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Prevalence and associated factors of domestic violence among women attending primary healthcare centres in Kuwait: A cross-sectional study

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Abstract

Domestic violence (DV) against women is a global problem. Its prevalence varies from region to region. Almost one-third of women are victims of DV worldwide. Various forms of violence against women have been identified, including physical, sexual, psychological, economic violence, and husband-controlling behaviour. The study was designed to estimate the prevalence of different types of DV among women attending primary healthcare (PHC) centres in Kuwait. We conducted a multicentre cross-sectional study among married or previously married women aged 18 to 65 years, attending the selected PHC centres over 29 months (February 2017 to June 2019). The inclusion criteria were married or previously married women aged 18-65 years, while certain groups such as never-married females, severely ill individuals, and those refusing to participate were excluded. 337 A comprehensive questionnaire covering the general characteristics of the participating women, exposure to different types of domestic violence, family characteristics, and husband characteristics. 337 women (56.1%) out of 601 were exposed to one or more types of DV. By type of violence, 255 women (42.4%) were exposed to psychological violence, 211 (35.1%) were exposed to physical violence, 173 (28.8%) were exposed to sexual violence, and 249 (41.4%) were exposed to economic violence. Having controlling behaviours was a significant predictor of exposure to all types of DV (P-value < 0.001). DV is a hidden problem that is still under-reported in Kuwait. We conclude that health professionals in different healthcare settings in Kuwait should be encouraged to document DV cases and conduct comprehensive surveys to disclose the nature and extent of the problem. *(Afr J Reprod Health 2023; 27 [11]: 33-43).*

Keywords: Prevalence; domestic violence; women; healthcare centres; kuwait

Résumé

La violence domestique (VF) contre les femmes est un problème mondial. Sa prévalence varie d'une région à l'autre. Près d'un tiers des femmes sont victimes de violence domestique dans le monde. Diverses formes de violence contre les femmes ont été identifiées, notamment la violence physique, sexuelle, psychologique, économique et le comportement de contrôle du mari. L'étude a été conçue pour estimer la prévalence de différents types de DV parmi les femmes fréquentant les centres de soins de santé primaires (SSP) au Koweït. Nous avons mené une étude transversale multicentrique auprès de femmes mariées ou déjà mariées âgées de 18 à 65 ans, fréquentant les centres de SSP sélectionnés pendant 29 mois (février 2017 à juin 2019). Les critères d'inclusion étaient les femmes mariées ou déjà mariées âgées de 18 à 65 ans, tandis que certains groupes tels que les femmes jamais mariées, les personnes gravement malades et celles refusant de participer ont été exclus. 337 Un questionnaire complet couvrant les caractéristiques générales des femmes participantes, l'exposition à différents types de violence domestique, les caractéristiques familiales et les caractéristiques du mari. 337 femmes (56,1%) sur 601 ont été exposées à un ou plusieurs types de DV. Par type de violence, 255 femmes (42,4%) ont été exposées à des violences psychologiques, 211 (35,1%) ont été exposées à des violences physiques, 173 (28,8%) ont été exposées à des violences sexuelles et 249 (41,4%) ont été exposées à des violences économiques. . Avoir des comportements de contrôle était un prédicteur significatif de l'exposition à tous les types de DV (valeur P <0,001). La VD est un problème caché qui est encore sous-estimé au Koweït. Nous concluons que les professionnels de la santé des différents établissements de soins au Koweït devraient être encouragés à documenter les cas de VD et à mener des enquêtes approfondies pour révéler la nature et l'étendue du problème. *(Afr J Reprod Health 2023; 27 [11]: 33-43).*

Mots-clés: Prévalence, violence domestique, femmes, centres de santé Koweït

Introduction

Domestic violence (DV) against women is a global problem. It has no cultural, geographic, religious, social, economic, or national boundaries. It is viewed as one of the gravest violations of human rights[1]. The United Nations defines violence against women as "any act of gender-based violence that results (or is likely to result) in physical, sexual or mental harm to women, occurring in public or private life"[2]. The prevalence of DV alters from region to region. According to the World Health Organization (WHO), almost one-third of women were victims of DV in 2014 worldwide[3]. These estimates may be far less than what happens in real life, as violence against women and girls remains a largely concealed problem that only a few females dare to admit openly[4,5].

