BMJ Open

A Scoping Review of healthcare professionals' views on Intimate Partner Violence in the Middle East and North Africa

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2023-079866
Article Type:	Original research
Date Submitted by the Author:	14-Sep-2023
Complete List of Authors:	Al-Salmi, Sabrina ; Royal College of Surgeons in Ireland and Medical University of Bahrain Aly, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain Najeeb, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain, Alumni Sefen, Jessica; Royal College of Surgeons in Ireland and Medical University of Bahrain Shaikh, Zoya; Royal College of Surgeons in Ireland and Medical University of Bahrain Zuaiter, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain Doherty, Sally; Royal College of Surgeons in Ireland and Medical University of Bahrain
Keywords:	Primary Prevention, Primary Health Care, Primary Care < Primary Health Care

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

A Scoping Review of healthcare professionals' views on Intimate Partner Violence in the Middle East and North Africa

Sabrina Al-Salmi[1], Farah W. Aly[1], Farah S.N. Naser[1], Jessica A.N. Sefen[1], Zoya Shaikh[1], Farah A.O.A. Zuaiter[1], Sally Doherty[1]

[1]School of Medicine, Royal College of Surgeons in Ireland, Al-Sayh, Muharraq, Bahrain

*Corresponding Author: Farah A O A Zuaiter

Postal Address:

Royal College of Surgeons in Ireland
Al-Sayh, Muharraq
P.O. Box 15503, Adliya
Kingdom of Bahrain

Email: 16135296@rcsi.com

Word Count: 2951 words

ABSTRACT

Background

This scoping review aims to charter healthcare providers (HCPs) in the Middle East and North Africa (MENA) about their knowledge, attitudes, and barriers to working with women who have experienced Intimate Partner Violence (IPV). The purpose of this review is to map the breadth of available peer-reviewed literature which may inform future educational training programs.

Methods

This scoping review follows the methodology of Arksey and O'Malley's framework. It involves studies up to December 2022 including but not limited to PUBMED, Medline, COCHRANE, CINAHL, and Arabic medical jourdnals. Data extraction and data analysis were performed independently by two reviewers. Descriptive statistics were used to summarise the data.

Results

Of the 1066 articles reviewed, 29 eligible studies were in this scoping review. HCPs' lack of knowledge about IPV protocol was reported in 28% of the articles, 21% of the articles reported a low level of awareness about IPV. The attitudes of HCPs varied; the dominant attitude reported was a preference to treat the presenting health complaint and not to engage in discussions about IPV. Finally, 31% of articles stated that the main barrier was the HCPs' lack of training relating to IPV.

Conclusion

Our paper concluded that there is a lack of research in understanding the knowledge, attitudes, and barriers surrounding HCPs in the MENA region and IPV. This scoping review highlights the need for further research, informing interventions, and training for HCPs in the region.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- The methodology of Arksey and O'Malley was used to ensure a consistent framework when drafting the review.

- This study's study selection was done electronically via the web-based program Rayyan and by two reviewers to reduce bias on inclusion and exclusion of articles.
- Language restriction was among the main limitations to the number of studies included in this review.
- The restricted number of domestic violence articles published in the MENA region served as a limitation to the validity of the study.
- A formal bias assessment was not conducted in this study.

KEYWORDS

Intimate Personal Violence, Middle East, Review

BACKGROUND

Intimate Partner Violence (IPV) is a major worldwide public health problem impacting millions of lives [1]. IPV is a complex subject, defined in this article in accordance to the Istanbul Convention: *"all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit, or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim"* [2].

Prevalence rates of IPV in Western countries range from 25% to 38%. While prevalence rates in the Middle East and North Africa (MENA) region range from 15% to 85% [1, 2]. Those women who experience IPV in their lifetime may suffer from numerous physical and mental health problems such as depression, posttraumatic stress disorder, anxiety disorders, substance abuse, suicidal behaviour, somatising disorders, eating disorders, and chronic pain [3, 4]. Undisclosed violence can also lead to feelings of guilt, shame, and worthlessness [5]. According to the Global Burden of Disease Study, IPV causes significant morbidity and mortality [6]. Healthcare workers need to be aware of the possible signs and symptoms of IPV, have training in the use of screening tools, and refer to community and advocacy programs to provide care and support in a non-judgmental, private, and confidential environment [3, 7-9].

Women who experience IPV will often require more healthcare visits compared to women who do not experience IPV [10]. IPV is associated with adverse health outcomes, including depression, anxiety, and

substance abuse [11]. Therefore, it is crucial to identify healthcare providers' views (HCPs) in the MENA region about their knowledge and attitudes to treating women who experience IPV.

The twenty-four countries of the MENA region include Saudi Arabia, Kuwait, Bahrain, United Arab Emirate (UAE), Oman, Qatar, Yemen, Lebanon, Syria, Jordan, Palestine, Israel, Turkey, Iran, Iraq, Morocco, Libya, Tunis, Algeria, Egypt, Malta, Djibouti, Ethiopia, and Sudan. These 24 countries represent an approximate population of 725 million [12]. Despite diversity across these countries, they tend to share a commonality of culture, religion (mainly Islam), and language (Arabic). While women have achieved parity across many of these countries, there still may exist social, economic, and political equality barriers [13]. IPV represents both public health and a human rights problem. The only countries with civil and legal laws to protect women against IPV are Jordan, Lebanon, Tunisia, Morocco, Bahrain, and Saudi Arabia [14]. The Supreme Council for Women established a shelter for female family violence victims in Bahrain. Women can receive care and guidance if they experience IPV [15].

IPV is perceived as taboo and not considered a crime in many MENA regions. Often it is a matter for the religious courts to resolve instead of the civil and legal authorities [3, 16, 17].

A recent systematic review of prevalence rates in the Arab region identified 46 datasets from peer-reviewed journals and 11 national surveys across 16 years from 2000 -2016. Results indicated that IPV ranged from 6 to 59% for physical abuse, 3 to 40% for sexual abuse, and 5 to 91% for emotional and psychological abuse. The authors pointed out the problem was a lack of a homogenous definition of IPV. [13]

Findings from recent literature in the MENA region reporting on IPV in the Arab region emphasize the influence of culture, modesty, family solidarity, and reputation [17, 18]. Al-Nsour et al. explored attitudes toward IPV in Jordan, discovering that one-third of perpetrators justified 'wife beating' due to the culture in their country [19]. Additionally, women do not turn to HCPs for help with IPV due to the cultural stigma of causing a 'scandal' [20]. A woman with unexplained injuries and a reluctance to discuss their injury are often because her partner accompanies her to the physician consultation. She may fear the outcomes related to reporting the crime [21]. These culturally biased attitudes are the main barriers to seeking help [22]. Less than 15% of female patients in the MENA region reported being asked by their HCP about IPV [23]. Compared to studies in non-Arabic communities that report 43 to 85% of female respondents [24].

The Arab community has a shared commonality of HCPs unwilling to integrate IPV into their practice [17, 25]. Cultural stereotypes increase the HCPs' reluctance to intervene due to fear for their safety, losing their patients, and opposing the norm of their conservative society [3]. With the influence of culture and religion on Arab HCPs, knowledge of and attitude to IPV is critical to providing education and training programs [3].

Therefore, the purpose of this review is to map the breadth of available peer-reviewed literature in a specific region to identify research gaps and focus on future research priorities and inform future educational training programs.

MATERIALS & METHODS

We are conducting a scoping review; unlike a systematic review, it allows the researcher to address and summarize a broader range of evidence and topics where multiple study designs are applicable [26]. Key concepts in a specific research area describe the wide range of evidence and sources [26]. Moreover, it highlights the gaps in the existing literature and is employed due to the lack of literature in a specific area of research [26]. The quality of the studies is not assessed in a scoping review. The research question allows for broader non-specific questions to be addressed. In this instance, we are interested in the views of healthcare providers about IPV. We have included articles that focus on the knowledge, attitudes, and barriers to working with women who experience IPV. The HCPs include doctors, nurses, and midwives, and social workers.

The methods described in this study were adopted by Arksey and O'Malley's methodological framework [26]. Their methodological framework for conducting a scoping review consisted of five stages. The following stages include identifying a research question, identifying relevant peer-reviewed studies, study selection, charting the data, and finally collating, summarizing, and reporting the results [26].

This scoping review is conducted for IPV advocates, IPV victims, their representatives, researchers, and healthcare providers, including doctors, nurses, policymakers, institutions, organizations, caregivers, and health-based students, such as nursing and medical students.

Literature search strategy

FAOAZ and SA did a search strategy [Supplemental Material 1]. All publications that target HCPs' views on IPV in the MENA Region were included. Key search terms were Healthcare providers, MENA region, IPV, knowledge, attitudes, and barriers. The following databases were searched: PUBMED, Medline, PsycINFO, Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Cochrane Database of Systematic Reviews (CDSR). All searches were performed up to the date of December 2022 with no date restriction. In addition, the references from all key papers were manually reviewed. A hand search of relevant articles in the Arabic Medical Journals was also conducted. For a sample of the search strategy [Figure 1].

Eligibility Criteria

For this scoping review, we included articles based on a broad eligibility criterion. This criterion contains articles: [1] published in English and Arabic [2] focused on IPV; [3] Included HCPs' views on IPV; [4] in the MENA region, [5] in full-text formats [6] with adult women [7] no date restrictions. Articles that did not meet this inclusion criterion or with abstracts and full texts that could not be obtained were excluded.

Data Extraction

Data was extracted by JANS. The study characteristics included the research location, year of publication, type of journal, methodology, design, participants.

Data Analysis

Descriptive statistics of the study sample was performed by ZS, to describe the sample study characteristics, design, and HCPs' views regarding IPV.

Patient and Public Involvement

We did not include patients or members of the public in the research, as this was beyond the study's scope.

RESULTS

Article Identification & Selection

Our search strategy resulted in a total of 1066 articles [Figure 1]. Of these articles, 150 came from the databases, 483 from references, and 433 from the hand search of Arabic Medical Journals. We did not encounter any papers with only Arabic abstract or full text. Of these, 99 were duplicated and removed before title screening. Therefore, 967 underwent title review, and the reviewers found that 354 abstracts were potentially eligible. After screening the abstracts, 130 full text studies were reviewed. However, only 29 studies were included in the scoping review [Supplemental Material 2]. The remaining articles were excluded as they did not mention knowledge, attitudes or barriers of HCPs towards IPV. All article screening and selection were completed using the web-based program Rayyan [27].

Figure 1: PRISMA Flow Chart

Study Characteristics

There was a total of 29 papers in this scoping review. The majority came from Kuwait (n = 9) followed by three studies from Israel and three from Jordan. Two studies were each conducted in Saudi Arabia, Morocco, and Iran. One study was conducted in each of the occupied Palestine Territory (oPT), Egypt, Ethiopia, Lebanon, Turkey, and Sudan. One study involved the entire MENA region (n = 1). The final study included is a review that had no mention of the actual country; hence it is classified as 'not mentioned/not applicable' under location in the Knowledge, Attitudes, and Beliefs table [Supplemental Material 3].

Study Designs

There were twelve different types of study designs in the 29 articles reviewed. The table in supplemental material 3 also outlines the study design and the type of participants; most studies had a range of participants from one to 10. One study (53) had 385 participants, and three review studies had no participants as they are reviews and don't directly involve any participants.

Some studies involved both doctors and nurses (n = 10). A few studies included either doctors (n = 3) or nurses (n = 6). One study included doctors, nurses, and midwives, and another included doctors, nurses, and female patients. Health Care Providers were included in two studies, this is a separate row on the table as the title 'HCP' does not specify the professional (ie. nurse/doctor) [Supplemental Material 3]. One study even included social workers [53]. Two included other participants besides HCPs: one included HCP and stakeholders, and the other targeted key HCPs and organizations in the community to recruit as participants.

Notes: HCPs do not specify what kind of healthcare worker has participated (ie. nurse or doctor or other) and hence are left as just 'HCPs'.

