

Risk Factors for Spousal Physical Violence Against Women in Saudi Arabia

Journal of Interpersonal Violence

1–25

© The Author(s) 2017

Reprints and permissions:

sagepub.com/journalsPermissions.nav

DOI: 10.1177/0886260517696861

journals.sagepub.com/home/jiv



Halah M. Eldoseri¹ and Phyllis Sharps²

Abstract

This study aimed to explore selected risk factors for spousal physical violence (SPV) in women frequenting primary health care clinics (PHCs) in Saudi Arabia. A cross-sectional study design was conducted in six PHCs, where one-on-one, private interviews with 200 women were conducted using a standardized World Health Organization (WHO) violence against women questionnaire (v.10.0). SPV was reported by 45.5% of women. Husband-specific risk factors including alcohol or drug addiction, unemployment, control of wealth in the family, and physical aggression toward other men were significant predictors for SPV. A multisectoral approach should be implemented with focus on providers' training, women's safety, and involvement of men in violence prevention and intervention programs.

Keywords

domestic violence, alcohol and drugs, battered women, cultural contexts

Introduction

Intimate partner violence (IPV) against women is a prevalent public health problem, whether globally or in the Eastern Mediterranean region (EMR). It

¹The Arab Gulf States Institute in Washington, DC, USA

²Johns Hopkins University, Baltimore, MD, USA

Corresponding Author:

Halah M. Eldoseri, The Arab Gulf States Institute in Washington, 1050 Connecticut Avenue NW Suite 1060, Washington, DC 20036, USA.

Email: heldo001@gmail.com

poses a serious threat to women's mental and physical health, including depression, suicide and self-harm, chronic physical pain, gynecological problems, femicide, and poor functional health among other adverse health outcomes (Dillon, Hussain, Loxton, & Rahman, 2013). The global prevalence rate of physical and sexual IPV against women is estimated at 15% to 71% (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). A twofold increase in the identification of affected women was reported when health care providers screen for IPV, particularly in pregnant women who were found to be 4 times more likely to be identified (Taft, 2013). In the EMR, IPV prevalence rate is one of the highest globally at 37% (WHO, 2013a). A high prevalence rate was documented by the demographic national health surveys of Egypt (1:3 women) and Palestine (37%). In particular, high prevalence rate was documented in clinical samples (59%), conflict areas (44.7%), and in women of lower socioeconomic status (26.2%) in the EMR (Boy & Kulczycki, 2008; Haj-Yahia, 2001; Hammoury & Khawaja, 2007; Khawaja & Barazi, 2005; Maziak & Asfar, 2003). In Saudi Arabia, the prevalence of a physical IPV ranged from 25.7% to 45.5% (E. M. Afifi, Al-Muhaideb, Hadish, Ismail, & Al-Qeamy, 2011; Eldoseri, Tufts, Zhang, & Fish, 2014; Tashkandi & Rasheed, 2009).

Variations in the global prevalence rates of IPV can be explained by the prevalent risk factors in different countries. Identification of the country-specific risk factors is therefore necessary for planning prevention and intervention strategies (Stith, Smith, Penn, Ward, & Tritt, 2004). However, identifying the most significant predictors of IPV requires an understanding of the multidimensional nature of violence. Theorists have used several models, but the ecological model has been popularly employed to elucidate risk factors for violence in child abuse, youth violence, violence to the elderly, and IPV (Belsky, 1980; Garbarino & Crouter, 1978; Heise, 1998; Schiamberg & Gans, 1999; Tolan & Guerra, 1994). According to the model, interpersonal violence is a result of interaction of several risk factors at different levels of the social environment (Figure 1). Risk factors for IPV can be related to the woman, her husband/intimate partner, family, or institutions (Heise, 1998).

International studies on IPV have identified several risk factors for physical IPV. Studies on middle- to low-income countries revealed that men perpetrators are more likely to have witnessed parental violence in childhood, involved in physical fights, held permissive attitudes toward using violence against women, had unequitable gender attitudes, or were of older age (Fleming et al., 2015). Standardized population-based household-surveys revealed common risk factors for physical or sexual IPV, including lower educational and socioeconomic status for both the woman and her partner, recent history of abuse, history of parental violence, younger or older age of

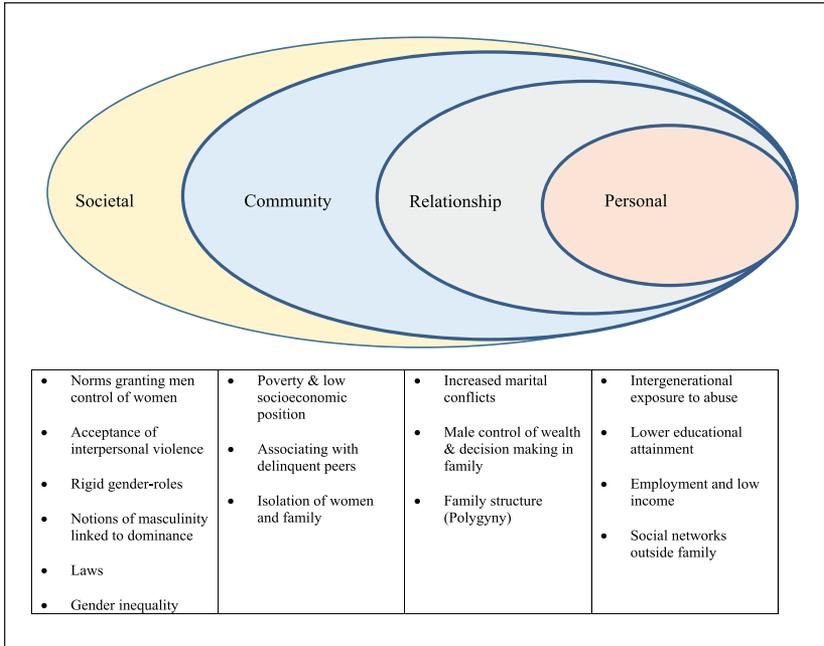


Figure 1. Risk factors for violence against women based on the socioecological model.

Source: Heise (1998).

a woman, supportive attitudes of a wife beating, relationship satisfaction, partner’s alcohol abuse, partner’s involvement in physical fights with other men, woman’s experience of sexual abuse before the age of 15 years, polygyny and less access of women to property rights (Abramsky et al., 2011; Heise & Kotsadam, 2015; Jesmin, 2015, Slep, Foran, Heyman, Snarr, & Usaf Family Advocacy Research Program, 2015). Male dominance and control of wealth in the family are strong predictors of violence against women, especially in societies where male dominance is endorsed in family relationships (Levinson, 1989). Women’s ownership of property or possessions was found to be protective from spousal violence across different cultures, and hence was included in this study (Vyas & Watts, 2009).

