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Commentary: Factors affecting the knowledge levels, awareness, attitudes, and behaviors of family physicians about child abuse and neglect in Turkiye and changes in them with the training provided

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A Commentary on

Factors affecting the knowledge levels, awareness, attitudes, and behaviors of family physicians about child abuse and neglect in Turkiye and changes in them with the training provided

by Bayraktar, M., Deniz, S., Balci, E., Güveli, R., and Bircan, A. (2025). *Front. Public Health*. 13:1581720. doi: 10.3389/fpubh.2025.1581720

Bayraktar et al. (1) provide compelling evidence on the transformative impact of in-service training on child abuse and neglect (CAaN) detection among family physicians. Their intervention achieved statistically significant improvements across knowledge domains, with effect sizes ranging from large to very large (Cohen's $d = 1.00$ – 3.51), markedly exceeding those reported in similar training programs for nurses and pediatric residents (2, 3). The study's rigorous pre-post design, use of validated scales, and coverage of nearly all family physicians in Nigde province strengthen its credibility and contextual relevance.

The commentary reflects a narrative literature review approach to contextualize the study. While not systematic, sources were selected based on relevance, recent publication (within the past 10 years), and citation in major databases including PubMed and Scopus. Keyword combinations such as “child abuse,” “family physicians,” “mandatory reporting,” and “training outcomes” were used in searches. Priority was given to peer-reviewed studies cited in systematic reviews, national policies, or WHO/UNICEF guidelines.

Prior research has predominantly focused on nursing students (4, 5) or hospital-based pediatricians (6), despite the central role of family physicians as first-contact providers in

preventive child health systems (7). Bayraktar et al.'s study thus addresses a critical gap. Moreover, their findings raise several key reflections.

First, in terms of effectiveness, while Horstman et al. (8) emphasize the psychological burdens physicians face when reporting CAaN without adequate preparation, the present study demonstrates that structured education reduces such hesitancy by enhancing knowledge and clarifying legal responsibilities.

Second, regarding implementation gaps, their study did not evaluate whether improvements in knowledge and attitudes translated into sustained behavioral change, echoing limitations noted in similar interventions (9, 10). Cross-country reviews also reveal insufficient integration of CAaN assessments into electronic medical records to prompt routine screening (11).

To optimize CAaN detection and reporting, future research and policy should expand into the following dimensions:

1. Longitudinal impact assessment: evaluate whether knowledge gains from training lead to higher reporting rates, improved protection outcomes, and reduced re-abuse among children.
2. Interprofessional training: extend modules to include nurses, midwives, dentists, and social workers, fostering collaborative recognition and management (12).
3. Standardized interview protocols: develop culturally contextualized forensic interviewing guides for family physicians, addressing gaps highlighted in scoping reviews (11).
4. Digital decision-support tools: embed CAaN risk assessment algorithms into family health center electronic systems to prompt routine screening.
5. Legal and psychological protection policies: explore strategies to protect physicians from potential legal retaliation or psychosocial distress following mandatory reporting, as underscored in Australian and New Zealand contexts (8).
6. Ethical dimensions and international frameworks: reporting child abuse involves significant ethical tensions—particularly in balancing physician-patient confidentiality with legal duties to protect the child. These efforts should align with global standards, such as WHO's "INSPIRE" strategies and UNICEF's child protection guidelines, which emphasize frontline health worker capacity-building and institutional support mechanisms.
7. Cultural and systemic barriers in Türkiye: despite legislative frameworks, Türkiye faces barriers such as fear of retaliation, insufficient institutional support, and sociocultural stigma that deter consistent CAaN reporting. Addressing these requires legal clarity, physician support systems, and public awareness campaigns.
8. Comparative implementation models: reference successful implementation in other countries (e.g., Scandinavian models that integrate multidisciplinary CAaN teams into primary care) to highlight best practices.

Conclusion

Bayraktar et al.'s intervention marks a critical step toward systematic CAaN prevention within Türkiye's primary care system. To sustain its impact, scaling such models nationally, evaluating their long-term outcomes, and integrating technology-driven and interprofessional frameworks will be essential. These advances may significantly enhance child safety outcomes in diverse contexts.

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