Outcomes

The main research question referred to the views of HCPs in the MENA region to IPV. Several themes of HCP's knowledge, attitudes, and barriers in relation to IPV were uncovered across the 29 articles. Knowledge refers to the statements made by HCPs about IPV, I think, I know, I do, while attitudes are distilled from the literature, I feel, I want, I would. Attitude statements were associated with feelings, whereas knowledge statements were associated with facts, information, or skills.

General views and knowledge

The most notable difference between HCPs was that male HCPs were more likely to screen for or diagnose IPV, evidenced in 3 articles (n=3, 10.3%). Next, two articles concluded that married HCPs had higher performances regarding assessing, intervening, documenting, referring, and following up with IPV cases (n=2, 6.9%).

The most contributing factor was a lack of availability or understanding of best practice protocols (n=8, 27.6%) followed by a lack of knowledge on IPV, i.e., the full definition (n=6, 20.7%).

Attitudes

The most common attitude was that HCPs believed that IPV is taboo and did not discuss or intervene (n=10, 34.5%). HCPs feared that screening would have several negative impacts such as offending patients (n=4, 13.8%), endangering victims (n=2, 6.9%), distressing victims (n=2, 6.9%) and that it would not be in the victims' best interest (n=2, 6.9%).

When screening for IPV, HCPs only managed physical symptoms (n=3, 10.3%) and would not intervene beyond physical or medical help (n=2, 6.9%). When HCPs did screen, they would become frustrated when their patients did not disclose or deny IPV (n=3, 10.3%).

Barriers

The most prevalent barrier was the lack of IPV training, which spanned 17 articles contributing to 58.6% of the articles. The next barrier was personal safety; ten articles reported HCPs were afraid of redirected violence to themselves; therefore, they did not want to intervene. Lack of time was reported in ten articles (31.0%). HCPs declared that they deemed themselves unfit to identify, help or deal with IPV victims (n=8, 27.6%). Moreover, there was also a common theme amongst eight articles (27.6%) of the absence of systems that support directing and helping HCPs deal with IPV victims, such as support services.

DISCUSSION

This study reviews 29 articles in the Arabic and English literature on the views of HCPs about IPV in the MENA region. We did not assess the quality of these studies. The highest number of studies were published in Kuwait (31.03%, n = 9). Fewer studies were published in North Africa relative to the Middle East. There was an increasing trend in the number of papers published from 2000-2005 (1 study, 3.44%), 2006-2010 (5 studies, 17.24%), and finally 2011-2015 (16 studies, 55.17%). However, there was a relative decline in the number of studies published between 2016 and 2020 (7 studies, 24.13%).

Most of the studies implemented a mixture of qualitative, quantitative, descriptive, and exploratory study designs. A cross-sectional study design was the most popular in 11 (37.93%)

There are several noteworthy findings from this review concerning the quantity and focus of the articles; we see a significant number of articles discussing a lack of time and training, which are common in the international literature. But specific to the MENA region are articles relating to a lack of knowledge about protocols and systems of support, the role of the law, unclear professional roles, fear for safety, managing misconceptions and taboos, and a lack of privacy in the consultation.

While female HCPs were more involved in IPV care (24.1%), there was a lack of knowledge on the importance of screening and treating IPV victims. One statement that stood out was that HCPs were unaware of the legal procedures or knowledge of any protocols for working with IPV victims.

The most common attitude of HCPs was the fear of offending IPV patients. Another statement mentioned that HCPs only focused on a woman's physical symptoms and tended to ignore any discussion about anxiety, depression, and mental health issues; only one paper stated that HCPs referred suicidal cases to psychiatrists.

The most reported statement was that HCPs perceive IPV as taboo, i.e., social, religious, or private. HCPs would, as a result, refrain from screening or asking questions regarding IPV if suspected. The second most prevalent attitude indicated that IPV is not a medical issue, which causes an obstacle for IPV victims who choose to disclose their experience to HCPs. Many patients end up missing out on treatments as a result of this.

This scoping review of the IPV literature reveals a gap in the knowledge, attitudes, and management of patients who present with injuries from inter-partner violence in the Middle Eastern region. This discovery highlights the urgent need to educate, train and provide a safe environment to report IPV. The barriers highlighted in this review are universally recognized but require a bespoke culturally relevant education program for health care workers. International best practice paired with culturally relevant training is the ideal scenario. As healthcare professionals working in this region, it is essential to seek and build awareness of the barriers to working with women who experience IPV. Providing a review of this literature intends to spark the conversation and create the impetus to ask critical questions and seek the best model of care to empower healthcare providers and those who experience IVP.

Strength and Limitations

This scoping review included a wide range of strengths; initially, two reviewers performed the study selection and review process twice. Our eligibility criteria included studies published in both Arabic and English Journals, giving readers a broader scope of the literature and a deeper insight into IPV in the region. We additionally chose not to include the date in our eligibility criteria, as the MENA region has a limited number of studies on HCPs' perspectives regarding IPV.

As with all research, our review also faced some limitations. The first was that our search was only limited to literature that was already published. As a result, publication bias may be an issue as studies reporting any negative results in the region may remain unpublished. While we included articles in English and Arabic, we excluded articles that were conducted in French, Turkish, and any other language within the region. Therefore, we limited our number of studies and did not include findings that present in some of the countries in the region. This we believe is one of the first scoping reviews in MENA, where IPV has been comprehensively discussed.

CONCLUSION

In conclusion, this scoping review was undertaken to understand the knowledge, attitudes, and barriers of HCPs towards IPV. It highlights the main obstacles that need to be addressed in order to assist IPV victims in the MENA region. These obstacles include lack of knowledge about the IPV protocol, fear factors that are embedded in the HCP due to certain cultural beliefs, and HCPs viewing IPV as a taboo matter. The most important way to overcome these obstacles is to implement a mandatory culturally relevant training program to educate HCPs about detecting, supporting, and treating IPV victims to help improve and potentially save their lives.

KEY MESSAGES

- It is known that the MENA region has a high rate of IPV, a decreased reporting to HCPs, and a decreased detection and treatment in healthcare practice.
- This review highlights and explores the cultural knowledge, attitudes, and barriers of HCPs in the MENA region.
- By understanding these knowledge, attitudes, and barriers; we can therefore develop culturally relevant training programs that directly address the gaps in the detection and treatment of IPV within the healthcare community in the MENA region.

LIST OF ABBREVIATIONS

CINAHL - Cumulative Index of Nursing and Allied Health Literature

CDSR – Cochrane Database of Systematic Reviews

IPV – Intimate Partner Violence

MENA – Middle East and North Africa

SOS-DoC – Support, Options, Strength – Document of observation, assessment & plans, and continuity

HCP – Health Care Practitioners

UAE – United Arab Emirates

oPT – Occupied Palestine Territory

CBPR – Community Based Participatory Research

MDT – Multidisciplinary Training

OPD – Outpatient Department

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable.

CONSENT FOR PUBLICATION

Not applicable.

AVAILABILITY OF DATA AND MATERIALS

Not applicable.

COMPETING INTERESTS

None declared.

FUNDING

This review received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

AUTHOR CONTRIBUTIONS

FSNN and FWA researched and worked on the background. FAOAZ and SA worked on the literature search strategy. JANSS extracted the data regarding the study characteristics. ZS analysed and interpreted the patient data where she performed descriptive statistics of the study sample to describe the sample study characteristics, design, and HCPs' views regarding IPV. SA and SD were significant contributors in writing the manuscript. All authors read and approved the final manuscript.

ACKNOWLEDGEMENTS

Not applicable.

REFERENCES

1. Violence against women World Health Organization [Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women.

2. Maziak W, Asfar T. Physical abuse in low-income women in Aleppo, Syria. *Health Care Women Int* 2003;24(4):313-26. doi: 10.1080/07399330390191689 [published Online First: 2003/05/15]

3. Usta J, Taleb R. Addressing domestic violence in primary care: what the physician needs to know. *Libyan J Med* 2014;9:23527. doi: 10.3402/ljm.v9.23527 [published Online First: 2014/03/22]

4. Taherkhani S, Negarandeh R, Simbar M, et al. Barriers to seeking help among abused Iranian women. *The Journal of Adult Protection* 2017;19(5):261-73. doi: 10.1108/JAP-03-2017-0007

5. van den Ameele S, Keygnaert I, Rachidi A, et al. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. *BMC Health Services Research* 2013;13(1):77. doi: 10.1186/1472-6963-13-77

6. Kyu HH, Abate D, Abate KH, et al. Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet* 2018;392(10159):1859-922. doi: 10.1016/S0140-6736(18)32335-3

7. Cronholm PF, Fogarty CT, Ambuel B, et al. Intimate partner violence. *American family physician* 2011;83(10):1165-72.

8. AlJuhani S, AlAteeq M. Intimate partner violence in Saudi Arabia: A topic of growing interest. *J Family Med Prim Care* 2020;9(2):481-84. doi: 10.4103/jfmpc.jfmpc_1139_19

9. Schrier MW, Rougas SC, Schrier EW, et al. Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals. *MedEdPORTAL* 2017;13:10622-22. doi: 10.15766/mep_2374-8265.10622

10. Rivara FP, Anderson ML, Fishman P, et al. Healthcare Utilization and Costs for Women with a History of Intimate Partner Violence. *American Journal of Preventive Medicine* 2007;32(2):89-96. doi: 10.1016/j.amepre.2006.10.001

11. Bacchus LJ, Ranganathan M, Watts C, et al. Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies. *BMJ open* 2018;8(7):e019995. doi: 10.1136/bmjopen-2017-019995

12. United Nations DoEaSA. World Population Prospects 2019: Highlights. 2019;ST/ESA/SER.A/423.

13. Elghossain T, Bott S, Akik C, et al. Prevalence of intimate partner violence against women in the Arab world: a systematic review. *BMC International Health and Human Rights* 2019;19(1):29. doi: 10.1186/s12914-019-0215-5

14. Ending Violence against Women and Girls. UN Women Arab States. [Available from: https://arabstates.unwomen.org/en/what-we-do/ending-violence-against-women-2]

15. Consideration of reports submitted by States Parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women 2007. [Available from: https://www.mofa.gov.bh/Portals/0/pdf/HumanRights/CEDAW%201-2%20-E.pdf]

16. Douki S, Nacef F, Belhadj A, et al. Violence against women in Arab and Islamic countries. *Arch Womens Ment Health* 2003;6(3):165-71. doi: 10.1007/s00737-003-0170-x [published Online First: 2003/08/16]

17. Usta J, Antoun J, Ambuel B, et al. Involving the health care system in domestic violence: what women want. *Ann Fam Med* 2012;10(3):213-20. doi: 10.1370/afm.1336 [published Online First: 2012/05/16]

18. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. *Violence Against Women* 2008;14(1):53-70. doi: 10.1177/1077801207311860 [published Online First: 2007/12/22]

19. Al-Nsour M, Khawaja M, Al-Kayyali G. Domestic Violence against Women in Jordan: Evidence from Health Clinics. *Journal of Family Violence* 2009;24:569-75. doi: 10.1186/s12889-019-6619-2

20. Lenze J, Klasen S. Does Women's Labor Force Participation Reduce Domestic Violence? Evidence from Jordan. *Feminist Economics* 2017;23(1):1-29. doi: 10.1080/13545701.2016.1211305

21. Ahmad I, Ali PA, Rehman S, et al. Intimate partner violence screening in emergency department: a rapid review of the literature. *J Clin Nurs* 2017;26(21-22):3271-85. doi: 10.1111/jocn.13706 [published Online First: 2016/12/29]

22. Kposowa AJ, Aly Ezzat D. Religiosity,Conservatism, and Acceptability of Anti-Female Spousal Violence in Egypt. *J Interpers Violence* 2019;34(12):2525-50. doi: 10.1177/0886260516660976 [published Online First: 2016/07/28]

23. Qasem HD, Hamadah FA, Qasem KD, et al. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. *Alexandria Journal of Medicine* 2013;49(2):181-87. doi: 10.1016/j.ajme.2012.07.006

24. Ramsay J, Richardson J, Carter YH, et al. Should health professionals screen women for domestic violence? Systematic review. *BMJ* 2002;325(7359):314-14. doi: 10.1136/bmj.325.7359.314

25. Niaz U, Hassan SU-N, Tariq Q. Situational Analysis of Intimate Partner Violence Interventions in South Asian and Middle Eastern Countries. *Partner Abuse* 2017;8:47 - 88. doi: 10.1891/1946-6560.8.1.47

26. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology* 2005;8(1):19-32. doi: 10.1080/1364557032000119616

27. Ouzzani M, Hammady H, Fedorowicz Z, et al. Rayyan—a web and mobile app for systematic reviews. *Systematic Reviews* 2016;5(1):210. doi: 10.1186/s13643-016-0384-4

28. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. *Sex Reprod Healthc* 2019;20:93-99. doi: 10.1016/j.srhc.2019.04.003 [published Online First: 2019/05/16]

29. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. *J Inj Violence Res* 2018;10(2):113-18. doi: 10.5249/jivr.v10i2.958 [published Online First: 2018/07/17]

30. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. *Med J Islam Repub Iran* 2014;28:148-48.