Likewise, EMR studies revealed similar risk factors for physical IPV, including rural residence, women’s financial dependency, lower educational attainment of a woman, younger or older woman’s age, history of exposure to domestic violence, younger age at marriage, longer duration of marriage, or acceptance of male dominance (Akmatov, Mikolajczyk, Labeeb, Dhaher, &

Khan, 2008; Boy & Kulczycki, 2008; Davoudi, Rasouljan, Asl, & Nojomi, 2014). In EMR studies, dominant men or men from patriarchal societies were found to be supportive of wife beating (Haj-Yahia, 1998; Yount & Li, 2009). Women employment, in low- to middle-income countries, had a mixed result as a risk factor for IPV; five studies found a protective effect while six studies found a risk association (Vyas & Watts, 2009). The majority of women and men in the EMR studies supported traditional gender roles and accepted at least one justification for wife beating (Boy & Kulczycki, 2008; Eldoseri et al., 2014; El-Zanaty & Way, 2006; Haj-Yahia, 1998; Khawaja, Linos, & El-Roueiheb, 2008). A multicountry study in Asia and Pacific countries found that violence against women was linked to cultural narratives which justify male domination and use of violence to maintain unequal gender power relations (Fulu, 2013). It is hypothesized that a husband's unemployment and a household poverty do not necessarily cause violence against women. Rather, a husband unemployment can affect the traditional provider role of the man in the family, thus causing stress, frustration, disagreement, and marital conflicts. Consequently, violence against women becomes a means for resolving male-identity crisis because it allows expression of power (Gelles, 1972; Jewkes, 2002). Men's use of physical aggression toward other men is a well-documented risk factor for violence against women (Abrahams, Jewkes, Laubscher, & Hoffman, 2006; Malamuth, Sockloskie, Koss, & Tanaka, 1991). Analysis of data from World Health Organization (WHO) multicountry study revealed that men perpetration of IPV was associated with a male-to-male violence rather than to neighborhood crime level (Kiss, 2015). Men's physical aggression toward other men, as a risk factor for IPV, was not well explored in the EMR.

In Saudi Arabia, women's related risk factors were found to be younger or older age, parental problems in childhood, lower or higher educational attainment, unemployment, or divorced status (Alzahrani, Abalkhail, & Ramadan, 2016; Barnawi, 2015; Bohlaiga et al., 2014; Fageeh, 2014; Tashkandi & Rasheed, 2009). Divorced women were found to be at an increased risk for IPV (Alzahrani et al., 2016; Barnawi, 2015; Tashkandi & Rasheed, 2009). Studies showed that women of higher educational levels were more respected by their husbands and they tended to have better choices of husbands in traditional societies (Clark, Hill, Jabbar, & Silverman, 2009; Maziak & Asfar, 2003). On the other hand, men's related risk factors included exposure to violence in childhood, smoking, alcohol and drug addiction, lower educational attainment, unemployment, military occupation, older age, and aggression toward other men (Z. Afifi, 2011; Alzahrani et al., 2016; Barnawi, 2015; Bohlaiga et al., 2014; Fageeh, 2014). Child physical abuse is prevalent in Saudi Arabia and reaches an alarming rate of 57.5% (Al-Eissa et al., 2015).

Although, alcohol consumption is prohibited based on the Islamic legal system of Saudi Arabia, higher rates of various substance abuse of 9% to 70.8% were recorded in the rehabilitation hospitals of Saudi Arabia (Bassiony, 2013). In addition, marital conflicts and dissatisfaction, longer duration of marriage, and having a higher number of children were identified as significant interpersonal risk factors (Z. Afifi, 2011; Barnawi, 2015; Bohlaiga et al., 2014; Tashkandi & Rasheed, 2009). Women in polygynous marriages were found to be at a significant risk for adverse mental health effects, somatization, lower marital satisfaction, lower self-esteem, and poor family functioning (Al-Krenawi & Graham, 2006). Polygyny is suggested to indirectly cause violence against women through its effect on increasing family stress, poor family functioning, and lower self-esteem in women (Hassouneh-Phillips, 2001; Maziak & Asfar, 2003). However, the link between polygyny and physical IPV was not consistently significant in the EMR studies. Therefore, polygyny was further explored as a potential risk factor for physical IPV in this study. Societal-related factors, such as gender norms and attitudes, were not explored extensively within Saudi Arabia in relation to IPV. In an earlier study, we found that 51% of women accepted wife beating if the women were cheating on their husbands (Eldoseri et al., 2014). The role of the extended family in the intervention against IPV is of a mixed nature. On one hand, the prevalent gender norms in Saudi Arabia prioritize maintaining familial ties and justify wife beating under certain conditions (Almosaed, 2004; Eldoseri et al., 2014). On the other hand, family is the main source of support for women experiencing IPV, though women viewed family intervention as harmful unless specifically requested (Clark et al., 2009). Saudi Arabia was ranked as 138 out of 145 countries based on indicators of gender gaps in economic participation and opportunities (Schwab et al., 2015). Women's employment and access to financial resources in Saudi Arabia are limited and among the lowest in the world. This is mainly due to the traditional social norms and government-restrictive policies, which limit women's opportunities in gender-mixed jobs (Al-Asfour & Khan, 2014; World Bank Group, 2016).

Background Overview of Women's Position in Saudi Arabia

Saudi Arabia is an absolute monarchy of an Islamic-based legal system. A woman is legally required, regardless of age, to obtain her male guardian's permission for basic rights such as obtaining passports, education, travel, or marriage. A male guardian is typically a woman's father, husband, or the next-of-kin male relative, including her son. A guardian's permission is widely institutionalized that officials would arbitrarily require a guardian's

permission even if it is not mandated by written policies or laws (Human Rights Watch, 2016). Women represent more than 50% of university graduates in Saudi Arabia, but only 21% of the labor force. Saudi Arabia was ranked as 134 out of 145 countries in gender gap scores, mainly due to limitations on economic and political participation of women (World Economic Forum & Global Gender Gap Report/Saudi Arabia, 2015). Marriages are traditionally arranged and approximately 50% of marriages are consanguineous. There is no legal minimum marital age and polygyny is permitted for up to four wives at the same time. Abortion is forbidden unless authorized by a medical committee, with the approval of both spouses, and only if a mother's health is at risk in case the pregnancy is not terminated (Mobaraki & Söderfeldt, 2010). Restrictions on work opportunities and mobility render women financially dependent on their male guardians with serious complications on women in abusive relationships. In addition, uncodified personal status laws restrict women's options for divorce and child custody and impede women's ability to leave violent homes (Eldoseri & Alsada, 2013).

