of partner violence determined from police records or studies in hospital emergency departments or other health care settings vary from those conducted in community-based surveys [*5–9*]. However, they may underestimate the extent of the problem due to the social stigma attached to reporting violence against women.

Spouse abuse is included under different definitions in different cultural settings and a uniform definition is lacking [*4,5,10*]. The Centers for Disease Control and Prevention defines domestic violence as "an actual or threatened physical or sexual violence, or psychological and emotional abuse, directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner" [*10*]. However, according to social conventions, most studies conducted on the subject in Muslim societies refer to husband and wife.

Data on the occurrence of violence against women are scarce in the Arab world. The few studies that have been conducted show that wife abuse is a significant health and social problem in this region. Islam dictates love and mercy between the spouses and protection of women from any physical, psychological and/or sexual violence at home or outside [*11*]. However, many Muslim women have been the victims of spouse abuse [*1,3*]. A community-based study conducted in Egypt in 1996 on a predominantly Muslim population reported that 16% of ever-married/partnered women had been exposed to physical abuse in the past year and 34% had experienced abuse at some time in their life [*4*]. Figures for past year physical abuse of women in the Syrian Arab Republic [*1*], Israel (Arab population) and the West Bank and Gaza Strip have been reported as 26%, 32% and 52% respectively [*4*].

There is little information about the incidence, prevalence and pattern of domestic violence against women in Saudi Arabia. One of the investigators (A.T.) encountered several cases of physical wife abuse during her practice in local primary health care centres (PHCCs). The patients did not report the cause for the bruises at the outset until further enquiries were made. This led to the question whether wife abuse was a hidden health/social problem in the community.

The aim of the study was to measure the magnitude and severity of physical and emotional wife abuse experienced by ever-married Saudi Arabian females attending PHCCs in Medina city. The study also explored whether victims of wife abuse discussed these incidents with their primary health care (PHC) physician.

Methods

A cross-sectional study was conducted on adult, ever-married Saudi Arabian women who attended PHCCs in Medina city from 7 to 26 February 2004.

Sampling

To determine the sample size the prevalence of wife abuse was considered as 30% (determined from a pilot study), type 1 error as 0.05, type 2 error as 0.02 and confidence interval as 1.96. With these conditions, the sample size of the study was estimated to be 660.

There are 32 PHCCs in Medina city; 4 were selected for the pilot study. Out of the remaining 28 centres, 16 were chosen for

the main study by simple random sampling. Each selected PHCC was visited for a total of 10–12 hours on 2 or 3 morning and/or evening shifts. All ever-married women of Saudi Arabian nationality aged 16–60 years who visited the PHCCs during that time period were considered for the sample. However, for safety reasons (as per the World Health Organization recommendations for research on violence [*12*]), if more than 1 woman of the same family attended the health centre on the same day, only 1 of them was selected. Widows were not included in the study because of the sensitivity of questions in the survey tool.

There were 1034 eligible attendees from the 16 PHCCs during the survey period. While they sat in the waiting room or in the clinic of the health centre, all these women were asked to participate in a study on women's health. Of the 1034 women, 336 (32.5%) refused because they were either too ill on that day, had immediate family concerns or did not wish to be involved in the study. The remaining 698 women who agreed to participate were informed about the objective of the research in a private room in the clinic for safety reasons. Verbal informed consent was obtained from each participant. All these women responded to the questionnaire on wife abuse in the initial stages of the interview. However, 9 women (1.3%) refused to continue when sensitive questions related to the topic came up. The final sample size was therefore 689 women.

Data collection

Data for the study were obtained by interviewing the participants. Information on physical abuse was collected according to the ethical and safety recommendations for research on domestic violence against women [*12–15*]. The present study adopted the criteria of physical or emotional wife abuse in accordance with the doctrines of Islamic law.

The names of the women were not recorded on the questionnaire and they were assured of confidentiality of information. They in turn were asked not to divulge the subject of the study to their friends and family members including the husband, for safety reasons. To prevent women from feeling stigmatized ("battered woman"), the questions were phrased to focus on abusive acts by a husband rather than in a subjective style such as "have you been abused?". The interview was conducted in a caring and sympathetic manner to develop rapport, maximize disclosure of violence and minimize distress to victims of abuse. For participants who became emotionally upset during the interview, time was given to recover their composure and efforts were made to handle them in a sensitive and supportive way.