31. Ahmed AM, Abdella ME, Yousif E, et al. Response of Sudanese doctors to domestic violence. *Saudi Med J* 2003;24(10):1077-80. [published Online First: 2003/10/28]

32. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. *Int Nurs Rev* 2016;63(3):422-8. doi: 10.1111/inr.12302 [published Online First: 2016/06/24]

33. Natan MB, Ari G, Bader T, et al. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. *International Nursing Review* 2012;59:108-14. doi: 10.1111/j.1466-7657.2011.00931.x

34. Colombini M, Alkaiyat A, Shaheen A, et al. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. *Health Policy Plan* 2020;35(3):245-56. doi: 10.1093/heapol/czz151 [published Online First: 2019/12/13]

35. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. *Br J Gen Pract* 2014;64(623):e313-20. doi: 10.3399/bjgp14X680077 [published Online First: 2014/05/29]

36. Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. *J Adv Nurs* 2009;65(8):1645-54. doi: 10.1111/j.1365-2648.2009.05019.x [published Online First: 2009/06/06]

37. AbuTaleb NI, Dashti TA, Alasfour SM, et al. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. *Alexandria Journal of Medicine* 2012;48(1) doi: 10.1016/j.ajme.2011.07.014

38. Al-Natour A, Gillespie GL, Felblinger D, et al. Jordanian nurses' barriers to screening for intimate partner violence. *Violence Against Women* 2014;20(12):1473-88. doi: 10.1177/1077801214559057 [published Online First: 2014/11/26]

39. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. *Journal of Nursing Education and Practice* 2015;5(9):11-16. doi: 10.5430/jnep.v5n9p11

40. Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. *J Trauma Nurs* 2010;17(2):112-7. doi: 10.1097/JTN.0b013e3181e736db [published Online First: 2010/06/19]

41. Alsaedi JA, Elbarrany WG, AL Majnon WA, et al. Barriers that impede primary health care physicians from screening women for domestic violence at Makkah ALmukarramah City. *The Egyptian Journal of Hospital Medicine* 2017;69(8):3058-65. doi: 10.12816/0042856

42. Zaher E. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. *From the Editor* 2014;7(10)

43. Alazmy SF, Alotaibi DM, Atwan AA, et al. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. *Alexandria Journal of Medicine* 2011;47(4) doi: 10.1016/j.ajme.2011.07.018

44. Almutairi M, Alkandari AM, Alhouli H, et al. Domestic violence screening among primary health care workers in Kuwait. *Alexandria Journal of Medicine* 2013;49(2):169-74. doi: 10.1016/j.ajme.2012.08.010

45. Alsafy NN, Kamel M. Knowledge of primary care nurses regarding domestic violence. *Alexandria Journal of Medicine* 2011;47(2) doi: 10.1016/j.ajme.2011.02.002

46. Alotaby IY, Alkandari BA, Alshamali KA, et al. Barriers for domestic violence screening in primary health care centers. *Alexandria Journal of Medicine* 2013;49(2):175-80. doi: 10.1016/j.ajme.2012.07.005

47. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, et al. Barriers for administering primary health care services to battered women: Perception of physician and nurses. *Alexandria Journal of Medicine* 2011;47(4) doi: 10.1016/j.ajme.2011.08.003

48. Alkhabaz A, Hammadi TA, Alnoumas SR, et al. Comparison of attitude of primary health care physicians and nurses towards domestic violence against women. *Bull Alex Fac Med* 2010;46(4):371-76.

49. Almutairi GD, Alrashidi MR, Almerri AT, et al. How to screen for domestic violence against women in primary health care centers. *Alexandria Journal of Medicine* 2013;49(1):89-94. doi: 10.1016/j.ajme.2012.07.004

50. Guruge S, Bender A, Aga F, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the ethiopian context. *ISRN Nurs* 2012;2012:307271. doi: 10.5402/2012/307271 [published Online First: 2012/06/12]

51. Ahmed AM, Abdelrahman NHA, Aedh AI, et al. Domestic Violence: With Emphasis on International Cultural and Societal Variations. *Majmaah Journal of Health Sciences* 2016;216(3771):1-16.

52. Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. *BMC Public Health* 2007;7(1):350. doi: 10.1186/1471-2458-7-350

53. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. *Eastern Mediterranean health journal* 2021;27(3) doi: 10.26719/emhj.20.125

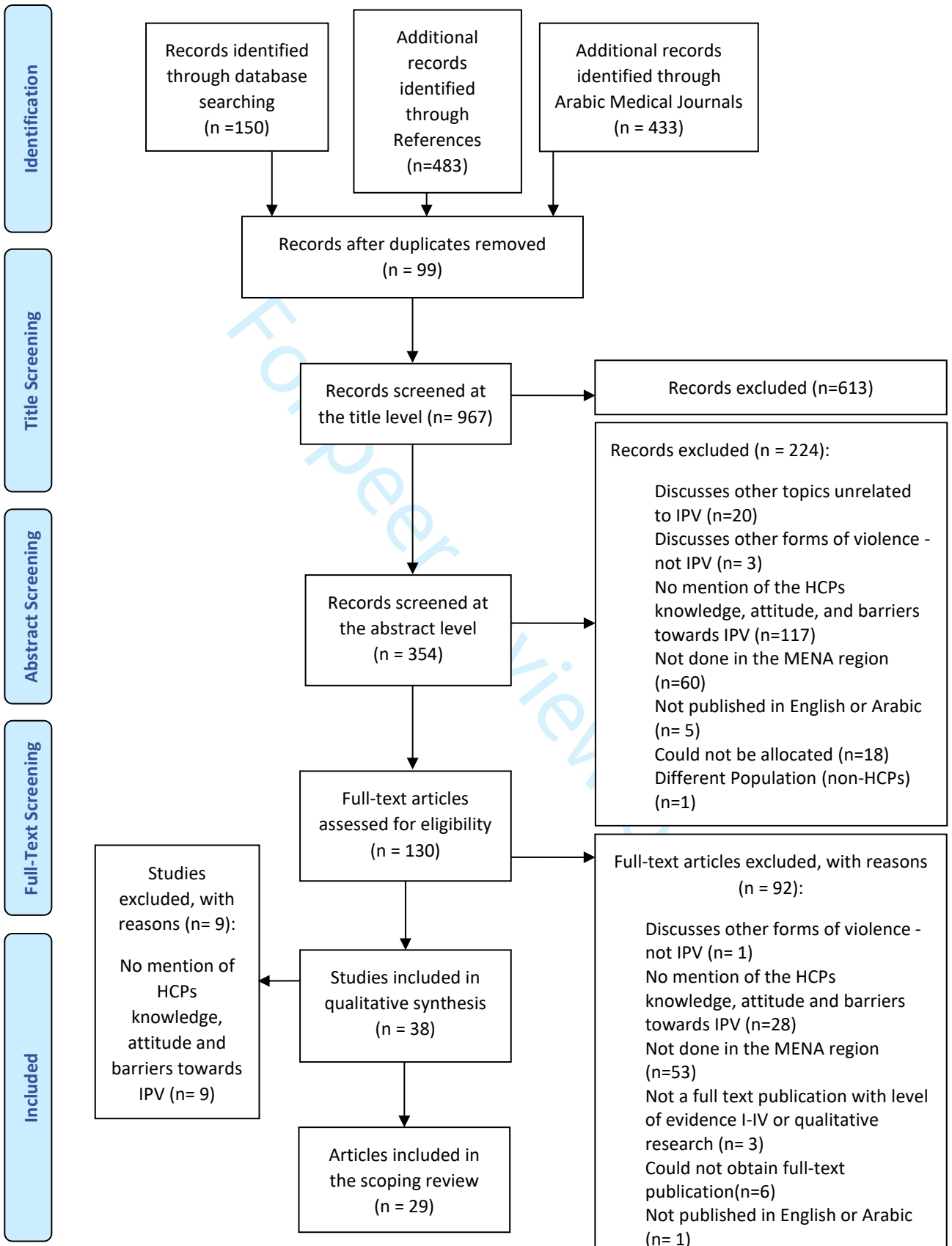
Supporting information

Figure 1. PRISMA Flow Chart (.pdf)

Supplemental Material 1 [Search Strategy] (.pdf)

Supplemental Material 2 [A List of Articles Included in the Scoping Review] (.pdf)

Supplemental Material 3 [Table on the Knowledge, Attitudes, and Beliefs of Included Articles] (.pdf)



Search Strategy (e.g. MEDLINE, CINAHL, APA Psychinfo)

Database: EBSCO MEDLINE, Pyshcinfo, CINAHL.

Search ID#	Search Terms	Results
S1	Domestic Abuse OR Domestic violence OR Domestic assault OR Intimate partner violence OR partner violence OR interpersonal violence OR spouse abuse OR family violence OR sexual violence OR dating violence OR partner abuse	90,205
S2	Primary healthcare OR Primary Healthcare Physician OR Physicians, General Practitioners OR Family Physicians OR Healthcare providers OR Patient Focused Care OR General Practice OR Care OR Primary Health OR Health Care Primary OR Primary Care OR Patient Centered Care	1,396,187
S3	Kuwait OR Bahrain OR United Arab Emirates OR Oman OR Qatar OR Saudi Arabia OR Lebanon OR Syria OR Palestine OR Israel OR Turkey OR Jordan	929,659
S4	Iran OR Iraq OR Yemen OR Morocco OR Libya OR Tunisia OR Algeria OR Egypt OR Malta OR Djibouti OR Ethiopia OR Sudan	476,267
S5	S3 OR S4	1,374,139
S6	Knowledge OR Understanding OR Ability OR Awareness OR Education OR Expertise OR Familiarity OR Grasp OR Grip OR Insight OR Intelligence OR Judgement	7,457,100
S7	Observation OR Recognition OR Comprehension OR Command OR Apprehension OR Skill OR Proficiency OR Capacity OR Capability OR Consciousness	3,348,600
S8	S6 OR S7	9,630,887
S9	Attitude OR Approach OR opinion OR Perspective OR Point of view OR Position OR Prejudice OR Stance OR Reaction OR Sensibility OR Stand OR Temperament	7,530,678
S10	View OR Inclination OR Leaning OR Predilection OR Disposition OR Headset OR Standpoint OR Frame of mind OR Mental state OR Proclivity OR Angle	1,258,559
S11	Reaction OR Ideas OR Conviction OR Orientation OR Feelings OR Thoughts OR Interpretation	3,872,651
S12	S9 OR S10 OR S11	9,436,742
S13	Barriers OR Boundary OR Boundaries OR Limit OR Limitations OR Impediment OR Obstacle OR Fortification OR Hurdle OR Hindrance OR Drawback OR Complication	5,653,834
S14	Difficulty OR Problem OR Disadvantage	2,421,074
S15	S13 OR S14	7,648,623
S16	S1 AND S2 AND S5 AND S8 AND S12 AND S15	8

Articles Included in the Scoping Review (n=29)

1. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.
2. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70
3. Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2013;49(2):181-7.
4. AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(1).
5. Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).
6. Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK. Domestic violence screening among primary health care workers in Kuwait. Alexandria Journal of Medicine. 2013;49(2):169-74.
7. Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI. Knowledge of primary care nurses regarding domestic violence. Alexandria Journal of Medicine. 2011;47(2):173-80.
8. Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M. How to screen for domestic violence against women in primary health care centers. Alexandria Journal of Medicine. 2013;49(1):89-94.
9. Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.
10. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(4).
11. Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK. Comparison of Attitude of Primary Health Care Physicians and Nurses Towards Domestic Violence Against Women. Bull Alex Fac Med. 2010;46(4):371-6.
12. Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. J Adv Nurs. 2009;65(8):1645-54.
13. Ben Natan M, Ben Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59(1):108-14.
14. Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. J Trauma Nurs. 2010;17(2):112-7.
15. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.
16. Al-Natour A, Gillespie GL, Felblinger D, Wang LL. Jordanian nurses' barriers to screening for intimate partner violence. Violence Against women. 2014;20(12):1473-88.
17. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.
18. Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. BMC Public Health. 2007;7(1):350.
19. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. J Inj Violence Res. 2018;10(2):113-8.
20. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. Medical Journal of the Islamic Republic of Iran. 2014;28:148.
21. Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA. Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City. The Egyptian Journal of Hospital Medicine. 2017;69(8):3058-65.