In the past few years, Saudi Arabia has made several steps to allow women inclusion into the Royal Consultative Council, Municipalities, and the Chambers of Commerce boards as well as allowing women to study and work in law and engineering fields (Thompson, 2015). The Protection against Abuse Law was passed in 2013 and mandates reporting of abuse cases to relevant authorities (HRW, 2013). Educational and awareness sessions to various public sectors were recently introduced by several governmental organizations (SPA, 2015; SPA 2016a). A hotline center has been launched this year to receive reports of abuse with priority given to family reconciliation in order to maintain familial ties (SPA, 2016b). However, the law provided broad, nonspecific definition of violence and granted wide discretionary authority for social workers and judges to decide on the proper response. In addition, implementation is challenged by the traditional patriarchal norms and the weak coordination of response within different sectors. Moreover, the law failed to acknowledge the existing limitations on women's mobility to escape violent homes or to access phones to report abuse. Therefore, many women at risk for violence are unable to leave their homes to seek help or report abuse to hotlines (Aldosari, 2013; Saliba, 2013).

Health care in Saudi Arabia is universally available to all citizens and legal residents (Health System Law of 2002, Resolution No. 76). Primary health care Clinics (PHCs), as a first point of contact for women, are opportunistic venues for IPV prevention and intervention efforts. Referral and support services for women experiencing domestic violence are available within the health care facilities, but training of health care providers is inadequate (Zaher & Mason, 2014). In Saudi Arabia, intimate relationships customarily

take place among married couples, therefore we used the term *spousal physical violence (SPV) against women* throughout this article instead of physical IPV. We aimed to explore selected risk factors at various levels of the ecological model.

Method

We used a cross-sectional design study to conduct structured, one-to-one interviews with women visiting selected public PHCs in Jeddah city, Saudi Arabia. The study was conducted between March and June of 2012. The primary investigator conducted the interviews with eligible and consenting women in Arabic.

Sampling

We planned for a sample size of 165 women to reach a study power of 0.90 and an effect size of 0.4 when alpha is set at .05. We also increased the sample size by 25% to a total of 200 women, to account for potential under-reporting according to the WHO recommendations (WHO, 2001). Six clinics out of 80 PHCs in Jeddah city were selected to cover the main administrative regions: one each from the East, Central, West, South, and two from the North region. PHC selection was purposive and determined by the cooperation of clinic's administration and the availability of a private area for the researcher to conduct the interviews with consenting women. A total of 213 ever-married, Saudi women between the ages of 18 and 65 years were found eligible and were invited to participate at the beginning of their clinics' visits. Thirteen women did not show up for their interviews or got interrupted by their husbands before completing their interviews. We aimed to conduct 40 interviews per PHC in each region with the exception of the Northern region, in which we completed 40 interviews from two PHCs. In total, we completed 200 interviews from five regions and six PHCs.

Instrument and Measures

We used a standard, structured (WHO) violence against women survey tool (version 10.0) to collect the study data from participating women. The questionnaire was originally made of 12 sections: Respondent and her family, general health, reproductive health, children, current or most recent partner, attitudes toward gender roles, respondent and her partner, injuries, impact and coping, past experience, financial autonomy, and a completion of the interview section. Due to the study time constraints, we omitted the sections

on reproductive health, children, and impact and coping. In addition, we only asked about the spousal “physical” violence (SPV) against women. The questionnaire was translated into Arabic and back-translated to English and the accuracy of language, including idioms, was assessed by an expert Arabic–English linguist. The internal consistency of the physical violence construct of the questionnaire was very good ($\alpha = 0.82$) and comparable with similar studies (Garcia-Moreno et al., 2006; Schraiber Latorre Mdo, França, Segri, & D’Oliveira, 2010).

Personal risk factors included questions on women and their husbands’ history of childhood violence or witnessing their fathers beating their mothers in childhood, husband’s alcohol and drug addiction, woman’s sexual abuse before 15 years of age, and the woman’s and her husband’s educational attainment and employment status. Interpersonal factors included questions on the dynamics of the marital relationship including (a) a husband’s control of wealth in the family, (b) the frequency of marital conflicts and (c) polygyny. A husband control of wealth in the family is a composite variable made of four different categorical (yes/no) questions: (a) A wife’s ability to spend her own money, (b) if a wife refused a job because of her husband, (c) if a husband is taking his wife’s money by force, and (d) if a husband refused to give his wife any money; a husband was considered financially controlling if the participant answered “yes” to any of the four questions. Community-related risk factors were examined by asking the participant about (a) A husband’s aggression toward other men and (b) The social isolation of a woman. A husband’s aggression is identified by asking the woman if she witnessed her husband’s physical aggression toward other men (yes/no). A woman was considered socially isolated if a woman answered “no” to either of the two questions on: (a) If she is able to communicate with her own family and (b) If she can rely on her family if she needs to. SPV against women was measured by asking a woman a series of questions: “Has your husband ever (a) slapped you or thrown something at you that could hurt you? (b) pushed you or shoved you or pulled your hair? (c) hit you with his fist or with something else that could hurt you? (d) kicked you, dragged you, or beaten you up? (e) choked or burnt you on purpose? (f) threatened to use or actually used a gun, knife, or other weapon against you?” In each act of SPV against women, participants were asked if the act happened in the past 12 months or ever and about the frequency of each act (once, few times, several times). A woman is considered positive for SPV if she answered “yes” to any of the physical violence questions. Mild acts of SPV included a woman being slapped, pushed, shoved, or pulled by hair by her husband. Severe acts of SPV included a woman being

hit with a fist or something else that could hurt, being kicked, dragged, beaten up, choked, or burned on purpose (Ellsberg et al., 2001).

Protection of Human Subjects and Ethical Consideration

The study proposal, protocol, flyer, and notification statement were approved by the institutional review boards of Old Dominion University and the Saudi Ministry of Health. All study procedures adhered to the ethical and safety guidelines for research on domestic violence against women (WHO, 2001). An Arabic notification statement was read by the study investigator to inform each of the participants on the study purpose, risks involved in participation, measures taken to protect confidentiality, and of the participant's right to withdraw from participation at any time.

Data Analysis

SPSS statistical package (version 17.0) was used to analyze the data (SPSS Inc., Chicago, Illinois, USA). Descriptive statistics were presented as frequencies and percentages. Bivariate and multivariate analyses were conducted to assess the significance of various risk factors to predict SPV. Chi-square test was used to determine the significance of association in the bivariate analysis of various risk factors and SPV. Risk factors which were significantly associated with SPV in the bivariate analysis were included in the multivariate logistic regression model. Woman's age, educational level, husband's educational level and employment status, husband's substance abuse status, husband's control of financial capacity of the wife, frequency of marital conflicts, and husband's involvement in physical fights with other men were entered as significant predictors for SPV in the multivariate model. Statistical significance is set at $p < .05$ with 95% confidence intervals (CIs).