Pilot study

A pilot study was conducted to assess the administrative and procedural logistics, the response rate, the clarity and logical sequence of questions, the time required and the prevalence of wife abuse to estimate the sample size for the main study. It was carried out in 4 PHCCs on 52 eligible women. The refusal rate was only 6%. Data of the pilot study are not included in the main study. Responses of the women showed that all questions were clearly understood and were logically sequenced. The prevalence of wife abuse was estimated to be 30%.

Questionnaires

A semi-structured questionnaire was used that included the following scales.

Conflict Tactics Scale

Information was collected about physical and emotional wife abuse through a

modified version of the 23-item Conflict Tactics Scale, Revised (CTS-R) [*16*]. A few additions were made by the investigators according to what is considered physical wife abuse by Islamic concepts such as "slapping on the face" [*11,17*]. Moreover, 2 questions related to emotional abuse that are commonly used by abusive husbands in this region, i.e. threats to take another wife or to divorce her, were added to the questionnaire. The content validity of the questions from the Islamic point of view was approved by a local expert in Islamic codes of conduct and rules [personal communication, M.A. Al Bar]. The content, construct and concurrent validity of the CTS and CTS-R have already been tested [*16,18*]. Questions on husband abuse that are part of the original CTS-R were not included in the study. All questions were translated into Arabic and then re-translated into English by an expert in this field. The accuracy of the translations was found to be 100%. The modified CTS-R used for the current research, addressed questions on emotional as well as physical wife abuse. Abuse was categorized into 2 levels of severity—minor and severe—according to the classification of Strauss et al. [*16*].

Responses to the questions of the CTS-R were arbitrarily coded according to the incidence of abusive acts during the previous year as well as during the married life of the interviewees. The codes were as follows: never happened (score 0), happened but before last year (score 1), happened 1–2 times in the last year (score 2), happened 2–12 times in the last year (score 3), happened 13–24 times in the last year (score 4) and happened > 24 times in the last year (score 5).

Lie scale

The questionnaire included 10 questions selected on the basis of their face validity from a section of the Minnesota Multiphase Personality Inventory [*19*]. This instrument is a highly reliable and valid personality test. The lie scale score was analysed for each woman and used as an indicator of validity and reliability of responses given by her in the survey tool. A score below 2 standard deviations of the mean score of the present sample was arbitrarily chosen as the cut-off point for the validity and reliability status of the interviewee.

Kansas Marital Satisfaction Scale

The last part of the questionnaire was the Kansas Marital Satisfaction Scale. Two out of the 3 questions of this instrument were selected for this study that measured a woman's satisfaction with the marriage and her relationship with her husband. The responses were measured by a 5-point Likert scale from extremely satisfied (score 1) to extremely dissatisfied (score 5). The concurrent and discriminant validity of this scale has been tested in other populations [*20*].

The women who were physically and/or emotionally abused were asked whether they had reported the incident to a PHC physician. If the response was in the negative, reasons for their lack of communication was elicited.

Data analysis

Analysis was done with *SPSS*, version 10. Descriptive statistics [frequencies and percentages, mean and standard deviation (SD)] are presented for prevalence of lifetime and past year physical and emotional wife abuse as well as for the severity and type of abuse. For divorced women, information on lifetime abuse as well as abuse experienced during the last year of their marriage was included in the study data.

The Mann–Whitney test was used for the difference between physically/emotion-

ally abused and not abused women for their level of satisfaction in marriage as well as in their relationship with the husband (mean scores analysed from the responses to the Kansas Marital Scale). The chi-squared test was used for the difference between frequencies of the abused and not-abused. Results were considered significant when $P < 0.05$.

Reliability

The Cronbach alpha was used to check the reliability for the current study. The value of Cronbach alpha was 0.7287 (good).