Various forms of violence against women include physical, sexual, psychological, and economic violence[6,7]. Physical violence is the use of physical force against a person, including being slapped, pushed, hit with a fist, kicked, dragged, threatened with a weapon, having a weapon used against the female partner, or deprivation of a person of access to adequate food, water, clothing, shelter, rest, or subjecting a person to inhuman treatment[8]. Sexual violence refers to the forceful engagement of a person in sexual contact, including being forced to have sexual intercourse against her will; having sexual intercourse because she was afraid of what her partner might do; or being forced to do sexual acts that she found humiliating or degrading[9,10]. Emotional, verbal, or psychological abuse is any conduct that makes another person feel constantly unhappy, miserable, humiliated, afraid, jittery, or worthless[11,12]. Lastly, economic abuse involves threatened deprivation of financial resources or hindering the use of the property to which a person has a material interest or is entitled by law[13].

Violence against women involves manipulating and coercing women, which is a serious issue in Kuwait[14]. Given the social and cultural framework of Kuwaiti society's patriarchal ideology and system, it is easy to comprehend how violence against women contributes to the husband's continued domination over his wife and the maintenance of his power and control over her[15,16]. A study of 248 married women who visited Kuwaiti obstetric clinics during their pregnancies indicated that 7% of women received injuries, 8% reported recent physical abuse, and 3% claimed that their spouses had used weapons to assault them physically[17].

In Kuwait, few studies have been conducted about DV among women. Data from a survey conducted in 2017 in Kuwait City found that 71% of women were physically assaulted; 81% were sexually abused; 89% were mentally tortured; 75% were mistreated because of cultural or religious reasons; and 65% were battered[18]. While the 2017 study by Al-Kazi et al. laid essential groundwork for understanding DV in Kuwait, our current research delves deeper into the issue by offering updated data on DV prevalence, specifically among women accessing PHC services, and by examining a wider range of DV types. This approach aims to address the evolving nature of DV and its potential impact on the health and well-being of women in Kuwait.

Methods

Study design and settings

We conducted a multicentre cross-sectional study according to the STROBE Statement Checklist for Cross-Sectional Studies[19] and STROCSS 2021: Strengthening the Reporting of the cohort, cross-sectional and Case-control Studies in Surgery[20]. The study was conducted in 10 PHC centres in Kuwait (two centres from each health region). The study was conducted over 29 months, from February 2017 to June 2019.

Inclusion and exclusion criteria

Married or previously married women aged 18 – 65 years old, attending the selected PHC centres during the fieldwork, and consenting to participate in this study were included. Never-married females, severely ill, unconscious, or mentally ill women, those with specific disabilities, and those who refused to participate were excluded.

Sample size and sampling

The sample size was calculated using the following equation[21]: $n = (Z2 \times p \times q)/D2$, which suggested a sample of 322 women where the prevalence of DV among ever-married women attending PHC was

30% [22]. The probability of its occurrence is estimated to be (p = 0.30), the probability of non-occurrence (q = 1-p = 0.70), and a value of 0.05 is chosen as the acceptable limit of precision (D) at 95% confidence intervals where (Z = 1.96). Considering a withdrawal rate of 20% and another 30% incomplete questionnaires, a total of 483 subjects were required. A multistage stratified with a proportional allocation technique was adopted for the investigation to select two centres from each health region (n=10). Ever-married women recruited from each clinic were proportionate to the number of women registered in each centre (Supplementary File 1).

Questionnaire development

The questionnaire was adapted from published similar articles and our own experience covering the general characteristics of the participating women, exposure to domestic violence, family characteristics, and husband characteristics (Supplementary File 2)[23,24].

1. Women's characteristics:
Sociodemographic characteristics include age, marriage age, nationality, occupation, education, personal income and sharing in house expenses, habits, and practices such as smoking and alcohol consumption, and mental health.

2. Family characteristics:
Duration of marriage, marriage type, number of siblings, family income, marital stability, kinship with the husband's family, and living with the husband's parents.

3. Husband characteristics:
Sociodemographic characteristics include age, marriage age, nationality, occupation, education, personal income, personal habits, and practices such as smoking, alcohol consumption, drug use, mental health, and husband's controlling behaviour.