Results

Participants' Characteristics

Almost half (46%) of the women in the sample were between 31 and 50 years of age. Women younger than 30 years of age were more likely than women older than 50 years of age to report SPV in the last year. Differences in spousal age was not significantly associated with SPV. The majority of women (89.5%) were currently married. Divorced status was significantly related to lifetime reports of SPV. The majority of women (89%) were married only

once. Women's frequency of marriage and their lifetime reports of SPV were significantly associated (Table 1).

Prevalence of SPV Against Women in the Study Sample

Almost half of the participants (44.5%) reported a lifetime SPV, while 16% of women reported SPV in the last year. Mild to moderate acts of SPV were more commonly reported than severe acts (Figure 2). Violence-related injuries were reported by 18.5% of women, and 7% reported SPV-related injuries in the last year. However, only 6.5% of women reported the real cause of their injuries to a health care provider. In turn, this explains why only 9.5% of women have ever received a medical attention for their violence-related injuries.

Personal Risk Factors

Despite the high prevalence of sexual (25.5%) and physical violence (54.5%) reported by women in their childhood, both forms of violence were not significant predictors of SPV (Table 1). Past year SPV was significantly associated with a husband's childhood history of beating. Past year SPV was also associated with a woman or her husband witnessing their fathers beating their mothers in childhood (Tables 1 and 2). We found that women who were younger than 30 years were more likely to report SPV than older women (Table 3). The majority of women (85%) and their husbands (91.8%) were educated for at least 12 years. However, only a smaller proportion (26.5%) of the women earned any income compared with the majority (86.7%) of husbands. Women who reported unemployed husbands were more likely to report past year (Table 3). Women who reported that their husbands were substance abusers were 12.7 and 6.5 times more likely to report SPV ever and in the last year, respectively (Table 3).

Interpersonal Risk Factors

Polygynous marriages in the study participants (17%) were not significantly related to SPV. Women who reported a husband's control of their financial capacity were 3 times more likely to report ever SPV and almost 15 times more likely to report SPV in the last year (Table 3). Frequent marital conflicts were significant correlates of ever and past year SPV (Table 1). Women who experienced frequent marital conflicts were 2 and 17.6 times more likely to report ever and past year SPV, respectively (Table 3).

Table 1. Bivariate Analysis of Women's Characteristics by SPV Status.

Variable	SPV Ever			SPV Past year			p Value
	No (n = 111)	Yes (n = 89)	p Value	No (n = 111)	Yes (n = 89)	p Value	
	n (%)	n (%)		n (%)	n (%)		
Age of a woman							
18-30 years	35 (17.5)	22 (11.0)	.223	43 (21.5)	14 (7.0)	.012*	
31-50 years	45 (22.5)	47 (23.5)		76 (38.0)	16 (8.0)		
> 50 years	31 (15.5)	20 (10.0)		49 (24.5)	2 (1.0)		
Woman's educational level							
No education	20 (10.0)	10 (5.0)	.105	27 (13.5)	3 (1.5)	.611	
≤ 12 years	56 (28.0)	58 (29.0)		95 (47.5)	19 (9.5)		
> 12 years	35 (17.5)	21 (10.5)		46 (23.0)	10 (5.0)		
Woman's earning an income							
No	82 (41.2)	64 (32.2)	.398	124 (62.3)	22 (11.1)	.328	
Yes	28 (14.1)	25 (12.6)		43 (21.6)	10 (5.0)		
Woman's marital status							
Married	103 (51.5)	76 (38.0)	.037*	148 (74.0)	31 (15.5)	.283	
Divorced	2 (1.0)	9 (4.5)		10 (5.0)	1 (0.5)		
Widowed	6 (3.0)	4 (2.0)		10 (5.0)	0		
Woman's frequency of marriages							
Once	105 (52.5)	73 (36.5)	.016*	149 (74.5)	29 (14.5)	.884	
Twice	6 (3.0)	15 (7.5)		18 (9.0)	3 (1.5)		
Three times	0	1 (0.5)		1 (0.5)	0		
Woman was beaten in childhood							
No	52 (26.0)	39 (19.5)	.775	76 (38.0)	15 (7.5)	.508	
Yes	59 (29.5)	50 (25.0)		92 (46.0)	17 (8.5)		

(continued)

Table 1. (continued)

Variable	SPV Ever		p Value	SPV Past year		p Value
	No (n = 111)	Yes (n = 89)		No (n = 111)	Yes (n = 89)	
	n (%)	n (%)		n (%)	n (%)	
Woman experienced sexual abuse before 15 years of age						
No	88 (44.2)	60 (30.2)	.102	127 (63.8)	21 (10.6)	.239
Yes	23 (11.6)	28 (14.1)		41 (20.6)	10 (5.0)	
Woman witnessed her father beat her mother in childhood						
No	93 (47.9)	68 (35.1)	.565	140 (72.2)	21 (10.8)	.042*
Yes	17 (8.8)	16 (8.2)		24 (12.4)	9 (4.6)	
Woman in a polygynous marriage						
No	93 (47.0)	71 (35.9)	.346	136 (68.7)	28 (14.1)	.316
Yes	16 (8.1)	18 (9.1)		30 (15.2)	4 (2.0)	
Frequency of marital conflicts						
Rare	49 (24.5)	18 (9.0)	.00*	66 (33.0)	1 (0.5)	.00*
Sometimes/Often	62 (31.0)	71 (35.5)		102 (51.0)	31 (15.5)	
Social isolation of a woman from her family [^]						
Not socially isolated	44 (22.0)	34 (17.0)	.885	67 (33.5)	11 (5.5)	.353
Socially isolated	67 (33.5)	55 (27.5)		101 (50.5)	21 (10.5)	

Note. SPV = spousal physical violence.

*p value < .05 is considered significant.

[^]Composite variable.

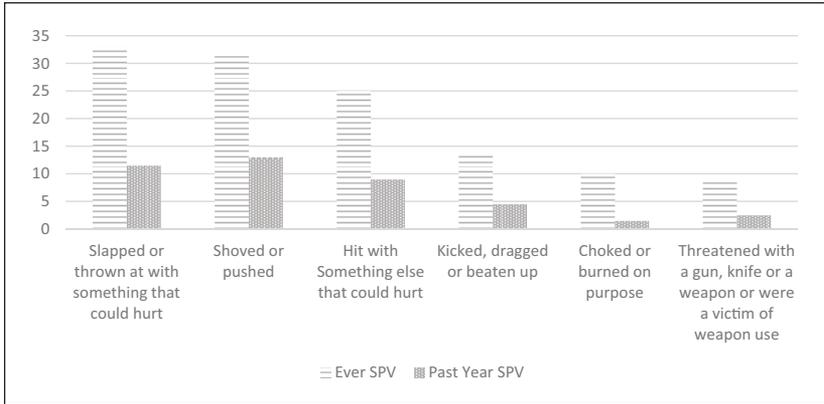


Figure 2. Proportions of ever and past year acts of SPV.

Note. SPV = spousal physical violence.