The result of the lie scale score showed that only 10 (1.5%) women had a score that fell beyond the cut-off point of –2 SD, i.e. they had a potential to lie in their responses in the study questionnaire. Since it was a very small percentage, they were not excluded from the sample.

Results

The age of the women ranged from 16 to 60 years and the mean age was 32.78 (SD 8.52) years.

Lifetime prevalence of wife abuse

The frequency of ever-abuse (physical and/or emotional) was found to be high (57.8%). Lifetime physical abuse was reported by 26.9% women, while 30.9% were subjected to emotional abuse without physical violence.

Prevalence of wife abuse during the past year

Out of 689 women, 403 (58.5%) had been abused during the past year physically and/or emotionally. Physical abuse was reported by 177 (25.7 %) out of 689 respondents. Of the physically abused women, minor incidents of abuse were experienced by 65 (36.7%) and severe incidents by 112 (63.3%) women. A total of 170 physically abused women (96.0%) also reported experiencing emotional abuse. Emotional abuse without physical violence during the past year was reported by 226 (32.8%) of the 689 women.

Specific acts of physical and emotional aggression

The women experienced different acts of emotional and/or physical abuse. The most common types of minor physical violence were slapping on the face (23.0%) and pushing/shoving (22.4%), while those for severe violence were slamming against a wall (15.0%), kicking (11.5%) or hitting with a dangerous object (11.5%). The most frequently occurring incidents of physical abuse (> 24 times) during the past year included being bodily pulled (7.8%) or pushed (6.0%) as well as arm twisting/hair pulling (5.9%) (Table 1). The physical abuse resulted in passing out and broken bone(s) in 8.0% and 3.1% of the women respectively.

The most common types of emotional abuse (with or without physical violence) perpetrated by the husbands on their wives were shouting episodes (57.8%), insults (34.9%) and threats to take another wife (30.1%). Table 2 shows that these 3 types of emotional wife abuse were also reported to occur most frequently (> 24 times) during the past year.

Physical wife abuse was not significantly associated with the age of women ($P = 0.55$). However, emotional wife abuse was found to occur more frequently in women aged ≥ 20 years (33.5%) than in younger women (12.5%) ($P = 0.03$) (Table 3).

Kansas Marital Satisfaction Scale

The level of satisfaction with their marriage was significantly lower among women who

Table 1 **Distribution of Saudi Arabian women by type of physical violence experienced during the past year and before that period (*n* = 689)**

Incidents of physical abuse	Lifetime frequency	Frequency in past year				Frequency before last year
		1–2 times	3–12 times	13–24 times	> 24 times	
	%	%	%	%	%	%
Minor						
Pushed/shoved	22.4	3.5	3.5	1.9	6.0	7.5
Slapped on the face	23.1	5.0	1.9	1.5	5.3	9.4
Twisted arms/pulled hair	20.4	3.5	2.6	1.2	5.9	7.2
Pulled	18.8	1.9	1.6	1.0	7.8	6.5
Something thrown that could hurt	16.4	2.3	2.0	1.6	4.5	6.0
Severe						
Slammed against wall	15.0	3.7	3.1	0.7	2.9	4.6
Kicked	11.6	1.8	1.5	0.9	2.4	5.0
Hit by something that could hurt	11.6	1.8	1.8	0.6	2.4	5.0
Choked	8.6	1.6	0.7	0.3	2.5	3.5
Punched	8.2	1.2	2.1	0.0	1.8	3.2
Scalded or burnt	4.8	0.9	0.0	0.1	0.3	3.5

Table 2 **Distribution of Saudi Arabian women by types of emotional abuse experienced during the past year and before that period (*n* = 689)**