22. Zaher E, Mason R. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. World Family Medicine Journal: Incorporating the Middle East Journal of Family Medicine. 2014;99(1145):1-6.
23. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health Policy Plan. 2020;35(3):245-56.
24. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sex Reprod Healthc. 2019;20:93-9.
25. Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context. ISRN nursing. 2012;2012.
26. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. The British journal of general practice : the journal of the Royal College of General Practitioners. 2014;64(623):e313-e20.
27. Ahmed AM, Abdella ME, Yousif E, Elmardi AE. Response of Sudanese doctors to domestic violence. Saudi Medical J. 2003;24(10):1077-80.
28. Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY. Domestic Violence: With Emphasis on International Cultural and Societal Variations. Majmaah Journal of Health Sciences. 2016;216(3771):1-16.
29. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021 Mar 1;27(3).

Table on the Knowledge, Attitudes, and Beliefs of Included Articles

No.	Author	Study Name	Location	Year of Publication	Type of Journal	Study Design	Participants	Number of participants	Knowledge	Attitudes	Barriers
1	AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI	Knowledge and perception of domestic violence among primary care physicians and nurses: a comparative study [37]	Kuwait	2012	Alexandria Journal of medicine	A comparative study	physician and nurses	565 physicians and 988 nurses	– N/A	– N/A	– Lack of IPV training
2	Ahmed AM, Abdella ME, Yousif E, Elmardi AE.	Response of Sudanese doctors to domestic violence [31]	Khartoum, Sudan	2003	Saudi Medical Journal	Not mentioned	Doctors	102	– Female HCPs see IPV as a genuine health problem – Female HCPs were more likely to interfere – Female HCPs have more knowledge about violence (ie. knowledge or definition of IPV, clinical presentation/findings/characteristics of IPV victims) – Lack of knowledge on IPV – HCPs with more work experience had more knowledge	– HCPs believe that IPV is a taboo matter – HCPs will not intervene beyond medical or physical help i.e., legal	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – HCPs have a fear of endless legal procedures
3	Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY.	Domestic Violence : With Emphasis on International Cultural and Societal Variations [51]	Not Applicable *	2016	Majmaah Journal of Health Sciences,	Review Article	NA **	NA **	N/A	– N/A	– Lack of IPV training
4	Aksan HAD, Aksu F.	The Training needs of turkish emergency department personnel regarding intimate partner violence [52]	Turkey	2007	BMC Public Health	A cross-sectional study	Nurses and physicians	215	– Lack of knowledge of legal procedures Female HCPs have more knowledge about violence (ie. knowledge or definition of IPV, clinical presentation/findings/characteristics of IPV victims)	– N/A	– Lack of IPV training – HCPs unable to identify, help or deal with IPV
5	Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK.	Gender difference of knowledge and attitude of primary health care staff towards domestic violence [43]	Kuwait	2011	Alexandria Journal of Medicine	observational cross-sectional study	health care workers	1553	– Female HCPs have more knowledge about violence (ie. knowledge or definition of IPV, clinical presentation/findings/characteristics of IPV victims)	– N/A	– N/A
6	Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK	Comparison of the attitude of primary health care physicians and nurses towards domestic violence against women [48]	Kuwait	2010	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	1553	– Lack of knowledge on IPV	– HCPs believed that IPV is a taboo matter	– Lack of IPV training – Personal safety (if violence was redirected to HCPs) – Lack of time – HCPs unable to identify, help or deal with IPV
7	Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M.	How to screen for domestic violence against women in primary health care centers [49]	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians, and nurses	210,464	– N/A	– N/A	– Absence of privacy in the clinical setting/OPD – IPV victims don't disclose to HCPs of the opposite sex
8	Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK	Domestic violence screening among primary health care workers in Kuwait [44]	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	210, 464	– Male HCPs more likely to screen for or diagnose IPV – Physicians are more likely to screen IPV than nurses – Lack of knowledge on IPV Female HCPs have more knowledge about violence	– HCPs believe that IPV is a taboo matter	– Absence of a system that supports directing and helping HCPs to deal with IPV victims
9	Al-Natour A, Gillespie GL, Felblinger D, Wang LL.	Jordanian nurses barriers to screening for intimate partner violence [38]	Jordan	2014	Violence against women	Cross-sectional Study	Jordanian nurses.	125	– N/A	– HCPs do not believe that IPV is a medical issue – HCPs fear that screening offends patients – HCPs fear that screening endangers victims – HCPs fear that screening angers patients – HCPs fear that screening is an invasion of privacy	– Personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – HCPs don't feel competent

										– HCPs don't think it's their business if patients don't disclose IPV	
10	Al-Natour A, Qandil A, Gillespie GL.	Intimate Partner Violence screening barriers as perceived by Jordanian nurses: qualitative descriptive study [39]	Jordan	2015	Journal of Nursing and Practice	qualitative descriptive study	nurses	12	– Lack of knowledge of protocol – HCPs fear that screening offends patients	– N/A	– Lack of IPV training – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – Unclear roles/authority – Absence of privacy in the clinical setting/OPD – Insufficient awareness amongst HCPs – IPV victims don't disclose to HCPs of the opposite sex
11	Al-Natour A, Qandil A, Gillespie GL.	Nurses' roles in screening for intimate partner violence: a phenomenological Study [32]	Jordan	2016	International Nursing Review	A phenomenological study	male and female Jordanian nurses	12	– Lack of knowledge of protocol Lack of knowledge on IPV	– HCPs believed that IPV is a taboo matter – Don't screen for IPV even if they suspect violence – Only manage physical symptoms, not mental symptoms – Become frustrated when patients don't disclose assault or deny exposure	– Lack of IPV training – Unclear roles/authority
12	Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M.	Barriers for domestic violence screening in primary health care centers [46]	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians (210) and nurses	210,464	N/A	– N/A	Lack of IPV training – Lack of experience
13	Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK	Barriers for administering primary health care services to battered women: perception of physician and nurses [47]	Kuwait	2011	Alexandria Journal of Medicine	Observational cross-sectional study	physicians and nurses.	1553	N/A	– HCPs believed that IPV is a taboo matter	– Lack of IPV training – Personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Insufficient staffing, structures, resources – Absence of privacy in the clinical setting/OPD – Heavy workload – Shame/embarrassment in asking questions – Lack of legal arrangements
14	Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA.	Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City [41]	Saudi Arabia	2017	The Egyptian journal of Hospital Medicine	cross-sectional study	PHCPs	62	– Male HCPs more likely to screen for or diagnose IPV – Married HCPs had higher performances – Lack of knowledge on IPV Lack of knowledge of legal procedures	– N/A	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Insufficient staffing, structures, resources – Heavy workload – Shame/embarrassment in asking questions
15	Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI.	Knowledge of primary care nurses regarding domestic violence [45]	Kuwait	2011	Alexandria Journal of Medicine	Exploratory, attitudinal surveys	nurses	988	– N/A	– N/A	– Lack of IPV training
16	Aziz MM, El-Gazzar AF.	Health Care Providers' Perceptions and Practices of Screening for	Upper Egypt (Assiut)	2019	Sexual & Reproductive Healthcare	Mixed Quantitative and Qualitative; Survey and FDGs	doctors and nurses, physicians and nurses in the FDG	122 doctors and 200 nurses returned surveys. 12 Physicians and 10 nurses in the FGDs.	– Lack of knowledge of protocol – Lack of knowledge of legal procedures – Lack of knowledge around necessary skills required	– Believe that IPV is a taboo matter – HCPs perceive IPV to be an ordinary matter within society	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time

		Domestic Violence in Upper Egypt [28]								– HCPs fear that screening offends patients, endangers victims, is distressing to them and causes interference – When screening for IPV, HCPs only manage physical symptoms, not mental 8symptoms, become frustrated when patients don't disclose assault or deny exposure and only refer suicidal cases to a psychiatrist	– Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Absence of privacy in the clinical setting/OPD – HCPs unable to council cases
17	Ben Natan M, Ben Ari G, Bader T, Hallak M.	Universal screening for domestic violence in a department of obstetrics and gynaecology: A patient and carer perspective [33]	Israel	2011	International Nursing Review	Correlative, cross-sectional design was utilized	physicians, nurses, female patients	100 physicians and nurses, 100 female patients	– Lack of knowledge of protocol – Knowledge about IPV training and protocols on how to deal with IPV cases allowed HCPs to screen IPV victims	– N/A	– Lack of IPV training
18	Boy A, Kulczycki A.	What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women [18]	MENA region	2008	Violence against women	Review article	Not applicable	none	– N/A	– When screening for IPV, HCPs will not intervene beyond medical or physical help i.e., legal	– HCPs unable to identify, help or deal with IPV
19	Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L.	Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory [34]	occupied Palestinian Territory (oPT)	2019	The Oxford Journal on Health Planning and Systems research; Health Policy and planning.	Case Study design using qualitative methods (interviews and a stakeholder meeting)	PHC providers and Stakeholders	23 PHC providers and 19 Stakeholders	– Lack of knowledge of protocol – Lack of knowledge on IPV	– HCPs believe that IPV is a taboo matter – HCPs believe there is limited capacity as IPV is a mental health issue – HCPs become frustrated when patients don't disclose assault or deny exposure – HCPs feel frustrated with the low referral uptakes by patients	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Insufficient staffing, structures, resources No law to protect HCPs
20	Goldblatt H.	Caring for abused women: impact on nurses' professional and personal life experiences [36]	Israel	2009	Journal of Advanced Nursing	A phenomenological study	female Israeli nurses	22	– N/A	– HCPs fear that screening leads to emotional involvement	– Lack of time – Difficult to set boundaries
21	Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al	Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context [50]	Ethiopia	2012	ISRN Nursing	Nursing-led Interdisciplinary project and literature review	NA	NA	– N/A	– HCPs believe that IPV is a taboo matter	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Unclear roles/authority
22	Ibrahim E, Hamed N, Ahmed L.	Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt [53]	Egypt	2021	Eastern Mediterranean health journal	A cross-sectional study	Healthcare Providers	385	– N/A	– HCPs did not want to interfere as they believe IPV is not part of medical practice	– Lack of time – Lack of IPV training – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs fear that patients would get angry if screened
23	Natan MB, Rais I.	Knowledge and attitudes of nurses regard-ing domestic violence and their effect on the identification of battered women [40]	Israel	2010	Journal of Trauma nursing	descriptive, quantitative study	hospital- and community-based nurses.	100	– Lack of knowledge of protocol	– Believe that IPV is a taboo matter	– Lack of IPV training