Community Risk Factors

A woman’s social isolation was not significantly associated with her risk for SPV (Table 1). Women who witnessed their husband’s involvement in physical fights with other men were 1 and 3.6 times more likely to report SPV ever and in the last year, respectively (Table 3). A woman’s ownership of possessions, such as land, house, car, private business, or savings at the bank—as proxies for a woman’s financial capacity—was not significantly associated with lower risk for SPV. The only exception was a woman’s ownership of jewelry, which was significantly associated with reports of ever SPV (Table 4). The majority of participants did not possess ownership of any type, whether as financial possessions or as an income from a job. Moreover, 33.2% of women reported that they cannot manage financially in case of an emergency.

Discussion

The high prevalence rate of SPV against women observed in this study is expected due to screening in a clinical setting. The observed high frequency of IPV in the PHCs of Saudi Arabia calls for establishing clinic-based protocols and rigorous training for health care providers on screening and intervention of violence. This is particularly important as the majority of women in this study did not disclose violent incidents or its related injuries to their health care providers. In addition, we found high reports of violence-related

Table 2. Bivariate Analysis of Husbands' Characteristics by SPV Status.

Variable	SPV Ever		p Value	SPV Past Year		p Value
	No	Yes		No	Yes	
	n (%)	n (%)		n (%)	n (%)	
	111 (55.5)	89 (44.5)		111 (55.5)	89 (44.5)	
Age						
18-30 years	14 (7.1)	9 (4.6)	.264	17 (8.7)	6 (3.1)	.058
31-50 years	55 (28.1)	54 (27.6)		88 (44.9)	21 (10.7)	
> 50 years	40 (20.4)	24 (12.2)		59 (30.1)	5 (2.6)	
Educational level						
No education	9 (4.6)	7 (3.6)	.037*	15 (7.7)	1 (0.5)	.015*
≤ 12 years	57 (29.2)	63 (32.3)		93 (47.7)	27 (13.8)	
> 12 years	40 (20.5)	19 (9.7)		55 (28.2)	4 (2.1)	
Employment status						
Not working	8 (4.1)	18 (9.2)	.010*	15 (7.7)	11 (5.6)	.001*
Working	101 (51.8)	68 (34.9)		148 (75.9)	21 (10.8)	
Husband was beaten in childhood						
No	35 (27.1)	26 (20.2)	.114	55 (42.6)	6 (4.7)	.013*
Yes	29 (22.5)	39 (30.2)		50 (38.8)	18 (14.0)	

(continued)

Table 2. (continued)

Variable	SPV Ever		p Value	SPV Past Year		p Value
	No	Yes		No	Yes	
	n (%)	n (%)		n (%)	n (%)	
	111 (55.5)	89 (44.5)		111 (55.5)	89 (44.5)	
Husband witnessed her father beat his mother in childhood						
No	65 (52.0)	46 (36.8)	.153	96 (76.8)	15 (12.0)	.048*
Yes	5 (4.0)	9 (7.2)		9 (7.2)	5 (4.0)	
Alcohol/drug addiction						
No	108 (54.3)	61 (30.7)	.000*	151 (75.9)	18 (9.0)	.00*
Yes	3 (1.5)	27 (13.6)		17 (8.5)	13 (6.5)	
Husband controls the wealth in the family [^]						
No	78 (39.0)	43 (21.5)	.002*	113 (56.5)	8 (4.0)	.00*
Yes	33 (16.5)	46 (23.0)		55 (27.5)	24 (12.0)	
Husband involved in physical fights with other men						
No	95 (48.0)	63 (31.8)	.032*	142 (71.7)	16 (8.1)	.00*
Yes	16 (8.1)	24 (12.1)		24 (12.1)	16 (8.1)	

Note. SPV = spousal physical violence.

*p value < .05 is considered significant.

[^]Composite variable.

Table 3. Multivariate Logistic Regression of Risk Factors for SPV.

Risk Factor	SPV Ever		SPV Past Year	
	OR (95% CI)	p Value	OR (95% CI)	p Value
Age of women				
18-30 years	REF		REF	
31-50 years	1.47 [0.65, 3.32]	.35	0.25 [0.07, 0.87]	.029*
> 50 years	1.20 [0.44, 3.30]	.72	0.02 [0.00, 0.33]	.005*
Woman's educational level				
No education	REF		REF	
< 12 years of education	1.20 [0.36, 3.95]	.77	0.31 [0.03, 2.87]	.31
> 12 years of education	0.74 [0.19, 2.89]	.67	0.74 [0.07, 7.92]	.80
Husband's educational level				
No education	REF		REF	
< 12 years of education	1.80 [0.45, 7.25]	.41	3.62 [0.28, 47.17]	.33
> 12 years of education	1.04 [0.22, 4.95]	.96	0.61 [0.31, 12.18]	.75
Husband's employment status				
Not working	REF		REF	
Working	0.36 [0.11, 1.20]	.09	0.19 [0.04, 0.97]	.046*
Husband's alcohol/drug addiction				
No	REF		REF	
Yes	12.70 [3.36, 48.03]	.000*	6.52 [1.56, 27.21]	.010*
Husband controls the financial capacity of the wife				
No	REF		REF	
Yes	3.05 [1.52, 6.12]	.002*	14.7 [3.89, 55.37]	.00*
Frequency of marital conflicts				
Rare	REF		REF	
Sometimes/often	2.30 [1.08, 4.91]	.031*	17.61 [1.89, 164.10]	.012*
Husband involved in physical fights with other men				
No	REF		REF	
Yes	1.04 [0.43, 2.50]	.93	3.55 [1.08, 11.65]	.04*

Note. SPV = spousal physical violence; CI = confidence interval.
 *p value < .05 is considered significant.

Table 4. Bivariate Analysis of Women’s Financial Capacity by SPV Status.

	SPV Ever		p Value	SPV Past Year		p Value
	No	Yes		No	Yes	
	n (%)	n (%)		n (%)	n (%)	
A woman’s ownership of	111 (55.5)	89 (44.5)		168 (84.0)	32 (16.0)	
Land						
No	101 (50.5)	83 (41.5)	.610	153 (76.5)	31 (15.5)	.237
Yes	10 (5.0)	6 (3.0)		15 (7.5)	1 (0.5)	
House						
No	103 (51.5)	86 (43.0)	.352	103 (51.5)	86 (43.0)	.352
Yes	8 (4.0)	3 (1.5)		8 (4.0)	3 (1.5)	
Private business						
No	110 (55.3)	88 (44.2)	.447	166 (83.4)	32 (16.1)	.839
Yes	0	1 (0.5)		1(0.5)	0	
Precious jewelry						
No	48 (24.0)	54 (27.0)	.016*	83 (41.5)	19 (9.5)	.200
Yes	63 (31.5)	35 (17.5)		85 (42.5)	13 (6.5)	
Car						
No	105 (52.5)	86 (43.0)	.734	160 (80.0)	31 (15.5)	.563
Yes	6 (3.0)	3 (1.5)		8 (4.0)	1 (0.5)	
Savings at the bank						
No	81 (40.5)	74 (37.0)	.092	128 (64.0)	27 (13.5)	.220
Yes	30 (15.0)	15 (7.5)		40 (20.0)	5 (2.5)	
A woman can manage financially in an emergency						
No	32 (16.1)	34 (17.1)	.173	54 (27.1)	12 (6.0)	.302
Yes	79 (39.7)	54 (27.1)		114 (57.3)	19 (9.5)	

Note. SPV = spousal physical violence.
 *p value < .05 is considered significant.

injuries of 18%, ranging from moderate to severe injuries, concurrent with findings of other studies in Saudi Arabia. The fact that women in this study readily disclosed sensitive information on their IPV violence experience and marital relationship dynamics to the study investigator, despite their reluctance to disclose it to health care providers, highlights the importance of training for health care providers on screening.