4. Exposure to domestic violence contained four domains:
Psychological (six items: isolating the woman and making her feel bad about herself, the humiliating woman in front of other people, threatening to hurt or harm her or someone close to her, locking her in a room or house, trying to convince her family/ friends or children that she is crazy or trying to turn them against her, or harassing her over the telephone).
Physical (seven items: Pushing woman / shocking her / or throwing something at her, slapping her, twisting her arm, or pulling her hair, punching her with his fist or with something that could hurt her, kicking/dragging, or beating her up, trying to choke her or burning her on purpose, or threatening you or attacking you with a knife/gun / any other weapon.
Sexual (three items: Forcing a woman physically to have sex against her will, forcing her to perform sexual acts that she did not want to, or forcing her to perform a degrading sexual action).
Economic (six items: denying access to adequate financial resources, hindering her from using her property, gripping her own money, obliging you to share in the house expenses, exploitative economic behaviours, or employment sabotage).

Pilot study

A pilot study was carried out on 20 ever-married women to test the clarity, applicability, and suitability of the used questionnaire, identify the difficulties that could be faced during the application, estimate the time needed for filling the questionnaire, and test the analytic procedure and overall response of the participants. This pilot study revealed that the questionnaire was suitable in general. The interview consumed 15 minutes on average. Internal consistency was checked using Cronbach's alpha test for each domain. For the current study, Cronbach's alpha for the composites ranged from 0.61 to 0.88.

Statistical analysis

The collected data were summarized and presented in tables. Normality was tested using the Kolmogorov-Smirnov test and histogram. Continuous normally distributed variables were presented as a mean with standard deviation. Categorical variables were presented as numbers and percentages with comparisons made using the Chi-square or Fisher extract test, and P-values $\leq$ 0.05 were considered statistically significant. The multinomial logistic regression model was used regarding factors associated with exposure to domestic violence with a 95% confidence interval (CI) odds ratio (OR). The previous tests were conducted using statistical analyses using the Statistical Package for the Social Sciences (SPSS)

software, version 22.0 (https://www.ibm.com/products/spss-statistics) (IBM Corp., Armonk, NY, USA).

Ethical considerations

Approval of the Ethical Committee of the Kuwaiti Ministry of Health, along with the permission of the Deputy Ministry of Health in Kuwait and heads of selected centres, was obtained. Written informed consent was obtained directly from the participating women, with a clear explanation of the study objectives and importance. Confidentiality was strictly maintained in accordance with Helsinki's Declarations of biomedical ethics. Participants were assured of their right to withdraw from the study without any negative impact on their care. Ethical approval was obtained from the research ethics committee of the faculty of medicine, Cairo University (approval number: 207/2012).

Results

Sociodemographic characteristics

The study included 601 women's responses who agreed to participate in our study from the selected PHC centres. Most participating women were aged 30 – 39 (36.8%), with a mean of 35.1 years. Kuwaiti women presented 79.4%, and other nationalities showed 20.6%. More than two-thirds had university or higher certificates (69.1%), 72.4% had permanent jobs, and 87.7% were married. Only 22.5% had monthly income less than 500 KD, and 32.8% had income ≥1000. 337 women (56.1%) were exposed to one or more types of DV. By type of violence, 255 women (42.4%) were exposed to psychological violence, 211 (35.1%) were exposed to physical violence, 173 (28.8%) were exposed to sexual violence, and 249 (41.4%) were exposed to economic violence.

Sociodemographic characteristics regarding psychological domestic violence

Regarding women's characteristics, early marriage (age < 20 years) was linked to a higher incidence of psychological violence (P < 0.03). A substantial income (≥ 1000 KD) was associated with a reduced likelihood of psychological violence (P < 0.04). Being underweight (low BMI) was associated with a higher risk of psychological violence (P < 0.03). Smoking and alcohol consumption showed no significant impact on the likelihood of experiencing psychological violence (P = 0.8 and 1, respectively). Mental health issues and poor perceptual health were associated with a greater risk of psychological violence (P < 0.001 and P < 0.03, respectively).

Regarding family characteristics, there were no significant associations between exposure to psychological violence and marriage duration, type, siblings, family expenses, kinship, or living arrangements. Insufficient income and marital instability had significant effects on exposure to psychological violence (P < 0.001).

In terms of the factors related to husbands' characteristics, exposure to psychological violence exhibited no significant associations with the husband's age, age at marriage, income, or drug abuse. Nevertheless, certain characteristics were notably linked to a heightened risk of psychological violence. Kuwaiti husbands were more likely to be associated with such violence (P = 0.02), while husbands with higher education, those who were overweight or obese, smokers and alcohol consumers faced an elevated risk (P < 0.001, P = 0.004, P < 0.001, respectively). Additionally, husbands with mental health issues, poor perceptual health status, a history of previous marriages, and those displaying controlling behaviours or resorting to physical punishment towards children were also found to have a higher propensity for psychological violence (P < 0.001, P = 0.01, P = 0.002, P < 0.001, respectively).

