

Knowledge, Detection, and Reporting of Domestic Violence among Family Medicine Residents of Eastern Province, Saudi Arabia

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Abstract

Introduction: Domestic violence (DV) is a global health-care problem, regardless of the socioeconomic backgrounds and education levels of the nations. Research has always shown that a woman is more likely to be abused by a spousal than by any other person.

Aim: This study aimed to assess the knowledge, detection, and reporting of DV among family medicine resident of Eastern Province, Saudi Arabia.

Materials and Methods: This is a prospective cross-sectional study conducted in the Eastern Province, Saudi Arabia, from November 2018 to September 2019. A modified self-administered questionnaire based on "The Physician Readiness to Manage Intimate Partner Violence Survey" developed and validated in the United States which was distributed among family medicine residents. Both descriptive and inferential statistics were conducted. $P = 0.05$ was considered statistically significant. All data analyses were performed using the SPSS version 20.

Results: There were 166 family medicine residents involved in this study. The mean age was 28.7 years old and majority were female with slightly more were resident 2 (29.5%). In this study, good and poor knowledge were found to be 50.6% and 49.4% of the family residents, respectively. Residents 1 (R1) showed the least knowledge, whereas Residents 2 (R2) showed more knowledge regarding intimate partner violence; however, this result did not differ significantly among the level of knowledge. The most commonly known identified risk factor of DV was alcohol/drugs. The percentage of DV as identified by the residents for the past 6 months was 21.7%. Only around 31.9% of the residents were able to screen new DV patients; however, around one-third (34.3%) of them do not currently screen DV.

Conclusion: There was a moderate level of knowledge regarding DV among the residents. Second level residents showed better knowledge than the other levels while the 1st year level exemplified the least. Alcohol/drugs were the frequently mentioned as the risk factors of DV. On the other hand, residents' practice of screening DV among the patients were found to be low.

Key words: Detection family medicine resident, Domestic violence, Intimate partner violence, Knowledge

INTRODUCTION

Domestic violence (DV) is a global health-care problem, regardless of the socioeconomic backgrounds and education levels of the nations. Research has always shown that a woman is more likely to be abused by a spousal than

by any other person.^[1] It refers to any violence take place in the home, including violence against children and the elderly.^[2]

Abuse can lead to significant consequences on the health of each member of the society. More than 1.6 million deaths can result worldwide every year. About 90% and more of these occur in low- and middle-income countries, and it is one of the leading causes of death in all parts of the world for persons ages 15–44.^[3]

The United Nations in 1993 defines violence against women^[4] as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental

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harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life.”^[5] In 1992, Centers for Disease Control and Prevention established the National Center for Injury Prevention and Control (NCIPC) as the primary federal organization for abuse determination. The Division of Violence Prevention is one of three divisions within NCIPC; their target is to prevent harms caused by violence.^[6]

International research always determines that a woman is more likely to be assaulted or abused by a current or former partner than by any other person. These studies indicate that a lifetime prevalence of partner violence is estimated between 20 and 50% of women who have ever been partnered.^[7] According to the WHO multicountry study on women’s health and DV, “lifetime prevalence of physical or sexual spousal abuse, or both, ranged from 15% to 71%, with two locations having a prevalence of less than 25%, seven between 25% and 50%, and six between 50% and 75%.”^[8] The findings confirm that physical and sexual partner violence against women is widespread.^[8]

In Arab, world’s studies regarding violence against women were conducted since the past decade. In 2009, a study in Jordan showed that percentages of women facing at least 1 form of control or abuse since marriage were control, 97.2%; psychological maltreatment, 73.4%; physical disorder, 31.2%; and sexual violence, 18.8%.^[9] Other study conducted in Egypt showed comparable results, 34% of women in the sample were ever assaulted by their current husband while 16% were beaten in the past year.^[1] In Saudi Arabia, different studies have addressed the problem of intimate partner violence (IPV) and another type of DV. In 2016, the prevalence of spousal abuse and its associated risk factors among Saudi female patients attending the primary health-care centers in Western Saudi Arabia concluded that one out of 10 women is a victim of spousal abuse in Taif, KSA. IPV or spousal abuse is significantly associated with a number of psychosocial factors. The detection of which might help to screen for individuals at risk.^[10] Other study was conducted in the Eastern Province concluded that DV is as common in Al-Ahsa as in other countries of the world with a lifetime prevalence of 39%.^[11] In a cross-sectional study by Fakeeh, about factors associated with IPV “Abused women had more children than non-abused women, and their spouses were significantly older than those of non-abused women. Financially dependent women and those with a high educational status were significantly more likely to report abuse. Assaulted women were also likely to report that their abuser was a smoker and had completed at least primary or secondary education. A significantly lower proportion of abused women said that their male partners were alcohol users. The results of logistic regression found

that financially dependent women had about 1.5-fold odds of being physically abused.”^[12]

