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Research Article

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Knowledge, Attitude and Practice of Intimate Partner Violence Screening Among Primary Healthcare Providers in Kuching, Sarawak

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ABSTRACT

Intimate partner violence (IPV) is a pressing global public health issue with significant physical, psychological, and social effects. Primary healthcare providers (PHP) are key in early identification and management. However, there is limited research on IPV screening practices in Malaysia's primary care settings. This study aimed to determine the prevalence of IPV screening among PHPs in Kuching, Sarawak, and to explore how screening practices relate to providers' demographics, knowledge, and attitudes. A cross-sectional study was carried out across 36 government health clinics in Kuching. A total of 307 PHPs, including doctors and paramedics, were selected through stratified random sampling. Data were collected via a validated self-administered questionnaire adapted from the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS). Descriptive statistics and Chi-square were used in the analysis. While 58% of PHPs reported conducting IPV screening, 85% lacked adequate skills for comprehensive IPV assessment and management. Screening was significantly more common among doctors and those with under 10 years of experience ($p<0.001$ and $p=0.008$, respectively). Providers who had undergone IPV training, particularly those trained for more than five hours, were more likely to screen (72.5%, $p=0.006$; 90.9%, $p=0.028$). Higher screening rates were also associated with better IPV knowledge (68.6% vs. 47.4%, $p<0.001$). Generally, attitudes toward IPV were positive. However, only views on substance use and victim understanding significantly influenced screening ($p=0.013$, $p=0.018$). IPV screening in primary care remains moderate with notable gaps in quality. Strengthening training and addressing provider knowledge and attitudes are essential for effective IPV management.

Keywords: Attitudes, Intimate Partner Violence, Knowledge, Malaysia, Primary Healthcare Providers, Screening Practices

List of Abbreviations

AMO	:	Assistant Medical Officer
FMS	:	Family Medicine Specialist
IPV	:	Intimate Partner Violence
KK	:	Klinik Kesihatan (Health Clinic)
KKIA	:	Klinik Kesihatan Ibu Anak (Maternal & Child Health Clinic)
KKOM	:	Klinik Komuniti (Community Clinic)
MO	:	Medical Officer
PHP	:	Primary Healthcare Providers
WHO	:	World Health Organisation

Introduction

The increasing number of intimate partner violence (IPV) has become an important public health concern for years and a major human rights violation. IPV is defined as an ongoing or past violence or abuse by an individual whom a person has an intimate relationship- current or former partners, between men and women. The acts of violence include physical, psychological, sexual, and controlling behaviours [1].

Based on the worldwide analysis by World Health Organisation (WHO), almost 1 in 3 (30%) of women have experienced

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physical and/or sexual violence by their partners [2]. Local studies revealed a wide range of IPV prevalence from 4.94% to 35.9% [3-5]. In 2021, 7468 cases of domestic violence reported in Malaysia constituted a 42% increment from previous year [6]. For the interest of this study, Sarawak has recorded 630 cases in 2021 with the highest cases (37%) reported in Kuching [7]. However, due to the sensitive nature of IPV and fear of reporting, there is a possibility of more cases being unreported and the number of cases can be beyond what has been shown.

IPV leads to devastating outcomes on the health and well-being of the victims and their off springs. The implications not only manifest during the acute setting but also later in the life of the survivors. Many studies found the adverse impacts of IPV on physical health, mental health and lifelong disability of the victims [8-10]. Violence during pregnancy and perinatal periods give rise to unfavourable outcomes on the maternal and neonatal health [11-13].

Due to the vast negative impacts of IPV, it is essential to address this issue to prevent further cases and unwanted damages. One preventive measure in healthcare system is to screen and detect those who may be exposed to violence. WHO does not recommend universal screening, rather it outlines the policy on responding to intimate partner violence [14]. In 2013, US Preventive Services Task Force (USPSTF) recommends IPV screening for reproductive age women and to provide support services for positive screening [15].