Sociodemographic characteristics regarding physical domestic violence

Women over 50 experienced the least physical domestic violence (12.2%) compared to other age groups (<30, 30-39, and 40-49, respectively) (P = 0.003). Higher education and monthly income ≥1000 KD were linked to a reduced likelihood of physical DV (P < 0.001). Mentally unhealthy women were more exposed to physical DV (P < 0.001). Age of marriage, nationality, occupation, BMI, smoking, and alcohol consumption had no significant effects.

Insufficient family income and marital instability were found to be strong factors significantly elevating the likelihood of women's exposure to physical domestic violence (DV) (P = 0.001 and < 0.001, respectively). Other factors,

including marriage duration, type of marriage, number of siblings, family expenses, and kinship, did not demonstrate any significant associations with physical DV. The husband's nationality, education, and monthly income had no significant associations with physical DV (P = 0.19, 0.13, and 0.25, respectively). Women married to husbands ≥50 years old experienced less physical DV (P = 0.03; 22.7%). Worker husbands increased the risk of physical DV (P = 0.002; 52.2%). physical DV exhibited strong associations with various factors including the husband's prior marriage, controlling behaviour, physical punishment of children, mental health, poor perceptual health status, overweight status, alcohol consumption, and drug abuse (P = 0.002, P < 0.001, P < 0.001, P < 0.001, P = 0.01, P = 0.03, and P = 0.03, respectively)

Sociodemographic characteristics regarding sexual domestic violence

Regarding women's characteristics, only education, monthly income, BMI, and mental health showed significant associations with sexual DV (P-values = 0.02, 0.002, 0.01, and < 0.001, respectively). Highly educated women and those with monthly income ≥1000 KD were less exposed to sexual DV (25.3% and 20.3%, respectively). Women with low BMI were more exposed to sexual DV than others (60%). The percentage of exposure to sexual DV among mentally unhealthy women was significantly higher than among mentally healthy women (54.7% versus 26.3%).

Regarding family characteristics, only not enough family income and marital instability were significantly associated with a higher percentage of women's exposure to sexual DV (39.7% versus 24.9%, P-value < 0.001) and (60.5% versus 21.4%, P-value < 0.001), respectively.

Regarding husband characteristics, wives of husbands with professional jobs were significantly less exposed to sexual DV (15.6%, P-value = 0.01). Also, the percentages of women exposed to sexual DV were higher when the husband had controlling behaviour (40.5% versus 13.7%, P-value < 0.001), hitting kids (55.8% versus 24.1%, P-value < 0.001), was mentally unhealthy (57.4% versus 26.0%, P-value < 0.001), smoking (39.1% versus 18.4%, P-value < 0.001), and consuming alcohol (65.9% versus 26.1%, P-value <0.001), as well as poor perceptual health status (45.7% versus 27.7%, P-value = 0.02).

Sociodemographic characteristics regarding economic domestic violence

Regarding women's characteristics, there was a significantly higher proportion of exposure to economic DV among women of low BMI (65%, P-value = 0.01), average monthly income (500 – 999 KD) (46.1; P-value = 0.047), mentally unhealthy (73.6%, P-value < 0.001), and those who perceived their health status as poor (58.1%, P-value = 0.05).

Regarding family characteristics, duration of marriage, type of marriage, number of siblings, kinship with the husband's family, and living with her husband's parents do not significantly correlate with economic DV. However, family income is a significant factor, with insufficient income increasing the risk of economic DV (51.3%, p = 0.004). Whether the wife shares in family expenses significantly impacts economic DV, with those not sharing expenses facing a lower incidence (25.3%, p < 0.001). Marital stability is also a significant factor, with unstable marriages significantly associated with a higher risk of economic DV (78.1%, p < 0.001).