The significance of the IPV as a public health problem because of its high prevalence and due to its massive impact not only on the women’s health but also the lives inside the womb. It is associated with severe health problems affecting both women and children, including injuries, gynecological disorders, mental health disorders, adverse pregnancy outcomes, and sexually transmitted infections.^[7,13]

Today, there are many international institutions against violence. More organizations, service providers, and policy-makers are recognizing that IPV has negative ramification for women’s health and the society.^[14]

Here, in Saudi Arabia, the council of ministers approved the regulations to protect against abuse in August 2013 by the law of protection from abuse.^[15] Hence, it was a great accomplishment regarding this public health problem and reflect the community acknowledgment and awareness of all aspects of health.

Since the family physician is the first contact with the patients in most health-care systems, he/she should be able to detect and report DV according to the laws and regulations available to his country. In many studies, this can be achieved by excellent staff and clinician training in effective patient-centered IPV assessment that ensures a safe and supportive environment for the patient,^[16] but unfortunately, many clinicians are unclear about their role in a multiagency response regarding DV.^[17,18]

The purpose of this research is to determine how ready are the family medicine residents of the Eastern Province, Saudi Arabia, in the field of detection and reporting DV. Since it is one of the top 50 topics in Saudi board family medicine curriculum,^[19] the focus will be on their current knowledge, how to detect and how to report such prevalent cases.

It is also the first study to be conducted in the Eastern Province of Saudi Arabia about the awareness of DV among family medicine resident, to assess their knowledge and clinical practice regarding IPV as the most prevalent type of DV worldwide^[4] and their essential role as first-line health-care provider. Hence, the study will evaluate our training progress in this field.

Aim and Objective

This study aims to assess the awareness, knowledge, detection, and reporting of DV among family medicine resident of Eastern Province, Saudi Arabia.

MATERIALS AND METHODS

This is a prospective cross-sectional study conducted in the Eastern Province, Saudi Arabia, from November 2018 to September 2019. A modified self-administered questionnaire based on “The Physician Readiness to Manage IPV Survey (PREMIS)” developed and validated in the United States.^[20] It contains five parts; responder profile, background, knowledge, opinions, and practice issues. The questionnaire was modified for use in the study, by deleting culturally sensitive items and the irrelevant items that did not reflect on result objectives. The survey was printed in hard copies and distributed by the primary investigator to the targeted subjects. Each subject needed approximately 25 min to complete the survey.

Study Subjects

All family medicine residents who were in training under Saudi Commission of Health Specialties in the Eastern Province, Saudi Arabia, were eligible in the study. The subjects were recruited when they attend the ½ day release activity for family medicine residents’ program by each center on Mondays after permission taken from each program director. A consecutive sampling technique had been applied and the sample size calculated using Raosoft

Website with maximum error allowed 5% (common choice), confidence level 95%, target population estimated to be 320, at least response rate 50% (recommended), total sample to be done is 175, since this was almost 50% of target population, we considered all residents at the visit time. Those residents not under training of family medicine program of Saudi Commission for Health Specialties in the Eastern Province were considered as excluded criterion.

Statistical Analysis

Descriptive statistics were presented as counts and proportion (%). The relationship between the level of knowledge and the sociodemographic characteristics of residents had been calculated using Chi-square test. *P* < 0.05 was considered as statistically significant. All statistical analyses were carried out using Statistical Packages for the Software Sciences version 20 (IBM SPSS, Chicago, Illinois, USA).