36/bmjopen-2023-079866 on 21 August 2024. Downloaded from

24	Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK.	Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women [23]	Kuwait	2013	Alexandria Journal of Medicine	Cross-sectional Study	Doctors and nurses	210 physicians and 464 nurses	– Male HCPs more likely to screen for or diagnose IPV – Physicians are more likely to screen IPV than nurses More knowledgeable HCPs more likely to screen for IPV	– HCPs fear that screening is not in patients' best interest – Screening reduces rates and effects of violence and improves the quality of life	– N/A
25	Rasoulian M, Shirazi M, Nojomi M.	Primary Health Care Physicians' Approach Toward Domestic Violence in Tehran, Iran [30]	Tehran, Iran	2014	Medical Journal of the Islamic Republic of Iran	Not mentioned	PHCPs	198	– Female HCPs were more likely to document IPV – HCPs believed that patients will disclose IPV if it is severe enough – HCPs believe that IPV is a critical health problem. – HCPs think that women should tolerate IPV to keep family privacy and honour	– HCPs believe that screening endangers victims and is distressing to them	– N/A
26	Usta J, Feder G, Antoun J.	Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners [35]	Lebanon	2014	British Journal of General Practice	Qualitative study	Physicians	70	– Lack of knowledge of protocol	– HCPs believe that IPV is a taboo matter – HCPs do not believe that IPV is a medical issue – HCPs only manage physical symptoms, not mental symptoms	– HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – No law to protect HCPs
27	van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M	The Role of the Healthcare Sector in the Prevention of Sexual Violence Against sub-Saharan Transmigrants in Morocco: A Study of Knowledge, Attitudes and Practices of Healthcare Workers [5]	Morocco	2013	BMC Health Services research	A KAP (Knowledge, Attitudes, Practices) questionnaire, identifying knowledge, attitudes and practices, guided the semi-structured interviews.	Male and Female HCW, Organizations	24 (12 men and 12 women)	Lack of knowledge of legal procedures	– HCPs fear that screening offends patient, is not in patients' best interest and opens up old wounds When screening for IPV, HCPs respect the choice of IPV victims to remain silent	– Absence of a system that supports directing and helping HCPs to deal with IPV victims – Insufficient staffing, structures, resources – HCPs don't feel competent Insufficient awareness amongst HCPs
28	Yousefnia N, Nekuei N, Farajzadegan Z.	The Relationship Between Healthcare Providers' Performance Regarding Women Experiencing Domestic Violence and Their Demographic Characteristics and Attitude Towards Their Management [29]	Iran	2018	Injury & Violence	Cross-sectional study	physicians, 46 midwives, and 212 nurses.	300	– Married HCPs had higher performances – Female HCPs have higher performances – Nurses had higher performances than physicians –	– N/A	N/A
29	Zaher E, Mason R.	Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study [42]	Saudi Arabia	2014	Middle East Journal of Family Medicine	Exploratory, attitudinal surveys	Doctors	30	N/A	N/A	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV

Legend:

*Location is not applicable in one of the included studies as it was a review article and was not based in a specific country.

**Participants are not applicable in review studies that do not have any direct participants

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	3,4,5
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	N/A
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	6
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	6
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Supplemental Material 1: Search Strategy
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	5,6
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	N/A
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	N/A

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	N/A
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	N/A
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	7 Figure 1 PRISMA Flow Chart
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	7,8,9 Supplemental Material 3: Table of KAB of included articles
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	N/A
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	N/A
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	N/A
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	9,10
Limitations	20	Discuss the limitations of the scoping review process.	10,11
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	11
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	12

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.

BMJ Open

A Scoping Review of healthcare professionals' views on Intimate Partner Violence in the Middle East and North Africa

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2023-079866.R1
Article Type:	Original research
Date Submitted by the Author:	25-Jan-2024
Complete List of Authors:	Al-Salmi, Sabrina ; Royal College of Surgeons in Ireland and Medical University of Bahrain Aly, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain Najeeb, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain, Alumni Sefen, Jessica; Royal College of Surgeons in Ireland and Medical University of Bahrain Shaikh, Zoya; Royal College of Surgeons in Ireland and Medical University of Bahrain Zuaiter, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain Doherty, Sally; Royal College of Surgeons in Ireland and Medical University of Bahrain
Primary Subject Heading:	General practice / Family practice
Secondary Subject Heading:	Global health, Medical education and training, Medical publishing and peer review, Public health
Keywords:	Primary Prevention, Primary Health Care, Primary Care < Primary Health Care

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

A Scoping Review of healthcare professionals' views on Intimate Partner Violence in the Middle East and North Africa

Sabrina Al-Salmi[1], Farah W. Aly[1], Farah S.N. Naser[1], Jessica A.N. Sefen[1], Zoya Shaikh[1], Farah A.O.A. Zuaiter[1], Sally Doherty[1]

[1]School of Medicine, Royal College of Surgeons in Ireland, Al-Sayh, Muharraq, Bahrain

*Corresponding Author: Farah A O A Zuaiter

Postal Address:

Royal College of Surgeons in Ireland
Al-Sayh, Muharraq
P.O. Box 15503, Adliya
Kingdom of Bahrain

Email: 16135296@rcsi.com

Word Count: 3863 words

ABSTRACT

Objectives

This scoping review aims to charter healthcare providers (HCPs) in the Middle East and North Africa (MENA) about their knowledge, attitudes, and barriers to working with women who experienced Intimate Partner Violence (IPV). The purpose of this review is to map the breadth of available peer-reviewed literature which may inform future educational training programs.

Design

Scoping review.

Data Sources

It involves studies up to December 2023 from PUBMED, Medline, COCHRANE, CINAHL, PsycINFO, and Arabic medical journals.

Eligibility Criteria

We have included articles published in English and Arabic; focused on IPV; included HCPs' views on IPV; the MENA region, full-text formats; with adult women; and no date restrictions.

Data Extraction and Synthesis

Studies were on research location, year of publication, type of journal, methodology, design, and participants. Data was extracted 'charted' from all studies to include study characteristics, knowledge, attitudes, and barriers. Then, the by charting the information into a table and creating a framework, the reviewers were then able to reach multiple outcomes as a result.

Results

Of the 1066 articles reviewed, 30 eligible studies were in this scoping review. HCPs' lack of knowledge about IPV protocol was reported in 27% of the articles, 20% of the articles reported a low level of awareness about IPV. The attitudes of HCPs varied; the dominant attitude reported was a preference to treat the presenting health complaint and not to engage in discussions about IPV. Finally, 30% of articles stated that the main barrier was the HCPs' lack of training relating to IPV.

Conclusion

Our paper concluded that there is a lack of research in understanding the knowledge, attitudes, and barriers surrounding HCPs in the MENA region and IPV. This scoping review highlights the need for further research, informing interventions, and training for HCPs in the region.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- The methodology of Arksey and O'Malley was used to ensure a consistent framework when drafting the review.
- This study's study selection was done electronically via the web-based program Rayyan and by two reviewers to reduce bias on inclusion and exclusion of articles.
- Language restriction was among the main limitations to the number of studies included in this review.
- The restricted number of domestic violence articles published in the MENA region served as a limitation to the validity of the study.
- A formal bias assessment was not conducted in this study.

KEYWORDS

Intimate Personal Violence, Middle East, Review

BACKGROUND

Intimate Partner Violence (IPV) is a major worldwide public health problem impacting millions of lives (1). IPV is a complex subject, defined in this article in accordance to the Istanbul Convention: *"all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit, or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim"* (2).

Prevalence rates of IPV in Western countries range from 25% to 38%. While prevalence rates in the Middle East and North Africa (MENA) region range from 15% to 85% (1, 2). Those women who

experience IPV in their lifetime may suffer from numerous physical and mental health problems such as depression, post-traumatic stress disorder, anxiety disorders, substance abuse, suicidal behaviour, somatising disorders, eating disorders, and chronic pain (3, 4). Undisclosed violence can also lead to feelings of guilt, shame, and worthlessness (5). According to the Global Burden of Disease Study, IPV causes significant morbidity and mortality (6). Healthcare workers need to be aware of the possible signs and symptoms of IPV, have training in the use of screening tools, and refer to community and advocacy programs to provide care and support in a non-judgmental, private, and confidential environment (3, 7-9).

Women who experience IPV will often require more healthcare visits compared to women who do not experience IPV (10). IPV is associated with adverse health outcomes, including depression, anxiety, and substance abuse (11). Therefore, it is crucial to identify healthcare providers' views (HCPs) in the MENA region about their knowledge and attitudes to treating women who experience IPV.

The twenty-four countries of the MENA region include Saudi Arabia, Kuwait, Bahrain, United Arab Emirate (UAE), Oman, Qatar, Yemen, Lebanon, Syria, Jordan, Palestine, Israel, Turkey, Iran, Iraq, Morocco, Libya, Tunis, Algeria, Egypt, Malta, Djibouti, Ethiopia, and Sudan. These 24 countries represent an approximate population of 725 million (12). Despite diversity across these countries, they tend to share a commonality of culture, religion (mainly Islam), and language (Arabic). While women have achieved parity across many of these countries, there still may exist social, economic, and political equality barriers (13). IPV represents both public health and a human rights problem. The only countries with civil and legal laws to protect women against IPV are Jordan, Lebanon, Tunisia, Morocco, Bahrain, and Saudi Arabia (14). The Supreme Council for Women established a shelter for female family violence victims in Bahrain. Women can receive care and guidance if they experience IPV (15).

IPV is perceived as taboo and not considered a crime in many MENA regions. Often it is a matter for the religious courts to resolve instead of the civil and legal authorities (3, 16, 17).

A recent systematic review of prevalence rates in the Arab region identified 46 datasets from peer-reviewed journals and 11 national surveys across 16 years from 2000 -2016. Results indicated that IPV ranged from 6 to 59% for physical abuse, 3 to 40% for sexual abuse, and 5 to 91% for emotional and psychological abuse. The authors pointed out the problem was a lack of a homogenous definition of IPV (13).

Findings from recent literature in the MENA region reporting on IPV in the Arab region emphasize the influence of culture, modesty, family solidarity, and reputation (17, 18). Al-Nsour et al. explored attitudes toward IPV in Jordan, discovering that one-third of perpetrators justified 'wife beating' due to the culture in their country (19). Additionally, women do not turn to HCPs for help with IPV due to the cultural stigma of causing a 'scandal' (20). A woman with unexplained injuries and a reluctance to discuss their injury are often because her partner accompanies her to the physician consultation. She may fear the outcomes related to reporting the crime (21). These culturally biased attitudes are the main barriers to seeking help (22). Less than 15% of female patients in the MENA region reported being asked about IPV by their HCPs, in comparison to studies in non-Arabic communities that report 43 to 85% of female respondents (23, 24).

The Arab community has a shared commonality of HCPs unwilling to integrate IPV into their practice (17, 25). Cultural stereotypes increase the HCPs' reluctance to intervene due to fear for their safety, losing their patients, and opposing the norm of their conservative society (3). With the influence of culture and religion on Arab HCPs, knowledge of and attitude to IPV is critical to providing education and training programs (3).

Therefore, the purpose of this review is to map the breadth of available peer-reviewed literature in a specific region to identify research gaps and focus on future research priorities and inform future educational training programs.

MATERIALS & METHODS

We are conducting a scoping review; unlike a systematic review, it allows the researcher to address and summarize a broader range of evidence and topics where multiple study designs are applicable (26). Key concepts in a specific research area describe the wide range of evidence and sources (26). Moreover, it highlights the gaps in the existing literature and is employed due to the lack of literature in a specific area of research (26). The quality of the studies is not assessed in a scoping review. The research question allows for broader non-specific questions to be addressed. In this instance, we are interested in the views of healthcare providers about IPV. We have included articles that focus on the knowledge, attitudes, and barriers to working with women who experience IPV. The HCPs include doctors, nurses, and midwives, and social workers.