Incidents of emotional abuse	Lifetime frequency	Frequency in past year				Frequency before last year
		1–2 times	3–12 times	13–24 times	> 24 times	
	%	%	%	%	%	%
Insulted	34.9	7.2	6.9	3.8	7.2	9.8
Threatened with taking another wife	30.1	4.5	5.7	2.0	9.6	8.3
Shouted at	57.8	8.8	16.1	6.5	18.2	8.2
Called ugly names	24.9	7.4	4.1	1.8	4.8	6.8
Threatened with divorce	21.1	4.1	2.0	1.3	5.7	8.0
Threatened with an object (thrown/hit)	19.4	3.5	2.6	1.5	4.5	7.3
Destroyed personal belongings	15.6	2.3	0.6	1.3	4.7	6.7
Spat upon	14.6	1.9	2.2	0.7	3.2	6.6
Threatened with knife/ weapon	6.9	0.8	0.6	0.5	1.2	3.8

Table 3 **Emotional abuse without physical violence in relation to age of Saudi Arabian women (*n* = 689)**

Age of woman (years)	Emotional abuse						*P*-value
	Yes		No		Total		
	No.	%	No.	%	No.	%	
< 20	3	12.5	21	87.5	24	3.4	0.03
≥ 20	223	33.5	442	66.5	665	96.5	
Total	226	32.8	463	67.2	689	100.0	

were physically abused [mean score 3.01 (SD 1.19)] than among those not abused [mean score 2.03 (SD 0.8)] ($P < 0.001$, Mann–Whitney test). A poorer relationship with the husband was also evident among women physically abused [mean score 3.12 (SD 1.17)] compared with those not abused [mean score 1.95 (SD 0.74)] ($P < 0.001$, Mann–Whitney test).

The level of satisfaction with marriage was not significantly different among women who were emotionally abused [mean score 2.23 (SD 0.87)] from those who were not abused [mean score 2.3 (SD 1.07)] ($P = 0.39$). Similarly, no variation was observed in the level of relationship with the husband among the emotionally abused [mean score 2.19 (SD 0.8)] and non-abused [mean score 2.28 (SD 1.1)] women.

Consultation with a physician

A sub-set ($n = 109$) of the physically and/or emotionally abused victims was asked whether they consulted a PHC physician when abused. Of these women, 36.7% said that they had informed and discussed the issue with their PHC physician. Reasons given by those who did not report to a physician included their belief that physicians were "outsiders/strangers" (16.5%) or that they showed a non-caring attitude, were too busy, had poor communication skills and lacked ability to deal with social problems (7.2%). Overcrowded health centres with no private facilities to discuss sensitive issues related to abuse was mentioned by a few women (3.6%), who feared that their safety would be jeopardized if their husbands knew about such disclosures.

Discussion

This is the first large cross-sectional study to examine the magnitude of wife abuse in an urban setting of Saudi Arabia. The sensitiveness of this subject has possibly deterred researchers from addressing the problem in the Saudi community. Although the study data cannot be generalized to all Saudi women, the study does represent a large group of middle and lower socioeconomic level women who visit PHCCs for commonly occurring ailments and health maintenance.

PHCCs offer an ideal place to detect and help victims of abuse, because the clients usually develop a trusting relationship with the family physician or general practitioner [*21*]. One of the reasons for choosing this study setting was to discover whether victims report these incidents to their PHC physicians. It was felt that if prevalence estimates of wife abuse justified it, this information would help in formulating guidelines for screening patients for wife abuse at the PHC level. It would also help in determining the role of PHC physicians as providers of medical, social and psychological support to victims.

The refusal rate for participation of 32.5% is not unexpected, considering that the study population was from a health care setting and some patients would be too ill for interview, have urgent child/family care responsibilities or have husbands or male family members waiting to take them home. A refusal rate similar to this study (32%) was reported by Cox et al. who investigated domestic violence among attendees of a hospital emergency department in urban, northern Canada [*7*]. Peralta and Fleming in their study on intimate partner violence mentioned the same reasons as our study for refusals among family medicine clinic attendees in Wisconsin, United States of America (USA) [*22*].

The prevalence of physical and/or emotional abuse in our study relates to wives being ill-treated by husbands, whereas most such research in Europe and North America relates to acts of abuse by an "intimate partner", which includes the spouse, ex-spouse, current/former boyfriend or current/former dating partner [*10*]. Hence, comparisons of our data with these series should be viewed in the light of this difference. Nevertheless, comparison of Saudi data with that of other countries reflects the extent of the problem in intimate relationships in populations with different sociocultural customs.