Our results showed that younger women were more likely to report past year SPV than women older than 31 years of age, possibly reflecting their recent exposure to SPV upon entry into marriage. Age of a woman was not consistently associated with higher risk for SPV in studies conducted in Saudi

Arabia or the EMR. The reason may be related to the fact that the experience of spousal violence maybe linked to culturally prevalent gender norms rather than age-related factor. We found that divorced women reported higher likelihood of SPV, in accordance with other international and regional studies. This finding warrants further investigation as to the context and dynamics of divorce as a predictor of SPV, as men in Saudi Arabia have a unilateral right to divorce and women can only apply for a judicial divorce, which is often complicated.

Our study found a significant association of a childhood history of violence in women and their husbands and their past year SPV. Our finding is consistent with the findings of other studies in Saudi Arabia; highlighting the need for primary prevention programs targeting both IPV and violence against children. The high likelihood of SPV observed in our study in women who reported husbands with a substance abuse addiction emphasizes the need for a safe and non-judgmental screening of women married to husbands with a substance abuse problems in PHCs. In Saudi Arabia, several factors may deter women from disclosing SPV due to a husband's addiction, including but not limited to, fear of loss of a husband's job or family income in case of a legal punishment or fear of social stigma and family isolation.

This study did not find a woman's education to have a protective effect on her risk for SPV. This may be attributed to the nature of the prevalent cultural norms which neutralize the impact of a woman's education by placing her at a subordinate position in the family regardless of her educational attainment. On the contrary, we found that a husband's education is significant in predicting a woman's risk for SPV, in parallel with the results of studies in Saudi Arabia or EMR. Moreover, this study did not find a protective effect for women's employment on her risk for SPV. This could be due to the small proportion of employed women in our study—and in Saudi Arabia in general—and the fact that women's autonomy in Saudi Arabia, regardless of their financial capacity, is predominantly controlled by their husbands. A husband's unemployment, on the contrary, was a significant risk factor for SPV in our study.

We found that increased marital conflicts, rather than polygyny, was a significant predictor of SPV, in accordance with the findings of similar studies. In Saudi Arabia, the institutionalized guardianship system elicits negative impacts on the egalitarian family relationships. Consequently, we found a significantly high likelihood of ever or past year SPV in women who reported financially controlling husbands. Women's reduced autonomy, due to their financial dependence on their husbands, renders them vulnerable for violence in Saudi Arabia. Husbands' physical aggression toward other men was also found to be a significant risk factor in this study for SPV; indicative of the adoption of violence as an expression of masculine power to resolve conflicts.

The finding is important in programming violence prevention strategies targeting men in Saudi Arabia. We did not find women's social isolation as a significant predictor for SPV, possibly because of the prevalent traditional norms which prioritize maintaining marital ties for the sake of children. Social isolation of women in our study was not associated with significant risk for SPV, perhaps due to the dual role of a woman's extended family in maintaining her marital relationship as a priority while emotionally supporting her.

The majority of women in our study (73%) were unemployed. However, participants' ownership of precious jewelry was the only factor significantly associated with risk for SPV. This is not surprising as the possession of jewelry by women in Saudi Arabia, and the Arab countries in general, is a customary practice to store wealth. Women are awarded precious jewelry by family members, spouses, and friends at life milestones, such as birth, engagement, marriage, and when giving birth, thus making jewelry a readily accessible form of wealth compared with other possessions. However, a considerable proportion of women in this study (66.8%) declared their inability to manage financially in an emergency. This finding points to the need for financial support for women as part of the domestic violence response strategy.

Limitations

Although we resorted to convenience sampling technique, we tried to enhance the representation of the women by sampling from PHCs at different geographic regions of Jeddah city. However, the findings of study only reflect women of similar socioeconomic status who frequent urban PHCs. The study did not include the legal non-national residents or the more affluent Saudi women who may use private or other means of health care services. Due to the gender-segregation norms in Saudi Arabia, women's response to questions about the husbands' behavior outside the home may not be accurately reported. Similarly, answers to questions on childhood history of women or their husbands may have been impacted by recall bias. Due to time constraints, we did not check the women's reports of violence-related injuries with their medical records, which may have resulted in an over- or under-reporting of violence-related injuries. The Saudi interviewer may have been viewed as an authority figure and this may have resulted in an undetermined effect on women's disclosure of sensitive information.

Conclusion

This study revealed three important findings, namely, the under-reporting of SPV or its related injuries to health care providers, the limited access of

participating women to financial resources, and the significance of husbands' characteristics as determinants for SPV more than women's characteristics. Under-reporting of SPV, and its related injuries, to primary health care providers highlights the need to implement WHO policy and clinical guidelines at PHCs as first points of response (WHO, 2013b). Currently, there is no training or standards of care available for health care providers in PHCs. Women who require documentation of violence-related injuries from a PHC can be referred to a specialized regional hospital with a letter disclosing the reason for referral in English, thus subjecting them to a potential retaliation by abusers which may block the care. Policy implications should consider measures of confidentiality, documentation of abuse, and multisectoral approach in the management of cases. Providers' training at various levels of care is highly recommended as women readily disclosed violence and sensitive information to the interviewer in this study. Particular care should target high-risk groups, such as women who are married to husbands with a substance abuse problem. On a country level, national campaigns targeting non-egalitarian gender roles and cultural justification of wife beating should be carried out to support healthier spousal relations and to reduce gender-based violence. Criminalization of violence should be enforced and monitored by the state. Financial autonomy of women should be addressed in the intervention and prevention programs to reduce their financial dependence on violent spouses.