The methods described in this study were adopted by Arksey and O'Malley's methodological framework (26). Their methodological framework for conducting a scoping review consisted of five stages. The following stages include identifying a research question, identifying relevant peer-reviewed studies, study selection, charting the data, and finally collating, summarizing, and reporting the results (26).

Our aim is investigating "what is known about the knowledge attitudes, and barriers of HCPs on IPV in the MENA region?" This scoping review is conducted for IPV advocates, IPV victims, their representatives, researchers, and healthcare providers, including doctors, nurses, policymakers, institutions, organizations, caregivers, and health-based students, such as nursing and medical students.

Literature search strategy

FAOAZ and SA did a search strategy [Supplemental Material 1]. All publications that target HCPs' views on IPV in the MENA Region were included. Key search terms were Healthcare providers, MENA region, IPV, knowledge, attitudes, and barriers. The following databases were searched: PUBMED, Medline, PsycINFO, Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Cochrane Database of Systematic Reviews (CDSR). All searches were performed up to the date of December 2023 with no date restriction. In addition, the references from all key papers were manually reviewed. A hand search of relevant articles in the Arabic Medical Journals was also conducted. A sample of the search strategy is available for review in the document labelled as Figure 1.

Eligibility Criteria

For this scoping review, we included articles based on a broad eligibility criterion. This criterion contains articles: [1] published in English and Arabic; [2] focused on IPV; [3] Included HCPs' views on IPV; [4] in the MENA region; [5] in full-text formats [6] with adult women; [7] no date restrictions. Articles that did not meet this inclusion criterion or with abstracts and full texts that could not be obtained were excluded.

Data Extraction

Based on the review's research question, a data extraction template was developed in the form of a table by two reviewers, JANS and ZS. They extracted or 'charted' the data focusing on the following categories: Study characteristics, which includes but is not limited to research location, year of publication, type of journal, methodology, study design and participants; knowledge, attitudes, barriers, and any factors that

fall under these categories. As seen in other Scoping reviews (26), determining what fell under each category differed per paper and there was a difference in the definition and understanding of each concept throughout the studies.

Data Synthesis

By charting the information into a table and creating a framework, the reviewers were then able to reach multiple outcomes as a result. The framework additionally allowed us to identify gaps in the research and describe the outcomes on each of the categories: Knowledge, Attitudes and Barriers.

Patient and Public Involvement

We did not include patients or members of the public in the research, as this was beyond the study's scope.

RESULTS

Article Identification & Selection

Our search strategy resulted in a total of 1060 articles [Figure 1]. Of these articles, 146 came from the databases, 481 from references, and 433 from the hand search of Arabic Medical Journals. We did not encounter any papers with only Arabic abstract or full text. Of these, 99 were duplicated and removed before title screening. Therefore, 961 underwent title review, and the reviewers found that 353 abstracts were potentially eligible. After screening the abstracts, 129 full text studies were reviewed. However, only 30 studies were included in the scoping review [Supplemental Material 2]. The remaining articles were excluded as they did not mention knowledge, attitudes or barriers of HCPs towards IPV. All article screening and selection were completed using the web-based program Rayyan (27).

Figure 1: PRISMA Flow Chart

Study Characteristics

There was a total of 30 papers in this scoping review. The majority came from Kuwait (n = 9) followed by three studies from Israel and three from Jordan. Three studies were each conducted in Saudi Arabia, and two were done in Morocco, and Iran. One study was conducted in each of the occupied Palestine Territory (oPT), Egypt, Ethiopia, Lebanon, Turkey, and Sudan. One study involved the entire MENA region (n = 1,

3.3%). The final study included is a review that had no mention of the actual country; hence it is classified as 'not mentioned/not applicable' under location in the Knowledge, Attitudes, and Beliefs table [Supplemental Material 3].

Study Designs

There were twelve different types of study designs in the 30 articles reviewed. Of these, the majority were cross-sectional studies (n=14, 46.7%), 3 were review articles (10%), 3 were qualitative studies (10%), 2 were Phenomenological studies (6.75%), and mixed as well as quantitative designs were each present in one study (3.3%). The table in supplemental material 3 fully outlines the 12 study designs and the type as well as number of participants. The range of participants in these studies ranged from 12 (28, 29) to 1,553 (30-33) participants. Three review studies are literature based and hence don't directly involve any participants (18, 34, 35).

Some studies involved both doctors and nurses (n = 11, 36.7%). A few studies included either doctors (n = 6, 20%) or nurses (n = 6, 20%). One study included doctors, nurses, and midwives (36), and another included doctors, nurses, and female patients (37). Health Care Providers were included in two studies, this is a separate row on the table as the title 'HCP' does not specify the professional (ie. nurse/doctor) [Supplemental Material 3]. One study even included social workers (38). Two included other participants besides HCPs; one included HCP and stakeholders, (39) and the other targeted key HCPs and organizations in the community to recruit as participants (5).

Notes: HCPs do not specify what kind of healthcare worker has participated (ie. nurse or doctor or other) and hence are left as just 'HCPs'.

Outcomes

This study reviews 30 articles in the Arabic and English literature on the views of HCPs about IPV in the MENA region. We did not assess the quality of these studies as this does not fall under the claim of a scope review. The highest number of studies were published in Kuwait (n = 9, 30%). Fewer studies were published in North Africa relative to the Middle East. There was an increasing trend in the number of papers published from 2000-2005 (n=1, 3.3%), 2006-2010 (n=5, 16.7%), and finally 2011-2015 (n=16,

53.3%). However, there was a relative decline in the number of studies published between 2016 and 2023 (n=8, 26.7%).

Most of the studies implemented a mixture of qualitative, quantitative, descriptive, and exploratory study designs. A cross-sectional study design was the most popular in 14 studies (46.7%).

The main research question referred to the views of HCPs in the MENA region to IPV. Several themes of HCP's knowledge, attitudes, and barriers in relation to IPV were uncovered across the 30 articles. Knowledge refers to the statements made by HCPs about IPV, I think, I know, I do, while attitudes are distilled from the literature, I feel, I want, I would. Attitude statements were associated with feelings, whereas knowledge statements were associated with facts, information, or skills.

General views and knowledge

The most notable difference between HCPs was that male HCPs were more likely to screen for or diagnose IPV, evidenced in 3 articles (n=3, 10%). Next, two articles concluded that married HCPs had higher performances regarding assessing, intervening, documenting, referring, and following up with IPV cases (n=2, 6.7%). Two articles identified that family physicians were more likely to have a good knowledge of IPV than general practitioners and were therefore more likely to screen for IPV (n=2, 6.7%). It was noted that female HCPs have more knowledge (n=4, 13.3%), saw IPV as a genuine health problem, were more likely to document IPV and were also more likely to interfere (n=1, 3.3%). Also, HCPs who had more work experience showed more IPV knowledge (n=2, 6.7%).

The most contributing factor was a lack of availability or understanding of best practice protocols (n=10, 33.3%) followed by a lack of knowledge on IPV, i.e., the full definition (n=8, 26.7%). 4 articles identified that HCPs were unaware of the legal procedure (10%). 1 article proved that knowledge about IPV training and protocols on how to deal with IPV cases, allowed HCPs to screen IPV victims (3.3%), and another stated that more knowledgeable HCPs are more likely to screen for IPV (3.3%).

Attitudes

The most common attitude was that HCPs believed that IPV is taboo, did not discuss or intervene (n=10, 33.3%), perceived IPV to be an ordinary matter within society and that women should tolerate IPV to keep their family's privacy and honour (n=1, 3.3%). HCPs feared that screening is an invasion of privacy (n=1,

3.3%), would not be in the victims' best interest (n=2, 6.7%), leads to an emotional environment (n=1, 3.3%) and that it would have several negative impacts such as offending patients (n=5, 16.7%), angering patients (n=1, 3.3%), endangering victims (n=2, 6.7%) and distressing victims (n=2, 6.7%). Some HCPs wouldn't screen for IPV even if they suspected violence (n=1, 3.3%). HCPs felt frustrated with the low referral uptakes by patients (n=1, 3.3%). Some HCPs felt shame/embarrassment in asking questions regarding IPV (n=1, 3.3%).

When screening for IPV, HCPs only managed physical symptoms (n=3, 10%) and would not intervene beyond physical or medical help (n=2, 6.7%). HCPs would only refer suicidal cases to psychiatrists and believed there is limited capacity as IPV is a mental health issue (n=1, 3.3%) and is not part of medical practice (n=2, 6.7%). When HCPs did screen, they would become frustrated when their patients did not disclose or deny IPV (n=3, 10%), believed that patients will disclose IPV if it is severe enough and would respect the choice of IPV victims to remain silent (n=1, 3.3%). HCPs also feared endless legal procedures (n=1, 3.3%).

Barriers

The most prevalent barrier was the lack of IPV training and experience, which spanned 19 articles contributing to 63.3% of the articles. The next barrier was personal safety; 10 articles reported HCPs were afraid of redirected violence to themselves; therefore, they did not want to intervene (33.3%). Lack of time was reported in 11 articles (36.7%). HCPs declared that they deemed themselves unfit to identify, help or deal with IPV victims (n=8, 26.7%). Moreover, there was also a common theme amongst 11 articles (36.7%) of the absence of systems that support directing and helping HCPs deal with IPV victims, such as support and referral services. Some HCPs claimed that there was an absence of privacy in the clinical setting (n=6, 20%). HCPs also were unsure about their roles or the authority they had in IPV cases (n=2, 6.7%) and claimed that there was insufficient awareness amongst HCPs (n=3, 10%). Another barrier identified was the heavy workload (n=2, 6.7%)

DISCUSSION

There are several noteworthy findings from this review concerning the quantity and focus of the articles; we see a significant number of articles discussing a lack of time and training, which are common in the

international literature. However, specific to the MENA region are articles relating to a lack of knowledge about protocols and systems of support, the role of the law, unclear professional roles, fear for safety, managing misconceptions, and a lack of privacy in the consultation.

The most reported statement and barrier was that HCPs perceive IPV as taboo, i.e., social, religious, or private. HCPs would, as a result, refrain from screening or asking questions regarding IPV if suspected. The second most prevalent attitude indicated that IPV is not a medical issue, which causes an obstacle for IPV victims who choose to disclose their experience to HCPs.

In comparison to the MENA region, a recent study published by Hudspeth et al. outlines the barriers to identification of IPV across various countries (40). These were found to be similar to the MENA region and included both environmental and social barriers. In the MENA region, the most common barrier was found to be lack of IPV training. However, in the study by Hudspeth et al, the largest barrier was the HCPs' healthcare environment and the impact it had on their interaction with patients (40).

This scoping review of the IPV literature reveals a gap in the knowledge, attitudes, and management of patients who present with injuries from IPV in the MENA region. This discovery highlights the urgent need to educate, train, and provide a safe environment to report IPV. The barriers highlighted in this review are universally recognized but require a bespoke culturally relevant education program for health care workers. International best practice paired with culturally relevant training is the ideal scenario. As HCP working in this region, it is essential to seek and build awareness of the barriers to working with women who experience IPV.

This review additionally aims to recognize and identify the need for HCPs education programs that target not only lack of training and knowledge of HCPs but also their attitudes and beliefs. A review by Sprague et al, aims to identify the components of educational programs that have the greatest positive impact on identifying and managing IPV (41). They found that programs that were delivered by IPV educators/experts or physicians, included specific treatment protocols and patient resources, and finally programs with an online training component and lasting for more than 5 sessions yielded the best results (41). It is important to highlight that although literature exists on the effectiveness of various training programmes for HCPs, the effectiveness of these programmes on the attitudes and behaviours of physicians is lacking worldwide (42). Additionally, many countries in the MENA region still lack

appropriate IPV legal policies and support services for victims. Therefore, many victims and HCPs do not have the necessary IPV laws, hospital policies, and services to sufficiently support them (13). This is only one of the many barriers to developing efficient training programs in the MENA region. Therefore, suggesting an ideal training program for HCPs in the MENA region is impossible without further research that explores the barriers and efficiency of training programs both in the MENA region and worldwide.