There is various screening tools have been introduced to screen patient with IPV in healthcare settings [16]. A systematic review on screening women for IPV reported favourable contribution in the identification of the victim and guides the intervention that reduce violence outcomes [17]. Primary care clinic is the entry-point to the healthcare system, hence, plays the important role to screen, identify, and assist the vulnerable population.

Generally, the screening by the healthcare providers vary between 2-50% including in primary care setting despite the advocation of screening [18]. Most of the clinicians reported to ask about abuse at 'times' and nearly a third had never screened their patients for violence [19]. One local study reported, 92.4% of the primary care attendees had never been asked about being abused by their partner, although 67.3% of the victims are willing to tell if being asked [20]. Barriers of screening includes lack of practitioner education, attitudes towards IPV and institutional limitations in policies, protocols and support services [21-23,19,24].

In Malaysia, studies on IPV screening in primary care settings are limited and were done more than a decade ago [19,25]. Hence, this study aims to identify the current practice of IPV screening in local practice, it's association as well as limitations of our primary healthcare providers (PHP) to perform IPV screening therefore helps with formulating appropriate intervention of IPV in primary care.

Methodology

Study Design and Sample

This cross-sectional study was conducted in 36 government health clinics in Kuching, Sarawak. The targeting participants were primary healthcare providers (PHP) consisting of doctors (Family Medicine Specialists and Medical Officers and paramedics (Assistant Medical Officers and Nurses). Eligibility criteria included PHP with direct access to the patients. Those who were working in non-clinical setting andnot available during the data collection period. The total sample size required for this study was calculated using Daniel's formula, based on previous reported prevalence of primary care practitioners screened for IPV of 35% [26], with 95% confidence interval. This gave a sample size of 254 in which it was then increased by 20% for non-respondents, giving a final sample size of 317. Recruitment was carried out through stratified random sampling to ensure a representative sample across different categories of healthcare providers. Following the existing Kuching's doctors to paramedic's ratio of 2:3, this translated to 127 doctors and 190 paramedics.

Measurement

This study used the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) tool. PREMIS is a validated instrument and was developed in the US. The instrument exhibited strong internal consistency and reliability with Cronbach's alpha ≥0.65 for the scales. A revised version of the instrument showed a good correlation with measured office IPV practice, good stability of psychometric features in a different physician group and stable results over a one-year period [27]. It is comprehensive and reliable in assessing physician readiness to manage IPV and has been widely used for IPV related research and training purpose. Permission for using the tool has been granted by the corresponding author, Dr John Harris.

The original tool consists of 67- items divided into 5 sections: respondent profile; background of perceived preparedness and perceived knowledge; opinions on staff preparedness, legal requirements, workplace issues, self-efficacy, alcohol/drugs, victim understanding, victim autonomy and staff constraints, and finally practical issues. Responses were made through Likert-type scale, true/false, multiple choice and open response options. Slight revision in the respondent profile and items related to using camera, taking photographs in the practice section were removed since the practice is not applicable in Malaysia's primary care setting.

Practice score had a total score of 125, while knowledge score was 38. Score of >50% in each category were considered moderate-good level and ≤50% as poor level. The attitudes' scores had a maximum range of 14-45, in which each sub-scale was categorized into positive attitude (>50%) and negative attitude (≤50%). The categories employed were determined in accordance with a recent study in the same field (Alsalman, Z., et al 2023). By using 50% as a cutoff aligns with conventional grading systems and provides a clear standard for defining "good" and "poor" threshold in academic and clinical competency assessment (Ben-David, 2000, Schuwirth & van der Vleuten, 2011).

Operational Definition: Moderate-good practice: Score of >50% in the adequacy to enquire, assess and manage cases of IPV.

Poor Practice: Score of ≤50% in the adequacy to enquire, assess and manage cases of IPV.

Moderate-Good Knowledge: Score of >50% in the competency of identifying potential IPV victims.

Poor Knowledge: Score of ≤50% in the competency of identifying potential IPV victims.

Positive Attitude: Refers to responses that reflect support and recognition of each subscale in relation to IPV.