The lifetime prevalence of women abused physically and emotionally in this study (57.7%) is similar to that reported among women attending a family practice clinic in Columbia, USA (55.1%) [*23*], as well as to findings from 5 Nordic countries (56%) [*8*]. However, a community-based study in Australia found a lower lifetime prevalence (28.5%) for domestic violence among middle-aged women [*24*] than our study, although their low response rate (56%) may have affected the results.

Studies conducted from emergency departments have reported lifetime prevalence for emotional and/or physical abuse ranging from 31% to 51% in different regions of the USA and Canada [5–7]; these figures are slightly lower than the prevalence rate found in this study which was conducted in PHCCs. The National Violence Against Women Survey in the USA found that 22.1% of American women had been abused physically by a current or former husband, co-habiting partner or boyfriend at some point in their lives since the age of 18 years [*25*]. This is close to the 26.9% for lifetime prevalence of physical abuse in the present study.

The prevalence of physical abuse during the last 12 months (25.7%) among Saudi women was much higher than that reported by women referred to gynaecology clinics in 5 Nordic countries (3.9%) [*8*], at community hospital emergency departments in the USA (14.4%) [*5*] and in a community survey of Norwegian women (18%) [*26*]. On the other hand, it is lower than figures reported for physical wife abuse in small-scale studies conducted in north India (42%–76%), south India (36%–38%) and Sri Lanka (60%) [*9*]. A variation in the prevalence of physical abuse found between these international studies and the current study can be explained by differences in the study settings, study design and characteristics of the population. On the other hand, in a culturally similar group of married, Arab women attending PHCCs in the Syrian Arab Republic [*1*], the prevalence of physical abuse during the past year (26%) was similar to our findings. In other groups of Arab women in Israel (30%) [*4*] and Egypt (30%) [*27*], the rate of physical abuse by a partner in the past 12 months was also close to our findings. However, a national community-based study from Egypt showed a lower prevalence than ours for physical abuse in the past year among ever married/partnered women (16%) [*4*] and this variation was

possibly because of differences in the study settings.

In Australia Mazza et al. reported a prevalence of 5.5% for severe physical abuse among middle-aged women in a community-based survey and 6.5% in a general practice study setting [*24*]. Our data show that the rate of severe physical abuse was high (16.3% of women) and this calls for the immediate attention of health and social service providers in the local region to institute appropriate interventions.

A prevalence of 32.8% in this study for emotional abuse without physical violence during the past year is also very high. International studies using a similar study instrument to ours (the Conflict Tactic Scale) as well as the Index of Spouse Abuse showed lower figures for non-physical abuse of women at university clinics in Columbia, USA (22.7%) [*23*], gynaecology clinics in the Nordic region (6.2%) [*8*], from a community-based study in Australia (11.3%) [*24*] and from a general practice clinic in Australia (20%) [*24*]. This raises the question whether differences exist in the characteristics of husbands from different cultures. The dynamics of the Arab nuclear family still generally reflect patriarchal power relations [*3*], even in these times of social change. Haj-Yahia's findings indicate that Arab men and women tend to justify violence of husbands towards wives if she is perceived to disobey or undermine his authority or fail to fulfil her obligations as a spouse and mother [*3*]. Although Islamic teachings do not support physical violence against a spouse, such traditions may still be prevailing in some families of the local community. In fact, a very small group of the abused study population (1.3%) believed in the traditional Arab views of accepting emotional abuse or even physical abuse such as slapping on the face from a husband.

Physical wife abuse was not significantly related to the age of the women. Others have made similar observations [*23*]. On the other hand, emotional abuse was significantly less common in younger (< 20 years) than older women (≥ 20 years). In this society, the early period of marriage is usually at younger ages (< 20 years) and emotional abuse by a husband is less likely to occur in this phase. Wijma et al. in the Nordic study also reported a lower frequency of abuse at younger ages (< 18 years) [*5*]. Sociodemographic and behavioural characteristics are known to be closely related to spouse abuse and this aspect of our study data will be published later.