Research should address men's views and behaviors in the perpetration of SPV, particularly in cases of substance abuse. Advocacy programs should be research-based and targeting men and women at higher risk for SPV.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

- Abrahams, N., Jewkes, R., Laubscher, R., & Hoffman, M. (2006). Intimate partner violence: Prevalence and risk factors for men in Cape Town, South Africa. *Violence and Victims, 21*, 247-264.
- Abramsky, T., Watts, C. H., Garcia-Moreno, C., Devries, K., Kiss, L., Ellsberg, M., . . . Heise, L. (2011). What factors are associated with recent intimate partner

- violence? Findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health*, 11, 109.
- Affifi, E. M., Al-Muhaideb, N. S., Hadish, N. F., Ismail, F. I., & Al-Qeamy, F. M. (2011). Domestic violence and its impact on married women's health in Eastern Saudi Arabia. *Saudi Medical Journal*, 32, 612-620.
- Affifi, Z. (2011). Determinants of domestic violence against women in an Eastern Saudi community. *Journal of Epidemiology & Community Health*, 65(Suppl. 1), A42. Retrieved from http://jech.bmj.com/content/65/Suppl_1/A42.3.citation-tools
- Akmatov, M. K., Mikolajczyk, R. T., Labeeb, S., Dhaher, E., & Khan, M. M. (2008). Factors associated with wife beating in Egypt: Analysis of two surveys (1995 and 2005). *BMC Women's Health*, 8, 15.
- Al-Asfour, A., & Khan, S. A. (2014). Workforce localization in the Kingdom of Saudi Arabia: Issues and challenges. *Human Resource Development International*, 17, 243-253.
- Aldosari, H. (2013). Saudi Arabia: The devil in details. *Aljazeera*. Retrieved from <http://www.aljazeera.com/indepth/opinion/2013/09/201393134730602749.html>
- Al-Eissa, M. A., AlBuhairan, F. S., Qayad, M., Saleheen, H., Runyan, D., & Almuneef, M. (2015). Determining child maltreatment incidence in Saudi Arabia using the ICAST-CH: A pilot study. *Child Abuse & Neglect*, 42, 174-182. doi:10.1016/j.chiabu.2014.08.016
- Al-Krenawi, A., & Graham, J. R. (2006). A comparison of family functioning, life and marital satisfaction, and mental health of women in polygamous and monogamous marriages. *International Journal of Social Psychiatry*, 52, 5-17.
- Almosaed, N. (2004). Violence against women: A cross-cultural perspective. *Journal of Muslim Minority Affairs*, 24, 67-88.
- Alzahrani, T., Abaalkhail, B. A., & Ramadan, I. K. (2016). Prevalence of intimate partner violence and its associated risk factors among Saudi female patients attending the primary healthcare centers in Western Saudi Arabia. *Saudi Medical Journal*, 37, 96-99. doi:10.15537/smj.2016.1.13135
- Barnawi, F. H. (2015). Prevalence and risk factors of domestic violence against women attending a primary care center in Riyadh, Saudi Arabia. *Journal of interpersonal violence*. doi:10.1177/0886260515587669.
- Bassiony, M. (2013). Substance use disorders in Saudi Arabia: Review article. *Journal of Substance Use*, 18, 450-466.
- Belsky, J. (1980). Child maltreatment: An ecological integration. *American Psychologist*, 35, 320.
- Bohlaiga, A., Al-Kakhli, B., Al-Mattar, H., Al-Bahrani, I., Al-Lowaim, K., Al-Baqshi, M., . . . Al-Hammad, Z. (2014). Prevalence and risk factors of abuse against married women in Eastern Saudi Arabia. *Journal of General Practice*, 2, 2.
- Boy, A., & Kulczycki, A. (2008). What we know about intimate partner violence in the Middle East and North Africa. *Violence Against Women*, 14, 53-70.
- Clark, C. J., Hill, A., Jabbar, K., & Silverman, J. G. (2009). Violence during pregnancy in Jordan its prevalence and associated risk and protective factors. *Violence Against Women*, 15, 720-735.

- Davoudi, F., Rasoulilian, M., Asl, M. A., & Nojomi, M. (2014). What do victims of physical domestic violence have in common? A systematic review of evidence from Eastern Mediterranean countries. *Women's Health Bulletin, 1*, e20155.
- Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: A review of the literature. *International Journal of Family Medicine*.
- Eldoseri, H., & Alsadah, N. Unfulfilled promises (2013). Joint Submission Report (JS4) for the 2nd Universal Periodic Review of Saudi Arabia. Human Rights Council. Cosponsored by the International Federation for Human Rights (FIDH) and the Coalition for Equality without reservation.
- Eldoseri, H., Tufts, K., Zhang, Q., & Fish, J. (2014). Adverse health effects of spousal violence among women attending Saudi Arabian primary health-care clinics. *Eastern Mediterranean Health Journal, 20*, 11.
- Ellsberg, M., Heise, L., Pena, R., Agurto, S., & Winkvist, A. (2001). Researching domestic violence against women: Methodological and ethical considerations. *Studies in Family Planning, 32*(1), 1-16. Retrieved from <http://www.jstor.org/stable/2696292>
- El-Zanaty, F., & Way, A. (2006). *Egypt Demographic and Health Survey 2005*: Ministry of Health and Population, National Population Council, Cairo, Egypt. El Zanaty Associates, and ORC Macro.
- Fageeh, W. M. (2014). Factors associated with domestic violence: A cross-sectional survey among women in Jeddah, Saudi Arabia. *BMJ Open, 4*, e004242.
- Fleming, P. J., McCleary-Sills, J., Morton, M., Levitov, R., Heilman, B., & Barker, G. (2015). Risk factors for men's lifetime perpetration of physical violence against intimate partners: Results from the international men and gender equality survey (IMAGES) in eight countries. *PLoS ONE, 10*, e0118639.
- Fulu, E., Warner, X., Miedema, S., Jewkes, R., Roselli, T., & Lang, J. (2013). Why do some men use violence against women and how can we prevent it. *Quantitative Findings from the United Nations Multi-Country Study on Men and Violence in Asia and the Pacific*. Bangkok: United Nations Development Programme, United Nations Population Fund, United Nations Women and United Nations Volunteers.
- Garbarino, J., & Crouter, A. (1978). Defining the community context for parent-child relations: The correlates of child maltreatment. *Child Development, 49*, 604-616.
- Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *The Lancet, 368*, 1260-1269.
- Gelles, R. J. (1972). *The violent home: A study of physical aggression between husbands and wives*. Beverly Hills, CA: Sage.
- Haj-Yahia, M. M. (1998). A patriarchal perspective of beliefs about wife beating among Palestinian men from the West Bank and the Gaza Strip. *Journal of Family Issues, 19*, 595-621.
- Haj-Yahia, M. M. (2001). The incidence of witnessing interparental violence and some of its psychological consequences among Arab adolescents. *Child Abuse & Neglect, 25*, 885-907.