Regarding husband characteristics, a significantly higher percentage of women exposed to economic DV with a husband in the age group 40 – 49 years (46.8%) as compared with other husband age categories as (<30, 30 – 39, and 40 – 49) (P-value = 0.001; 37.3%, 41.3%, and 37.1%, respectively). Women of Kuwaiti husbands were significantly more liable to exposure to economic violence (44.0% versus 32.6%, P-value = 0.02) or previously married husbands (52.6% versus 39.9%, P-value = 0.03). Also, husband smoking (50.0% versus 32.8%, P-value < 0.001) and consuming alcohol (73.2% versus 39.1%, P < 0.001) were significant factors. Mentally unhealthy husband (66.7% versus 38.9%, P-value < 0.001), poor perceptual health status (60.0% versus 40.3%, P = 0.02), with low BMI (62.5%, P-value = 0.03), were significantly associated with wives' exposure to economic violence. Husband-controlling behaviour was significantly associated with higher exposure (53.8% versus 25.5%, P-value < 0.001). The same pattern was observed if the husband used to hit kids (72.1% versus 36.2%, P-value < 0.001).

Table 1: Multinomial logistic regression model regarding factors associated with exposure to different types of domestic violence (DV)

Variables	Psychological DV				Physical DV				Sexual DV				Economic DV			
	P-value	Odds Ratio	95% Confidence Interval		P-value	Odds Ratio	95% Confidence Interval		P-value	Odds Ratio	95% Confidence Interval		P-value	Odds Ratio	95% Confidence Interval	
			Lower	Upper			Lower	Upper			Lower	Upper			Lower	Upper
Husband Controlling Behavior																
No	*Ref*															
Yes	< 0.001	4.2	2.82	6.26	< 0.001	3.78	2.44	5.87	< 0.001	3.15	2.01	4.89	< 0.001	2.73	1.85	4.02
Husband Smoking																
No	*Ref*				N/A				*Ref*				N/A			
Yes	0.003	1.79	1.22	2.63					0.005	1.81	1.20	2.72				
Husband Alcohol Use																
No	N/A				*Ref*				N/A				N/A			
Yes					0.006	3.53	1.44	8.66								
Marriage Stability																
No	*Ref*															
Yes	< 0.001	0.15	2.82	6.26	< 0.001	0.16	0.09	0.27	< 0.001	0.3	0.19	0.48	< 0.001	0.26	0.14	0.48
Mental Health																
Unhealthy	*Ref*				N/A				N/A				*Ref*			
Healthy	0.006	0.33	0.15	0.72									0.008	0.381	0.19	0.78
Age (Years)																
< 30	N/A				*Ref*				N/A				N/A			
30 – 39					0.76	0.92	0.53	1.59								
40 – 49					0.85	0.94	0.49	1.79								
≥ 50					0.004	0.19	0.06	0.58								
Age of Marriage (Years)																
< 20	*Ref*				N/A				N/A				N/A			
20 – 29	0.006	0.5	0.33	0.83												
≥30	0.39	0.66	0.25	1.72												
Woman Monthly Income																
< 500	N/A				*Ref*				N/A				N/A			
500 - 999					0.53	0.85	0.51	1.42								
≥1000					0.01	0.44	0.25	0.77								
Wife Shares in House Expenses																
No	N/A				N/A				N/A				*Ref*			
Yes													< 0.001	3.2	1.78	5.74

Multinomial logistic regression model regarding factors associated with exposure to different types of domestic violence

For Psychological DV, Husband Controlling Behavior emerges as a significant predictor ($p < 0.001$). Women whose husbands exhibit controlling behaviour are 4.2 times more likely to experience Psychological DV, with a 95% confidence interval (CI) ranging from 2.82 to 6.26. Husband Smoking is also a significant predictor ($p = 0.003$), with women having husbands who smoke being 1.79 times more likely to experience Psychological DV (95% CI: 1.22 to 2.63). Additionally, Marriage Stability significantly affects Psychological DV ($p < 0.001$), with women in stable marriages having lower odds (0.15) of experiencing this type of DV (95% CI: 0.09 to 0.27). Mental Health plays a role, too ($p = 0.006$), as women with healthy mental health are less likely to experience Psychological DV (0.33) compared to those with unhealthy mental health (95% CI: 0.15 to 0.72). (Table 1)

In the case of Physical DV, the husbands' controlling behaviour remains a significant predictor ($p < 0.001$). Women with controlling husbands have 3.78 times higher odds (95% CI: 2.44 to 5.87) of experiencing Physical DV. Husband Smoking is also a predictor ($p = 0.005$), with these women having 1.81 times higher odds (95% CI: 1.20 to 2.72) of experiencing Physical DV. Marriage Stability is significant ($p < 0.001$), and women in stable marriages have lower odds (0.16) of Physical DV (95% CI: 0.09 to 0.27). Mental Health ($p = 0.008$) and Age ($p < 0.004$) are also associated factors. (Table 1)