As expected, the level of satisfaction with the marriage and relationship with the husband was better among the women who were not physically abused compared with those abused. However, emotional abuse failed to show this variation in the 2 groups of women. Possible reasons for this finding are that emotional abuse is a less serious marker and occurs more commonly than physical abuse, hence it may not be a dominant factor in the level of satisfaction with the marriage. Moreover, other factors which were not explored may be better predictors for these marital issues.

Early identification of spouse abuse is necessary to improve the health care response of victims. The present study showed that only one-third of the abused women in the subset population had discussed this issue with their PHC physician. The most important barriers to communication were patients' opinions about the physician, such as lack of trust because physicians were "strangers/outsiders", lack of faith in their skills to deal with social problems and lack of rapport. These concerns could be valid, considering the current local situation of PHC physicians and their training to deal with such issues. We found that all female PHC

physicians except one at the health centres studied were non-Saudi Arabian (although Arabic-speaking) and this cultural barrier was perhaps the reason for the reluctance of the abused women to discuss personal issues with doctors. Other patient barriers to not informing the PHC physician included lack of privacy in crowded PHC clinic settings and fear if husband was informed.

One of the limitations of the study was that information on wife abuse was self-reported by the women. Hence, the prevalence of abuse may be under- or overestimated. It is possible that traumatic events were under-reported because of social desirability bias or benevolence of the victims for the perpetrator of abuse. If such was the case, the prevalence rates of abuse in this study may have been slightly underestimated. It was difficult to validate the responses of the women since their husbands were not interviewed at the same time. As per World Health Organization recommendations [*12*] it is not appropriate to interview husbands at the time of the study for safety considerations for the victims as well as the interviewer. However, validity and reliability of the responses, as determined by the lie scale were encouraging, as only 1.5% of the women had a potential to lie. Another limitation of this cross-sectional study could be the recall bias in retrospective reporting of abusive events that occurred in the past year or during the lifetime of victims.

Eligible women who did not participate in the study due to acute illness, immediate family concerns (32.8%) or due to the sensitive nature of the study (1.3%) might be a group of wives who were different from the study group. Due to the urgent needs of most non-participants, it was difficult to get information about their demographic and other characteristics. Hence the prevalence rate of abuse might be slightly misrepresented.

It is difficult to know from the current data whether wife abuse occurred as a result of an abusive act perpetrated by the wife on the husband or was initiated by the husband. The sequence of events leading to the abusive acts was not explored and was beyond the scope of the study.

Recommendations

Given the high prevalence of abuse we found, our PHC physicians need training to be alert to the signs and symptoms of potential abuse in women reporting with injury, certain obstetric and gynaecological problems, psychosomatic diseases and psychiatric difficulties such as anxiety and depression. Health care providers need to attend not only to physical and psychosocial problems but also to helping in providing referrals to other specialties and counselling services, if needed, as well as legal services in cases of severe abuse.

Barriers to communication need to be reduced. Private rooms are needed in PHCCs for discussion sessions should there be any indication of abuse suffered by a woman. Moreover, physicians need to reassure their clients about the confidentiality of information and discuss safety issues with them. Provision of more female Saudi Arabian physicians in PHCCs may improve Saudi Arabian women's confidence in revealing and discussing issues of abuse. However, if special effort is made to train PHC physicians to identify and prioritize cases of abuse, provide support and handle them with care and empathy, physicians would gain the trust of the community even if they are non-Saudi Arabian.

Further studies are recommended on beliefs and practices concerning marriage in Saudi Arabian society. Such research should address the issue of husband abuse and the dynamics of abusive spouse relationships in the region.

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Violence against women

Violence by an intimate partner is one of the most common forms of violence against women.

WHO and partners collaborate to decrease violence against women through initiatives that help to identify, quantify and respond to the problem, including:

- Building evidence on the scope and types of violence in different settings. This is a key step in understanding the magnitude and nature of the problem at a global level.
- Developing guidance for Member States and health professionals to prevent violence and strengthen health sector responses to it.
- Disseminating information to countries and supporting national efforts to advance women's rights and prevent violence.
- Collaborating with international agencies and organizations to deter violence against women globally

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