- Hammoury, N., & Khawaja, M. (2007). Screening for domestic violence during pregnancy in an antenatal clinic in Lebanon. *The European Journal of Public Health, 17*, 605-606.
- Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women, 4*, 262-290.
- Heise, L. L., & Kotsadam, A. (2015). Cross-national and multilevel correlates of partner violence: An analysis of data from population-based surveys. *The Lancet Global Health, 3*, e332-e340.
- Human Rights Watch (HRW). (2013). *Saudi Arabia: New law to criminalize domestic abuse*. Beirut.
- Human Rights Watch (HRW). (2016). *Boxed in: women and Saudi Arabia's male guardianship system*. Beirut, Lebanon: Author. Retrieved from https://www.hrw.org/sites/default/files/report_pdf/saudi-arabia0716web.pdf
- Jesmin, S. S. (2015). Social determinants of married women's attitudinal acceptance of intimate partner violence. *Journal of Interpersonal Violence*. doi: 10.1177/088620515597436
- Jewkes, R. (2002). Intimate partner violence: Causes and prevention. *The Lancet, 359*, 1423-1429.
- Khawaja, M., & Barazi, R. (2005). Prevalence of wife beating in Jordanian refugee camps: Reports by men and women. *Journal of Epidemiology & Community Health, 59*, 840-841.
- Khawaja, M., Linos, N., & El-Roueiheb, Z. (2008). Attitudes of men and women towards wife beating: Findings from Palestinian refugee camps in Jordan. *Journal of Family Violence, 23*, 211-218.
- Kiss, L., Schraiber, L. B., Hossain, M., Watts, C., & Zimmerman, C. (2015). The link between community-based violence and intimate partner violence: the effect of crime and male aggression on intimate partner violence against women. *Prevention science, 16*(6), 881-889.
- Levinson, D. (1989). *Family violence in cross-cultural perspective*. Newbury Park, CA: Sage.
- Malamuth, N. M., Sockloskie, R. J., Koss, M. P., & Tanaka, J. (1991). Characteristics of aggressors against women: Testing a model using a national sample of college students. *Journal of Consulting and Clinical Psychology, 59*, 670-681.
- Maziak, W., & Asfar, T. (2003). Physical abuse in low-income women in Aleppo, Syria. *Health Care for Women International, 24*, 313-326.
- Mobaraki, A. E. H., & Söderfeldt, B. (2010). L'inégalité entre hommes et femmes en Arabie saoudite et ses conséquences sur la santé publique [Gender inequity in Saudi Arabia and its role in public health]. *Eastern Mediterranean Health Journal, 16*, 113.
- Saliba, I. (2013). Saudi Arabia: New regulation on protection against abuse. *Global Legal Monitor*. Retrieved from <http://www.loc.gov/law/foreign-news/article/saudi-arabia-new-regulation-on-protection-against-abuse/>
- Saudi Press Agency (SPA). (2015). *Family Protection Day, workshops and lectures to educate youth and families on violence*. Retrieved from <http://www.alyaum.com/article/4099901>

- Saudi Press Agency (SPA). (2016a). *Minister of Social Affairs approves a "relief" awareness campaign for domestic violence*. Retrieved from <http://www.alyaum.com/article/4134903>
- Saudi Press Agency (SPA). (2016b). *Social Affairs Minister Launches domestic violence reporting center*. Retrieved from <http://www.al-jazirahonline.com/news/2016/20160321/77507>
- Schiamborg, L. B., & Gans, D. (1999). An ecological framework for contextual risk factors in elder abuse by adult children. *Journal of Elder Abuse & Neglect, 11*, 79-103.
- Schraiber, L. B., Latorre Mdo, R., França, I., Jr., Segri, N. J., & D'Oliveira, A. F. (2010). Validity of the WHO VAW study instrument for estimating gender-based violence against women. *Revista de saude publica, 44*, 658-666.
- Schwab, K., Samans, R., Zahidi, S., Bekhouche, Y., Ugarte, P.P., & Ratcheva, V. (2015). *The Global Gender Report 2015*. 10th Anniversary Edition, the World Economic Forum Publication.
- Slep, A. M. S., Foran, H. M., Heyman, R. E., Snarr, J. D., & Usaf Family Advocacy Research Program. (2015). Identifying unique and shared risk factors for physical intimate partner violence and clinically-significant physical intimate partner violence. *Aggressive Behavior, 41*, 227-241.
- Stith, S. M., Smith, D. B., Penn, C. E., Ward, D. B., & Tritt, D. (2004). Intimate partner physical abuse perpetration and victimization risk factors: A meta-analytic review. *Aggression and Violent Behavior, 10*, 65-98.
- Taft, A., O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L., & Feder, G. (2013). Screening women for intimate partner violence in healthcare settings. *The Cochrane Library*.
- Tashkandi, A., & Rasheed, P. (2009). Wife abuse: A hidden problem. A study among Saudi women attending PHC centres. *Eastern Mediterranean Health Journal, 15*, 1242-1253.
- Thompson, M. C. (2015). Saudi women leaders: challenges and opportunities. *Journal of Arabian Studies, 5*, 15-36. doi:10.1080/21534764.2015.1050880
- Tolan, P., & Guerra, N. (1994). *What works in reducing adolescent violence*. Boulder, CO: The Center for the Study and Prevention of Violence.
- Vyas, S., & Watts, C. (2009). How does economic empowerment affect women's risk of intimate partner violence in low and middle income countries? A systematic review of published evidence. *Journal of International Development, 21*, 577-602.
- World Bank Group. (2016). *Women, business and the law 2016: Getting to equal*. Washington, DC: World Bank. License: Creative Commons Attribution CC BY 3.0 IGO. doi:10.1596/9781-1-4648-0677-3.
- World Economic Forum & Global Gender Gap Report/Saudi Arabia. (2015). Retrieved from <http://reports.weforum.org/global-gender-gap-report-2015/economies/#economy=SAU>
- World Health Organization. (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women*. Geneva, Switzerland: Author.

- World Health Organization (WHO). (2013a). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva, Switzerland: Author.
- World Health Organization (WHO). (2013b). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, Switzerland: Author.
- Yount, K. M., & Li, L. (2009). Women's "justification" of domestic violence in Egypt. *Journal of Marriage and Family, 71*, 1125-1140.
- Zaher, E., & Mason, R. (2014). Saudi Family-Medicine Residents' readiness to manage partner violence: A needs assessment study. *Middle East Journal, 12*, 14-19.

Author Biographies

Halah M. Eldoseri, PhD, is a visiting scholar at the Arab Gulf States institute at Washington D.C. Her research focuses on the impact of gender norms on women's health, legal position and access to resources in Saudi Arabia and the Arab Gulf States.

Phyllis Sharps, PhD, RN, FAAN, is a professor of community and public health nursing and the associate dean for community programs and initiatives at the School of Nursing, Johns Hopkins University. She is involved in an ongoing community-based participatory research of maternal and child health nursing and intimate partner violence.