For Sexual DV, Husband Controlling Behavior remains a significant predictor ($p < 0.001$). Women with controlling husbands have 3.15 times higher odds (95% CI: 2.01 to 4.89) of experiencing Sexual DV. Husband Alcohol Use is associated with Sexual DV ($p = 0.006$), with these women having 3.53 times higher odds (95% CI: 1.44 to 8.66). Marriage Stability ($p < 0.001$) plays a role, and women in stable marriages have lower odds (0.3) of Sexual DV (95% CI: 0.19 to 0.48). Mental Health ($p = 0.008$) also affects Sexual DV. (Table 1)

In the context of Economic DV, Husband Controlling Behavior remains a significant predictor ($p < 0.001$). Women with controlling husbands are 2.73 times more likely (95% CI: 1.85 to 4.02) to experience Economic DV. Wife Shares in House Expenses is also significant ($p < 0.001$), with women sharing expenses being 3.2 times more likely (95% CI: 1.78 to 5.74) to experience Economic DV. Additionally, Age ($p = 0.004$) and Wife's Monthly Income ($p = 0.01$) are associated factors. (Table 1).

Discussion

The term 'violence and harassment' refers to a range of unacceptable behaviours and practices or threats, whether a single occurrence or repeated, that aim at, result in, or are likely to result in physical, psychological, sexual, or economic harm [25]. Current prevalence is defined as the proportion of ever-partnered women reporting that at least one act of violence occurred during the 12 months before the interview[2]. The prevalence of DV differs from region to region. The prevalence estimates of intimate partner violence (IPV) range from (23.2%) in high-income countries and (24.6%) in the WHO Western Pacific region to (37%) in the WHO Eastern Mediterranean region and (37.7%) in the WHO South-East Asia region[26]. The present study aims to estimate the prevalence of different types of DV among women attending PHC centres in Kuwait.

In our study, we found that the majority of women participating were aged between 30 and 39, held university or higher education certificates, were married, and had permanent jobs. These demographic characteristics align with findings from other studies conducted by Alsaleh and Basar et al., providing a comparative basis for understanding the prevalence and types of DV in different demographic groups[27,28].

Our study found that more than half of the participants were exposed to overall types of DV, while Alkoot I. *et al*., study showed that the prevalence of DV against women was around (20%) in Kuwait[29]. Similar to our results, Basar *et al*., study revealed that DV affected (41.3%) of women, whereas in Saudi Arabia, Afifi *et al*., study showed that (39.3%) of women were exposed to DV, while in Slovenia, Selic *et al*., study showed that the overall rate of DV was (15.3%)[27,30,31]. These discrepancies can be explained by Variations in cultural norms, societal attitudes between different regions, and variability in the ability of primary health care physicians readiness to identify and screen for intimate partner violence[32,33].

In light of our findings, it becomes evident that psychological violence was the most prevalent form of Domestic Violence (DV), affecting (42.4%) of the participants. Following closely behind were instances of economic violence at 41.4%, physical violence at (35.1%), and sexual violence at (28.8%). These statistics underscore the prevalence of psychological and economic abuse as significant issues within the context of DV. Comparatively, Basar et al., reported a different distribution of violence types among women, with verbal violence being the most prominent at (74.3%), followed by emotional violence at (67.7%), physical violence at (44.8%), economic violence at (18.5%), and sexual violence at (13.4%)[27]. Mohamadian et al., also revealed distinct patterns, indicating that (53.2%) of participants experienced emotional abuse, (33.8%) experienced physical abuse, and (23.7%) experienced sexual abuse[34]. According to Özcan *et. al*.,'s meta-analysis reported that the highest prevalence was verbal violence, followed by physical, emotional, economic, and sexual violence [35]. These variations in prevalence emphasize the need for tailored interventions and strategies to address the specific manifestations of DV in different cultural and geographical contexts, thereby contributing to a more comprehensive understanding of this pervasive issue.