Negative Attitude: Refers to responses that reflect reluctant and lack of belief of each subscale to IPV.

Data Collection Method

Permission for the recruitment of participants and the registry of PHP that fulfilled the inclusion criteria were obtained from the Kuching Division Health Office. Selection of the PHP were then made through random name generator in Excel according to their medical position group. Identified PHP were given a self-administered questionnaire that can be answered in an online via Google-link or in a paper-based copy which was distributed through FMS/MO in-charge of each clinic. The purpose of study and informed consent was attached in each questionnaire.

Data Analysis

All collected date were coded following the PREMIS coding and scoring manual and were analysed by using the Statistical Package of the Social Sciences (SPSS) statistical program version 29. The descriptive analysis computed in frequencies, percentages, mean or median together with the interquartile range for each scale/sub-scale. Test for normality was carried out by using Kolmogorov-Smirnov and the Shapiro-Wilks test. Pearson's Chi squared and Fisher Exact Test were used to test the association between practice of IPV screening with PHP profiles, knowledge and attitude. A p-value of less than 0.05 is considered as a level of significance throughout the study.

Ethical Considerations

This study was approved by Research and Ethics Committee Universiti Kebangsaan Malaysia Medical Centre (UKM PPI/111/8/JEP-2023-578) and Ministry of Health Medical Research and Ethics Committee (NMRR ID-23-02559-IBD (IIR). The permission to conduct the study in Government Health Clinics in Kuching Division was obtained from State Director of Department of Health. An informed consent was provided along with the questionnaire and all the information obtained in this study were kept and handled in confidential manner.

Results

Primary Healthcare Providers' Profiles

The total number of PHP was 307 (response rate of 96.8%). The mean age of participants was 35.0 years (SD = 8), with a median working experience of 10 years (IQR = 8). Participants were categorized based on their professional roles, with Medical Officers (MO) forming the largest group (37.8%), followed by Nurses (30.9%), Assistant Medical Officers (AMO) (29.6%), and Family Medicine Specialists (FMS) (1.6%). Only 22.5% of PHP reported receiving training on IPV as shown in Table 1.

Table 1: Primary Healthcare Providers' Profiles

Characteristic	Mean (SD)	Median (IQR)	n (%)
Age (year)		35.0 (8)	
Working experience (year)		10.0 (8)	
Gender			
Male			115 (37.5)
Female			192 (62.5)
Ethnicity			
Malay			129 (42)
Chinese			44 (14.3)
Indian			7 (2.3)
Bumiputera Sarawak			119 (38.8)
Bumiputera Sabah			8 (2.6)
Marital status			
Single			62 (20.2)
Married			236 (76.9)
Divorced			9 (2.9)
Medical position			
FMS			5 (1.6)
MO			116 (37.8)
AMO			91 (29.6)
Nurses			95 (30.9)
Current place of practice			
KK with FMS			122 (39.7)
KK without FMS			123 (40.1)
KKIA			39 (12.7)
Klinik Komuniti			23 (7.5)
Daily number of patients seen			
<20			81 (26.4)
20-49			172 (56)
≥50			54 (17.6)
IPV training			
Yes			69 (22.5)
No			238 (77.5)
Hours of IPV training (n=69)	2.5 (2.92)		

Practice of Ipv Screening

Out of a total of 307 PHP surveyed, more than half (58%) self-reported the practice of IPV screening, while 42% did not engage in screening practices (Table 2).

A further analysis of the practice score among those who reported screening (n=178) revealed that the majority demonstrated poor practice performance characterised by lacking the necessary skills to investigate, evaluate, and handle IPV cases. Specifically, 85% of PHP scored ≤50% on their IPV screening practice, while only 15% achieved a score greater than 50%, indicating good practice behaviour (Figure 1).

Majority of PHP reported practical barriers related to the availability of protocol, IPV materials, and referral resources, as illustrated in Figure 2.