Strength and Limitations

This scoping review included a wide range of strengths; initially, two reviewers performed the study selection and review process twice. Our eligibility criteria included studies published in both Arabic and English Journals, giving readers a broader scope of the literature and a deeper insight into IPV in the region. We additionally chose not to include an end date in our eligibility criteria, as the MENA region has a limited number of studies on HCPs' perspectives regarding IPV.

As with all research, our review also faced some limitations. The first was that our search was only limited to literature that was already published. As a result, publication bias may be an issue as studies reporting any negative results in the region may remain unpublished. While we included articles in English and Arabic, we excluded articles that were conducted in French, Turkish, and any other language within the region. Therefore, we limited our number of studies and did not include findings that present in some of the countries in the region. This, we believe, is one of the first scoping reviews in MENA, where IPV has been comprehensively discussed. Another limitation in this study is that the articles included in this study only discussed the negative but not the positive attitudes and beliefs of HCPs towards IPV. Perhaps adding positive attitudes and beliefs or enablers to managing and screening for IPV would have facilitated an understanding of possible solutions to addressing IPV in the MENA region.

CONCLUSION

In conclusion, this scoping review was undertaken to understand the knowledge, attitudes, and barriers of HCPs towards IPV. It highlights the main obstacles that need to be addressed in order to assist IPV victims in the MENA region. These obstacles include lack of knowledge about the IPV protocol, fear factors that are embedded in the HCP due to certain cultural beliefs, and HCPs viewing IPV as a taboo matter. The most important way to overcome these obstacles is to implement a mandatory and culturally relevant

training program to educate HCPs about detecting, supporting, and treating IPV victims to help improve and potentially save their lives.

Implications

This scoping review draws attention to the knowledge, attitudes, and beliefs of HCPs towards IPV. Now that this paper identified some of the barriers to screening and managing IPV in the MENA region, it highlights the need for further studies to investigate the means and components of an effective education and training program in the MENA region. This training programme should be one that tackles not only the knowledge of HCPs but also their attitudes and beliefs. In addition to studies that investigate the effectiveness of these education programs in the region, it would be beneficial if further literature is done to address the positive attitudes and enablers to managing and screening for IPV within HCPs in the MENA region.

KEY MESSAGES

- It is known that the MENA region has a high rate of IPV, a decreased reporting to HCPs, and a decreased detection and treatment in healthcare practice.
- This review highlights and explores the cultural knowledge, attitudes, and barriers of HCPs in the MENA region.
- By understanding these knowledge, attitudes, and barriers; we can therefore develop further studies on culturally relevant training programs that directly address the gaps in the detection and treatment of IPV within the healthcare community in the MENA region.
- In addition to establishing effective education programs in the MENA region; the establishment and recognition of IPV policies, laws, and support services are also vital to the prevention and management. Therefore, further studies are also required to identify the gap of laws and services to find a way to tackle them.

LIST OF ABBREVIATIONS

CINAHL - Cumulative Index of Nursing and Allied Health Literature

CDSR – Cochrane Database of Systematic Reviews

IPV – Intimate Partner Violence

MENA – Middle East and North Africa

SOS-DoC – Support, Options, Strength – Document of observation, assessment & plans, and continuity

HCP – Health Care Practitioners

UAE – United Arab Emirates

oPT – Occupied Palestine Territory

CBPR – Community Based Participatory Research

MDT – Multidisciplinary Training

OPD – Outpatient Department

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable.

CONSENT FOR PUBLICATION

Not applicable.

AVAILABILITY OF DATA AND MATERIALS

Not applicable.

COMPETING INTERESTS

None declared.

FUNDING

This review received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

AUTHOR CONTRIBUTIONS

FSNN and FWA researched and worked on the background. FAOAZ and SA worked on the literature search strategy. JANSS extracted the data regarding the study characteristics. ZS analysed and interpreted the patient data where she performed descriptive statistics of the study sample to describe the sample study characteristics, design, and HCPs' views regarding IPV. SA and SD were significant contributors in writing the manuscript. All authors read and approved the final manuscript.

ACKNOWLEDGEMENTS

Not applicable

REFERENCES

1. Violence against women World Health Organization [Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women.

2. Maziak W, Asfar T. Physical abuse in low-income women in Aleppo, Syria. Health Care Women Int. 2003;24(4):313-26.

3. Usta J, Taleb R. Addressing domestic violence in primary care: what the physician needs to know. Libyan J Med. 2014;9:23527.

4. Taherkhani S, Negarandeh R, Simbar M, Ahmadi F. Barriers to seeking help among abused Iranian women. The Journal of Adult Protection. 2017;19(5):261-73.

5. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.

6. Kyu HH, Abate D, Abate KH, Abay SM, Abbafati C, Abbasi N, et al. Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. The Lancet. 2018;392(10159):1859-922.

7. Cronholm PF, Fogarty CT, Ambuel B, Harrison SL. Intimate partner violence. American family physician. 2011;83(10):1165-72.

8. AlJuhani S, AlAteeq M. Intimate partner violence in Saudi Arabia: A topic of growing interest. J Family Med Prim Care. 2020;9(2):481-4.

9. Schrier MW, Rougas SC, Schrier EW, Elisseou S, Warrie S. Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals. MedEdPORTAL. 2017;13:10622-.

10. Rivara FP, Anderson ML, Fishman P, Bonomi AE, Reid RJ, Carrell D, et al. Healthcare Utilization and Costs for Women with a History of Intimate Partner Violence. American Journal of Preventive Medicine. 2007;32(2):89-96.

11. Bacchus LJ, Ranganathan M, Watts C, Devries K. Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies. BMJ open. 2018;8(7):e019995.

12. United Nations DoEaSA. World Population Prospects 2019: Highlights. 2019;ST/ESA/SER.A/423.

13. Elghossain T, Bott S, Akik C, Obermeyer CM. Prevalence of intimate partner violence against women in the Arab world: a systematic review. BMC International Health and Human Rights. 2019;19(1):29.

14. Ending Violence against Women and Girls.

15. Consideration of reports submitted by States Parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women 2007.

16. Douki S, Nacef F, Belhadj A, Bouasker A, Ghachem R. Violence against women in Arab and Islamic countries. Arch Womens Ment Health. 2003;6(3):165-71.

17. Usta J, Antoun J, Ambuel B, Khawaja M. Involving the health care system in domestic violence: what women want. Ann Fam Med. 2012;10(3):213-20.

18. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70.

19. Al-Nsour M, Khawaja M, Al-Kayyali G. Domestic Violence against Women in Jordan: Evidence from Health Clinics. Journal of Family Violence. 2009;24:569-75.

20. Lenze J, Klasen S. Does Women's Labor Force Participation Reduce Domestic Violence? Evidence from Jordan. Feminist Economics. 2017;23(1):1-29.

21. Ahmad I, Ali PA, Rehman S, Talpur A, Dhingra K. Intimate partner violence screening in emergency department: a rapid review of the literature. J Clin Nurs. 2017;26(21-22):3271-85.

22. Kposowa AJ, Aly Ezzat D. Religiosity,Conservatism, and Acceptability of Anti-Female Spousal Violence in Egypt. J Interpers Violence. 2019;34(12):2525-50.

23. Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2013;49(2):181-7.

24. Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. BMJ. 2002;325(7359):314-.

25. Niaz U, Hassan SU-N, Tariq Q. Situational Analysis of Intimate Partner Violence Interventions in South Asian and Middle Eastern Countries. Partner Abuse. 2017;8:47 - 88.

26. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. International Journal of Social Research Methodology. 2005;8(1):19-32.

27. Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan—a web and mobile app for systematic reviews. Systematic Reviews. 2016;5(1):210.

28. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.

29. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.

30. AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(1).

31. Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).

32. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(4).

33. Alkhabaz A, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly M. Comparison of attitude of primary health care physicians and nurses towards domestic violence against women. Bull Alex Fac Med. 2010;46(4):371-6.

34. Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the ethiopian context. ISRN Nurs. 2012;2012:307271.

35. Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY. Domestic Violence: With Emphasis on International Cultural and Societal Variations. Majmaah Journal of Health Sciences. 2016;216(3771):1-16.

36. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. J Inj Violence Res. 2018;10(2):113-8.

37. Natan MB, Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59:108-14.

38. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021;27(3).

39. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health Policy Plan. 2020;35(3):245-56.

40. Hudspeth N, Cameron J, Baloch S, Tarzia L, Hegarty K. Health practitioners' perceptions of structural barriers to the identification of intimate partner abuse: a qualitative meta-synthesis. BMC Health Services Research. 2022;22(1):96.

41. Sprague S, Swaminathan A, Slobogean GP, Spurr H, Arseneau E, Raveendran L, et al. A scoping review of intimate partner violence educational programs for health care professionals. Women Health. 2018;58(10):1192-206.

42. Arora S, Rege S, Bhate-Deosthali P, Thwin SS, Amin A, García-Moreno C, et al. Knowledge, attitudes and practices of health care providers trained in responding to violence against women: a pre- and post-intervention study. BMC Public Health. 2021;21(1):1973.

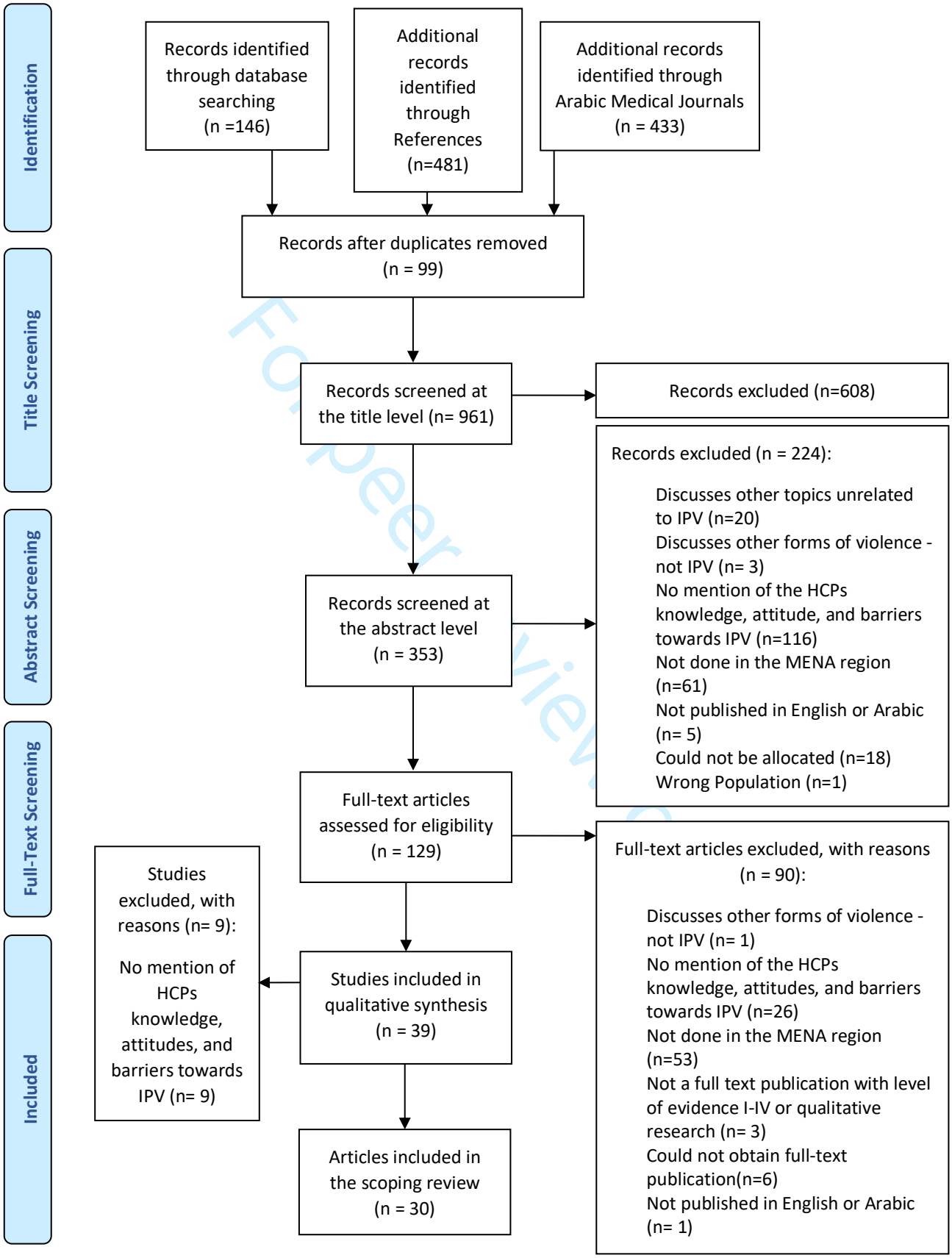
Supporting information

Figure 1. PRISMA Flow Chart (.pdf)

Supplemental Material 1 [Search Strategy] (.pdf)

Supplemental Material 2 [A List of Articles Included in the Scoping Review] (.pdf)

Supplemental Material 3 [Table on the Knowledge, Attitudes, and Beliefs of Included Articles] (.pdf)



Search Strategy (e.g. MEDLINE, CINAHL, APA Psychinfo)

Database: EBSCO MEDLINE, Pyshcinfo, CINAHL.