Regarding the significant association with exposure to violence, we compare our results with Mohamadian *et al*., and Basar *et al*., studies. Our study presented every type of violence separately, while Mohamadian et al., and Basar et al., studies represented the overall violence[27,34]. Mohamadian et al.,'s study showed that the education level of exposed women to violence, marriage age, marriage duration, number of children, women's occupation, husband's education level, and kinship with husband's family were significantly associated with exposure to violence[34]. Basar *et al*.'s study showed that the education level of exposed women to violence, income status of women, age of husband, husband's education level, and marriage age were significantly associated with exposure to violence[27].

In contrast, our study has examined different types of violence separately and found varying sociodemographic factors associated with each type of domestic violence. For psychological domestic violence, the earliest marriage age (< 20 years), the husband's education level, and the women's monthly income were significantly associated with exposure. Physical domestic violence was significantly associated with the education level of the women exposed, women's monthly income, and the age of the husband. The education levels of women and women's monthly income were significantly associated with exposure to sexual DV. Women's monthly income and the age of their husbands were significantly associated with exposure to economic DV. This is in line with studies by Mohamadian et al. and Basar *et al*. that identified factors contributing to overall violence[27,34].

Based on our regression analysis, being wives of smoker husbands and having healthy mental health were significant predictors of exposure to psychological DV (P-values = 0.003 and 0.006, respectively). However, Selic *et al*., showed that smoking and unhealthy mental health (depression) were not significant predictors of exposure to psychological DV (P-values = 0.8 and 0.4, respectively)[31]. In contrast, the regression analysis of R. Ahmadi *et al*., study showed that the strongest predictor of psychological aggression among the women was unemployment of the husband (OR = 2.66), addiction of the husband (OR = 2.29), low education husband (OR = 1.93), and unemployment of woman (OR =1.46)[36].

Wives of alcohol-user husbands were significant predictors of exposure to physical DV (P-values = 0.006; OR = 3.53). In agreement with the regression analysis of R. Ahmadi *et al*.,'s study, the husband's addiction (OR = 1.91) was the strongest predictor of physical DV[36]. These findings indicate a strong link between substance use and physical DV, underscoring the need for interventions targeting substance use in efforts to prevent and address DV.

Conclusion

We found that 337 women out of 601 who participated in the survey were subjected to domestic violence; the issue is currently underreported in Kuwait since so few women are willing to be upfront about it. It is imperative to support various healthcare settings in recording DV instances and perform a thorough survey to reveal Kuwait's hidden DV problem.

Limitations

Limitations of the study include its cross-sectional nature, which makes it difficult to establish

causality, although the results align with findings from other studies. Another limitation is that most of the questions in the tools used were subjective, increasing the possibility of recall bias. Additionally, the study included a small number of physicians, and their responses regarding domestic violence (DV) practices may be influenced by recall bias and over-reporting. The findings may not be generalizable to other healthcare settings as the study focused solely on primary care physicians and their responses may differ from those of specialized physicians. Furthermore, the study's findings cannot be generalized to the entire population of women in Kuwait as it only included women attending primary healthcare settings. Additionally, demographic information about non-respondents was not available for comparison. Finally, the study did not assess physicians' knowledge of screening strategies for DV.

Recommendations

Efforts to address violence against women and enhance support services require action at the country, society, and health system levels. At the country level, close collaboration with international agencies is crucial to access support and programs to reduce violence. It is important to encourage different healthcare settings to document domestic violence cases and establish laws and roles for addressing abused women in health settings. Strengthening research and capacity for assessing interventions is also vital.

At the societal level, awareness programs should educate couples about respectful relationships, while premarital counselling can disseminate information and support women's health and rights. Providing supportive care materials can reinforce health education messages effectively. Training programs for primary healthcare physicians can improve their knowledge and practice in managing domestic violence cases within the health system. Developing guidelines and protocols based on national standards and research findings will aid in identifying and intervening in cases of violence. Reducing the workload on healthcare staff and training them in supportive care will improve patient interactions.

Future research should include a comprehensive survey to uncover the extent of domestic violence in Kuwait. Investigating the implementation of an early detection framework, exploring additional factors related to physicians' knowledge and practice, and studying factors influencing healthcare responses are important areas of focus. Additionally, proposing and testing an implementation plan for victim care will ensure effective and cost-efficient support services.

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Conflicts of interest

None.

Ethical approval

Approval of the Ethical Committee of the Kuwaiti Ministry of Health was obtained, and the permission of the Deputy Ministry of Health in Kuwait, as well as heads of selected centres.

Informed consent

Informed consent was obtained from all participants in this study.

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