RESULTS

PREMIS questionnaires were distributed to 175 residents of Family Medicine Program in different levels in the Eastern Province, Saudi Arabia. There were 166

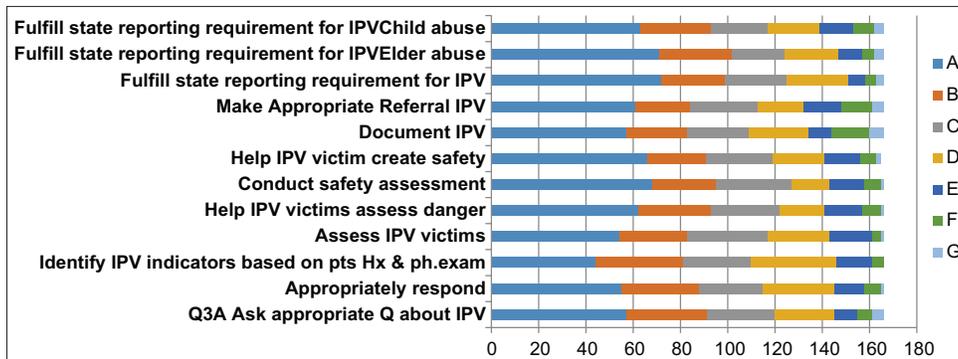


Figure 1: Which best describes how prepared are you to perform the following. A=Not prepared, B=Minimally prepared, C=Slightly prepared, D=Moderately prepared, E=Fairly well prepared, F=Well prepared, G=Quite well prepared

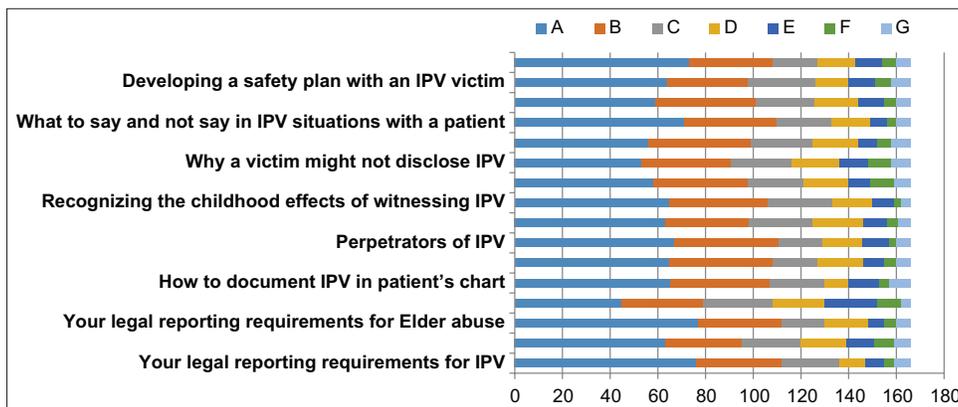


Figure 2: How much you feel you know about. A=Nothing, B=Very little, C=Little, D=Moderate, E=Fair, F=Quite abet, G=Very much

complete (94.8%) response rates, 30.7% were male and 69.3% were female. The mean age was 28.7 years old and the mean practice duration was 3.2 years across all levels [Table 1].

Perceived Preparation to Manage IPV Patients and Perceived Knowledge of IPV

Physician scores for perceived knowledge reflected those for perceived preparation. Levels of perceived preparation were low for all items. On all items across the two scales, there were no significant differences between residency levels.

One-third of the physicians, around 34.34% (57) find themselves not prepared to ask appropriate questions about IPV, where only 3% (5) were well prepared, the rest 64% were minimally to moderately prepared [Figure 1]. Furthermore, around 33% (55) were not prepared to respond to disclosures of abuse or to assess IPV victims, and only around 4.8% (8) think that they were well prepared, the rest 62% were minimally to moderately prepared to do so.

Almost 55.5% (92) responded as not to minimally prepared to help IPV victim to create safety plan, and only 5% (9)

think that they were well prepared to do so, the rest 39% were slightly to moderately prepared to help IPV victim to create safety plan [Figure 2].

Many physicians, around 36.7% (61), are not prepared to document IPV or even make appropriate referrals.

Around 45% of the responders report said that they know nothing about the legal reporting requirements for IPV, and only 4.2% (7) know very much. Almost, 27% (45) report said that they know nothing about signs or symptoms of IPV, and only around 17% (29) know little about them. More than 50% do not know how to document IPV in patient charts or referral sources for the victims and only 5% (9) have knowledge about them it.

Actual IPV Knowledge

For R1 level, majority of them (57%) have had poor knowledge, while 42.9% had good results. For R2 level, 40.8% poor, while 59.2% scores scored good. Regarding R3 level, 48.9% had poor knowledge and the rest 51.1% scores scored good results. Finally, for R4 level, 54.5% had poor knowledge and 45.5% had scores good. For items testing actual knowledge about IPV, there were no significant differences in scores between based on residency levels ($P = 0.460$) or gender ($P = 0.106$).