Table 2: Practice Of Screening, N=307

		Yes, n (%)	No, n (%)
Practice of screening		178 (58)	129 (42)

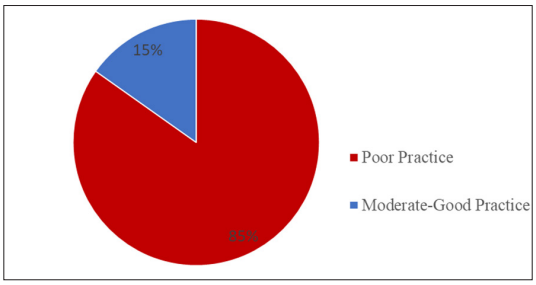

Figure 1: Practice Scores

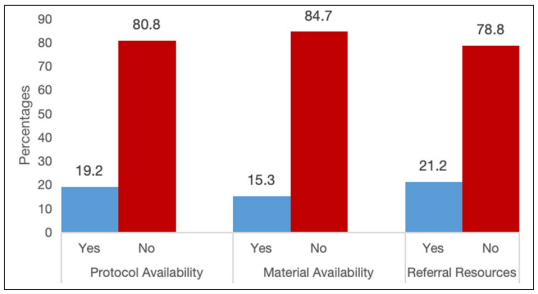

Figure 2: Practical Issues

Association Between Php Profiles with Practice of Ipv Screening

Table 3 summarizes the association between the practice of IPV screening and various PHP profiles. PHP with less experience, those in higher medical roles (FMS/MO), and those with IPV-specific training who received at least more than 5 hours of training were more likely to engage in IPV screening.

Table 3: Association Between Practice of Screening with Php Profiles

	Practice of screening		X^2	p value
	Yes, n (%)	No, n (%)		
Age (year)				
<35	108 (62.8)	64 (37.2)	3.715	0.054[a]
≥35	70 (51.9)	65 (48.1)		
Working experience (year)				
<10	102 (65.4)	54 (33.6)	7.137	0.008[a*]
≥10	35 (45.5)	42 (54.5)		
Gender				
Male	61 (53.0)	54 (47.0)	1.840	0.175[a]
Female	117 (60.9)	75 (39.1)		
Ethnicity				
Bumiputera	143 (55.9)	113 (44.1)	2.846	0.092[a]
Non-bumiputera	35 (68.6)	16 (31.4)		
Marital status				
Single/divorced	44 (62.0)	27 (38.0)	0.604	0.437[a]
Married	134 (56.8)	102 (43.2)		
Medical position				
FMS/MO	96 (79.3)	25 (20.7)	37.395	<0.001[a*]
Paramedics (AMO/Nurses)	82 (44.1)	104 (55.9)		
Current place of practice				
KK with FMS	63 (51.6)	59 (48.4)	3.341	0.068[a]
KK without FMS	115 (62.2)	70 (37.8)		
Average number of patients per day				
<20	42 (51.9)	39 (48.1)	5.910	0.052[a]
20-49	110 (64.0)	62 (36)		
≥50	26 (48.1)	28 (51.9)		
IPV training				
Yes	50 (72.5)	19 (27.5)	7.663	0.006[a*]
No	128 (53.8)	110 (46.2)		

Hours of training				
≤5	168 (56.8)	128 (43.2)		0.028[b*]
>5	10 (90.9)	1 (9.1)		
[a]Chi square test [b]Fisher exact test *statistically significant p value <0.05				

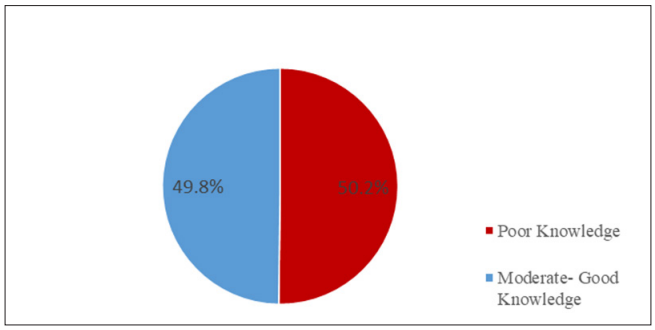

Figure 3: Knowledge Scores

Table 4: Association Between Knowledge with Practice of IPV Screening

	Practice of screening		**X^2**	**p value**
	Yes,n (%)	**No, n(%)**		
Knowledge score				
Poor	73 (47.4)	81 (52.6)	14.192	<0.001*
Moderate-Good	105 (68.6)	48 (31.4)		
*statistically significant p value <0.05				

Association Between Attitudes and Practice of Ipv Screening

Figure 4 presents the distribution of attitudes towards various aspects of IPV among PHP. The data indicates that PHP generally hold positive attitudes across most IPV-related domains, particularly concerning alcohol/drug-related issues, staff constraints, victim understanding, and victim autonomy. Areas like staff preparedness and workplace issues show more balanced attitudes. However, most attitudes do not significantly impact IPV screening practices (Table 5). The only statistically association in IPV screening were observed in attitudes towards alcohol/drugs and victim understanding with p value of 0.013 and 0.018 respectively

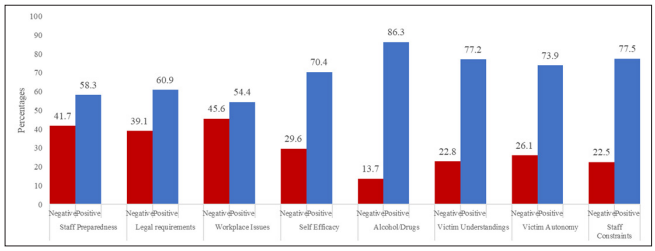

Figure 4: Attitudes on IPV

Table 5: Association Between Attitudes and Practice of IPV Screening

Attitudes	**Practice of screening**		**X^2**	**p value**
	Yes,n (%)	**No, n(%)**		
Staff preparedness				
Negative	69 (53.9)	59 (46.1)	1.496	0.221
Positive	109 (60.9)	70 (39.1)		
Legal requirements				
Negative	72 (60.0)	48 (40.0)	0.330	0.566
Positive	106(56.7)	81 (43.3)		
Workplace issues				
Negative	80 (57.1)	60 (42.9)	0.074	0.785
Positive	98(58.7)	69 (41.3)		
Self efficacy				

Negative	55 (60.4)	36 (39.6)	0.321	0.571
Positive	123 (56.9)	93 (43.1)		
Alcohol/drugs				
Negative	17 (40.5)	25 (59.5)	6.119	0.013*
Positive	161 (60.8)	104 (39.2)		
Victim understanding				
Negative	32 (45.7)	38 (54.3)	5.600	0.018*
Positive	146 (61.6)	91 (38.4)		
Victim autonomy				
Negative	40 (50.0)	40 (50.0)	2.828	0.093
Positive	138 (60.8)	89 (39.2)		
Staff constraints				
Negative	39 (56.5)	30 (43.5)	0.078	0.780
Positive	139 (58.4)	99 (41.6)		
*statistically significant p value <0.05				

Discussion

The prevalence of IPV screening among PHP in this study was 58%, indicating that just over half of the participants engage in screening. While this is higher than global averages reported in other studies of 2-35%, it still highlights a substantial gap in practice in which a deeper evaluation revealed that 85% of those who screened scored poorly in practice performance [28]. This suggests that although the intent to screen exists, the capacity to perform comprehensive IPV assessment remains limited. Such gaps in practice are consistent with other studies that highlight a lack of structured training, standard protocols, and referral pathways as major barriers [22,23].

This study identified significant associations between the practice of IPV with PHP characteristics, including professional roles, years of experience, and IPV training. The results show that doctors (FMS and MO) were significantly more likely to perform IPV screening (79.3%) compared to paramedics and nurses (44.1%, $p<0.001$). This finding aligns with previous research, who observed that higher medical roles often involve more direct decision-making and adherence to clinical guidelines, which may explain their greater engagement in IPV screening [25]. Doctors typically receive more extensive training in clinical decision-making, patient communication, and guideline implementation, making them better equipped to recognize and manage IPV cases [26]. The likelihood of screening was also higher among PHPs with fewer than 10 years of experience, potentially due to recent educational exposure and greater adherence to clinical protocols [20].