Female scores scored good knowledge around 54.5% more than males who had score scored good 41.2%. Regarding the strongest single risk factor for being an IPV victims, only 27.7% (46) had choose the correct answer (the gender as female), while the majority (47.6%) (79) think that partner abuse alcohol/drugs is the strongest risk factor. Around 39.8% were able to choose the correct response regarding what is true about the batterers as (they use violence as a mean of to control their victim).

The majority of residents had a poor understanding of the medical conditions associated with IPV, such as chronic unexplained pain, anxiety, substance abuse, and depression but most of them, 64% (107), agreed that frequent injures are associated with IPV. About 56% (93) of the residents choose children as the reasons why woman experiencing abuse may feel unable to leave the relationship. However, less than 30% thought that it was appropriate to ask directly

Table 1: Demographic characteristics of the responders

Variables	Frequency	Percentage
Residency level		
R1	28	16.90
R2	49	29.50
R3	45	27.10
R4	44	26.50
Sex, %		
Male	52	30.70
Female	115	69.30
Age		
Years, mean	28.7	
Practice years		
Mean	3.2	
Mean number of estimated patients per week		
<20	9	5.40
20–39	63	38.00
40–59	57	34.30
60+	36	21.70
Total	166	100

Knowledge groups * residency level groups cross tabulation

			Residency level groups				Total
			R1	R2	R3	R4	
Knowledge groups	Poor	Count	16	20	22	24	82
			57.1%	40.8%	48.9%	54.5%	49.4%
Good	Count	12	12	29	23	20	84
			42.9%	59.2%	51.1%	45.5%	50.6%
Total	Count	28	49	45	44	166	
		100.0%	100.0%	100.0%	100.0%	100.0%	

if the partner had ever hit or hurt the woman, and the majority 61% (102) prefer indirect asking.

Practice Issues: Detection and Reporting

Identifying abuse only 21.7% (36) of the residents had identified at least one new DV case in the preceding 6 months, and 60.8% (101) never identified DV cases.

Screening for IPV

About 34.3% (57) do not currently screen for DV and around 31.9% (53) screen new patients. Only 2.4% (4) screen pregnant women and female patients periodically. The majority of the responders do not screen teenagers or young adult women, were only 9% (15) screen single or divorced women for IPV. Almost 96.4% (160) of the resident do not screen married women and only 3.6% do screening. Only around 8% (14) of the resident were able to ask about possibility of IPV when seeing patients with injuries, chronic pelvic pain, IBS, headache, diarrhea, and anxiety.

How often in the past 6 months have you asked about possibility of IPV when seeing patients with the following

	Never to sometimes	nearly always	Always	N/A
Injuries	117 72.3%	13 7.8%	12 7.2%	21 12.7%
Chronic pelvic	134 80.6%	12 7.2%	2 1.2%	18 10.8%
Irritable bowel syndrome	133 80.1%	12 7.2%	6 3.6%	15 9.0%
Headache	131 78.9%	14 8.4%	6 3.6%	15 9.0%
Depression anxiety	113 68%	18 10.8%	14 8.4%	21 12.7%
Hypertension	138 83%	8 4.8%	3 1.8%	17 10.2%
Eating disorder	129 77.6%	16 9.6%	4 2.4%	17 10.2%

Majority of the responders 54.8% (91) were unsure about the protocol for dealing with adult IPV case at their centers and only 6.6% (11) were knowledgeable and used it, also, most of the residents 78.5% (122) are were not familiar with their institution's policies regarding screening and management of IPV victims, around 60% never document patient's statement of IPV in the patient chart or ever used a body map to document patient injures. Almost 4.2% (7) are able to notify appropriate authorities if IPV victim identified and conducted a safety assessment for them or for their children. About 48.2% (80) were unsure about availability of IPV patient education or resource materials at their practice centers and only 5.4% (9) were sure about them. Furthermore, 15% (26) feel that they have adequate referral resources for the victims, but 46.4% (77) were unsure.