Training emerged as a strong predictor of screening behavior. PHPs who received IPV-related training, especially those who had more than 5 hours of it, were significantly more likely to screen. These results echo findings from previous studies, who emphasized that structured, comprehensive IPV training equips healthcare providers with the knowledge, confidence, and skills necessary to identify and manage IPV cases effectively. Training also addresses barriers such as fear of offending patients, lack of knowledge about referral resources, and uncertainty about screening protocols, all of which are commonly cited by healthcare providers [23,18,28].

Knowledge levels were significantly associated with practice. PHPs with moderate to good knowledge on IPV were more likely to conduct screening (68.6%) compared to those with poor knowledge (47.4%). These findings are consistent with previous studies conducted in Malaysia and other low- and middle-income countries, where inadequate IPV knowledge among healthcare providers has been consistently observed (Colombini, Mayhew, and Watts 2008) [20]. Rabin et al. (2009) noted that providers with greater knowledge of screening tools were more likely to implement them confidently and effectively. This knowledge disparity may be attributed to the limited exposure to IPV training and the absence of standardised screening guidelines among PHP in Malaysia, which has persisted over the years.

Although the overall attitudes of PHPs toward IPV were predominantly positive, only specific domains—namely victim understanding and substance use—were significantly associated with screening practice. This aligns with prior literature emphasizing that certain attitudes, particularly those related to complex cases such as alcohol- or drug-related IPV, influence providers' screening behaviors [24,9]. PHPs with positive attitudes toward understanding victims and recognizing substance abuse as a factor in IPV demonstrated significantly higher screening rates, indicating that these attitudinal dimensions may enhance provider empathy and responsiveness.

However, most other attitude variables (e.g., staff preparedness, self-efficacy, and workplace issues) were not significantly associated with IPV screening practice, although providers with positive views on these aspects did show slightly higher engagement. These findings suggest that while favorable attitudes are necessary, they are insufficient on their own without systemic support, time allocation, and clinical infrastructure [19,27]. Moreover, it reinforces the importance of institutional investment in enabling environments for screening, beyond individual provider readiness [29,30].

Strengths And Limitations

There are several limitations to this study. Firstly, the self-reported nature of the survey may introduce response bias, as PHP could overestimate their screening practices. The study

was conducted to a specific district in Malaysia, limiting the generalization of findings to other primary healthcare settings in this country.

As for the strength, the use of a validated and reliable instrument (PREMIS Questionnaire) may ensure robust data collection. The study also may provide essential insights into PHP practices, knowledge, and attitudes regarding IPV screening, contributing to the scarce literature on IPV screening in primary healthcare settings in Malaysia.

Recommendations

Enhanced comprehensive training programs that combine theoretical knowledge with practical skills are essential. Training could involve all clinical PHP, focusing on screening techniques, effective communication, and how to manage cases of IPV.

Malaysia's Ministry of Health might consider to develop and enforce national guidelines for routine IPV screening to standardize practices and ensure consistency across healthcare providers in Malaysia.

Research recommendation: Conduct intervention-based studies to assess the impact of IPV training on screening behaviour.

Conclusion

This study presented the current knowledge, attitude and practice of IPV screening among primary healthcare providers in Kuching, Sarawak. Over half of PHP in Kuching reporting routine screening practices, but only small portion has good practice behaviour despite adequate knowledge on IPV. The findings underscore critical gaps in preparedness and systemic support that hinder effective IPV response in primary care. Limited training exposure, inadequate screening tools, and the absence of standardized protocols contribute to underperformance despite generally positive provider attitudes.

Therefore, it is important to address the barriers among PHP to improve the primary care service in screening of IPV.

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