DISCUSSION

This study sought to determine the knowledge, detection, and reporting of DV among family medicine residents of Eastern Province, Saudi Arabia. In this study, half of the residents were having a good knowledge toward DV while the rest had poor knowledge (49.4%). We further observed that among the residency levels, R2 showed better knowledge and it showed mostly among females. However, these results did not differ significantly among the group. The knowledge of clinicians toward DV varies with each region. In neighboring country,^[21] researchers reported that although knowledge and attitude score were not statistically significant predictors of DV; nonetheless, those physicians who were screening for violence had significantly higher mean percentage for overall knowledge score which corroborated our study findings. In Israel, Khan *et al.*,^[22] when they compared the knowledge and attitudes of family medicine and general practitioners (GPs), they found that family physicians reported more exposure to battered women and had better knowledge of its prevalence and its risk factors. They also showed a greater tendency to view the problem as universal which was not on the line with our results. In the United Kingdom,^[20] when they examined the knowledge, attitudes, and clinical practice of selected primary health-care clinicians. They found out that clinicians had basic knowledge about DV but exhibited a positive attitude toward engaging with women experiencing abuse. They further observed that GPs were more prepared and more knowledgeable than practice nurses, to which they can be able to identify a higher number of DV cases. In addition, in the United States,^[23] residents showed higher levels of background and knowledge of IPV than medical students and they further observed that being a resident, being female, and being confident about talking to patient regarding IPV was the predictors for increased clinical knowledge about IPV which showed better outcome compared to our study.

In this study, we identified that being a female, being abusive of alcohol/drugs, and frequent injuries are associated with IPV. Alcohol/drugs were also determined to being associated with DV which was reported by Ramsey *et al.*^[20] They further indicated that majority of the responders wrongly agreed that alcohol abuse is a leading cause of DV.

Identifying patient who was exposed to DV is necessary to provide the required intervention among the victim. In this study, residents were able to identify 21.7% of at least one new case of DV in the preceding 6 months. In contrast, there were 60.8% of residents never identified DV. This result is not consistent from the paper published by Ramsey *et al.*,^[20] among the 272 clinicians, 54% of the clinicians had identified at least one new DV case for the past 6 months which was higher than our study finding. On the other hand, Wenzel *et al.*^[24] reported that family medicine residents

were able to identify 5.4% DV cases at some points of their lives with 2.9% of them were self-reported being currently involved in abusive relationships while 2.2% relayed histories of past abuse which was lower than our outcome.

It is important to note that proper action is necessary in case a patient was exposed to DV. In this study, more than a half of the residents were uncertain about the protocol pertaining to DV cases with only 6.6% had sufficient knowledge about it. Moreover, the management and screening among IPV victims were also poorly exercised and documented and a relatively fewer IPV cases (7 cases) were able to refer to appropriate authorities for the necessary assessment and intervention. Likewise, a little below a half of them (48.2%) were not aware of IPV patient education or resource materials at the current health-care setting. These results are not congruent from the study published by Ramsey *et al.*^[20] They observed that between 36% and 48% of clinicians reported that they provided information, education, or counseling to the victim while 43% had made a referral to other agencies. Furthermore, the practice of documentation was also better compared to our study since, 70% of the clinicians were practicing documentation of abuse with 30% never or seldom provided referral or resource materials.

The practice of DV screening among injured patients was also poorly achieved in this study. Among the residents of all levels, 34.3% of them do not apply DV screening among injured patients, whereas 31.9% did it otherwise. This result corroborates with the paper of Ramsey *et al.*^[20] They accounted that 60.3% of the clinicians do not routinely ask about DV while Sugg *et al.*^[25] observed that 39.3% of the primary care providers expressed confidence in asking about physical abused among patients while 45% were never or seldom asked about DV when examining injured patients which was also in line with our study results.

CONCLUSION

There was a moderate level of knowledge regarding DV among the residents. Second level residents showed better knowledge than the other levels while the 1st year level exemplified the least. Alcohol/drugs were the frequently mentioned as the risk factors of DV. On the other hand, residents' practice of screening DV among the patients was found to be low. In consideration with the importance of DV as public health issue, more educations are needed regarding the importance of screening DV among the residents.

Recommendations

1. Improve guidelines regarding screening and management of IPV.

2. Mandate training of family medicine residents to practice the approved IPV screening and management guidelines.
3. Routine courses with contract renewal to ensure the effectiveness of the training.

Actions

1. To distribute the study to program directors and primary care centers chairmen.
2. To distribute appropriate pamphlets/brochures of guidelines summaries and how to notify IPV.

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