Search ID#	Search Terms	Results
S1	Domestic Abuse OR Domestic violence OR Domestic assault OR Intimate partner violence OR partner violence OR interpersonal violence OR spouse abuse OR family violence OR sexual violence OR dating violence OR partner abuse	90,205
S2	Primary healthcare OR Primary Healthcare Physician OR Physicians, General Practitioners OR Family Physicians OR Healthcare providers OR Patient Focused Care OR General Practice OR Care OR Primary Health OR Health Care Primary OR Primary Care OR Patient Centered Care	1,396,187
S3	Kuwait OR Bahrain OR United Arab Emirates OR Oman OR Qatar OR Saudi Arabia OR Lebanon OR Syria OR Palestine OR Israel OR Turkey OR Jordan	929,659
S4	Iran OR Iraq OR Yemen OR Morocco OR Libya OR Tunisia OR Algeria OR Egypt OR Malta OR Djibouti OR Ethiopia OR Sudan	476,267
S5	S3 OR S4	1,374,139
S6	Knowledge OR Understanding OR Ability OR Awareness OR Education OR Expertise OR Familiarity OR Grasp OR Grip OR Insight OR Intelligence OR Judgement	7,457,100
S7	Observation OR Recognition OR Comprehension OR Command OR Apprehension OR Skill OR Proficiency OR Capacity OR Capability OR Consciousness	3,348,600
S8	S6 OR S7	9,630,887
S9	Attitude OR Approach OR opinion OR Perspective OR Point of view OR Position OR Prejudice OR Stance OR Reaction OR Sensibility OR Stand OR Temperament	7,530,678
S10	View OR Inclination OR Leaning OR Predilection OR Disposition OR Headset OR Standpoint OR Frame of mind OR Mental state OR Proclivity OR Angle	1,258,559
S11	Reaction OR Ideas OR Conviction OR Orientation OR Feelings OR Thoughts OR Interpretation	3,872,651
S12	S9 OR S10 OR S11	9,436,742
S13	Barriers OR Boundary OR Boundaries OR Limit OR Limitations OR Impediment OR Obstacle OR Fortification OR Hurdle OR Hindrance OR Drawback OR Complication	5,653,834
S14	Difficulty OR Problem OR Disadvantage	2,421,074
S15	S13 OR S14	7,648,623
S16	S1 AND S2 AND S5 AND S8 AND S12 AND S15	8

Additional File 2: Articles Included in the Scoping Review (n=29)

1. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.
2. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70
3. Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2013;49(2):181-7.
4. AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(1).
5. Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).
6. Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK. Domestic violence screening among primary health care workers in Kuwait. Alexandria Journal of Medicine. 2013;49(2):169-74.
7. Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI. Knowledge of primary care nurses regarding domestic violence. Alexandria Journal of Medicine. 2011;47(2):173-80.
8. Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M. How to screen for domestic violence against women in primary health care centers. Alexandria Journal of Medicine. 2013;49(1):89-94.
9. Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.
10. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(4).
11. Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK. Comparison of Attitude of Primary Health Care Physicians and Nurses Towards Domestic Violence Against Women. Bull Alex Fac Med. 2010;46(4):371-6.
12. Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. J Adv Nurs. 2009;65(8):1645-54.
13. Ben Natan M, Ben Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59(1):108-14.
14. Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. J Trauma Nurs. 2010;17(2):112-7.
15. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.
16. Al-Natour A, Gillespie GL, Felblinger D, Wang LL. Jordanian nurses' barriers to screening for intimate partner violence. Violence Against women. 2014;20(12):1473-88.
17. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.
18. Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. BMC Public Health. 2007;7(1):350.
19. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. J Inj Violence Res. 2018;10(2):113-8.
20. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. Medical Journal of the Islamic Republic of Iran. 2014;28:148.

21. Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA. Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City. The Egyptian Journal of Hospital Medicine. 2017;69(8):3058-65.
22. Zaher E, Mason R. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. World Family Medicine Journal: Incorporating the Middle East Journal of Family Medicine. 2014;99(1145):1-6.
23. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health Policy Plan. 2020;35(3):245-56.
24. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sex Reprod Healthc. 2019;20:93-9.
25. Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context. ISRN nursing. 2012;2012.
26. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. The British journal of general practice : the journal of the Royal College of General Practitioners. 2014;64(623):e313-e20.
27. Ahmed AM, Abdella ME, Yousif E, Elmardi AE. Response of Sudanese doctors to domestic violence. Saudi Medical J. 2003;24(10):1077-80.
28. Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY. Domestic Violence: With Emphasis on International Cultural and Societal Variations. Majmaah Journal of Health Sciences. 2016;216(3771):1-16.
29. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021 Mar 1;27(3).
30. Alsalman Z, Shafey M, Al Ali L. Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to Identify, Screening, and Respond? Int J Womens Health 2023;15:623-33. doi: 10.2147/ijwh.S401926 [published Online First: 20230418]

Table on the Knowledge, Attitudes, and Beliefs of Included Articles

No.	Author	Study Name	Location	Year of Publication	Type of Journal	Study Design	Participants	Number of participants	Knowledge	Attitudes	Barriers
1	AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI	Knowledge and perception of domestic violence among primary care physicians and nurses: a comparative study (1)	Kuwait	2012	Alexandria Journal of medicine	A comparative study	physician and nurses	565 physicians and 988 nurses (total of 1553)	– N/A	– N/A	– Lack of IPV training
2	Ahmed AM, Abdella ME, Yousif E, Elmardi AE.	Response of Sudanese doctors to domestic violence (2)	Khartoum, Sudan	2003	Saudi Medical Journal	Not mentioned	Doctors	102	– Female HCPs see IPV as a genuine health problem – Female HCPs were more likely to interfere – Female HCPs have more knowledge about violence (ie. knowledge or definition of IPV, clinical presentation/findings/characteristic of IPV victims) – Lack of knowledge on IPV – HCPs with more work experience had more knowledge	– HCPs believe that IPV is a taboo matter – HCPs will not intervene beyond medical or physical help i.e., legal	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – HCPs have a fear of endless legal procedures
3	Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY.	Domestic Violence : With Emphasis on International Cultural and Societal Variations (3)	Not Applicable *	2016	Majmaah Journal of Health Sciences,	Review Article	NA **	NA **	N/A	– N/A	– Lack of IPV training
4	Aksan HAD, Aksu F.	The Training needs of turkish emergency department personnel regarding intimate partner violence (4)	Turkey	2007	BMC Public Health	A cross-sectional study	Nurses and physicians	215	– Lack of knowledge of legal procedures Female HCPs have more knowledge about violence (ie. knowledge or definition of IPV, clinical presentation/findings/characteristic of IPV victims)	– N/A	– Lack of IPV training – HCPs unable to identify, help or deal with IPV
5	Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK.	Gender difference of knowledge and attitude of primary health care staff towards domestic violence (5)	Kuwait	2011	Alexandria Journal of Medicine	observational cross-sectional study	health care workers	1553	– Female HCPs have more knowledge about violence (ie. knowledge or definition of IPV, clinical presentation/findings/characteristic of IPV victims)	– N/A	– N/A
6	Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK	Comparison of the attitude of primary health care physicians and nurses towards domestic violence against women (6)	Kuwait	2010	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	1553	– Lack of knowledge on IPV	– HCPs believed that IPV is a taboo matter	– Lack of IPV training – Personal safety (if violence was redirected to HCPs) – Lack of time – HCPs unable to identify, help or deal with IPV
7	Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M.	How to screen for domestic violence against women in primary health care centers (7)	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians, and nurses	210 physicians and 464 nurses (total of 674)	– N/A	– N/A	– Absence of privacy in the clinical setting/OPD – IPV victims don't disclose to HCPs of the opposite sex
8	Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK	Domestic violence screening among primary health care workers in Kuwait (8)	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	210 physicians and 464 nurses (total of 674)	– Male HCPs more likely to screen for or diagnose IPV – Physicians are more likely to screen IPV than nurses – Lack of knowledge on IPV Female HCPs have more knowledge about violence	– HCPs believe that IPV is a taboo matter	– Absence of a system that supports directing and helping HCPs to deal with IPV victims
9	Al-Natour A, Gillespie GL, Felblinger D, Wang LL.	Jordanian nurses barriers to screening for intimate partner violence (9)	Jordan	2014	Violence against women	Cross-sectional Study	Jordanian nurses.	125	– N/A	– HCPs do not believe that IPV is a medical issue – HCPs fear that screening offends patients – HCPs fear that screening endangers victims – HCPs fear that screening angers patients – HCPs fear that screening is an invasion of privacy	– Personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – HCPs don't feel competent

										– HCPs don't think it's their business if patients don't disclose IPV	
10	Al-Natour A, Qandil A, Gillespie GL.	Intimate Partner Violence screening barriers as perceived by Jordanian nurses: qualitative descriptive study (10)	Jordan	2015	Journal of Nursing and Practice	qualitative descriptive study	nurses	12	– Lack of knowledge of protocol – HCPs fear that screening offends patients	– N/A	– Lack of IPV training – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – Unclear roles/authority – Absence of privacy in the clinical setting/OPD – Insufficient awareness amongst HCPs – IPV victims don't disclose to HCPs of the opposite sex
11	Al-Natour A, Qandil A, Gillespie GL.	Nurses' roles in screening for intimate partner violence: a phenomenological Study (11)	Jordan	2016	International Nursing Review	A phenomenological study	male and female Jordanian nurses	12	– Lack of knowledge of protocol Lack of knowledge on IPV	– HCPs believed that IPV is a taboo matter – Don't screen for IPV even if they suspect violence – Only manage physical symptoms, not mental symptoms – Become frustrated when patients don't disclose assault or deny exposure	– Lack of IPV training – Unclear roles/authority
12	Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M.	Barriers for domestic violence screening in primary health care centers (12)	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	210 physicians and 464 nurses (total of 674)	N/A	– N/A	Lack of IPV training – Lack of experience
13	Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK	Barriers for administering primary health care services to battered women: perception of physician and nurses (13)	Kuwait	2011	Alexandria Journal of Medicine	Observational cross-sectional study	physicians and nurses.	1553	N/A	– HCPs believed that IPV is a taboo matter	– Lack of IPV training – Personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Insufficient staffing, structures, resources – Absence of privacy in the clinical setting/OPD – Heavy workload – Shame/embarrassment in asking questions – Lack of legal arrangements
14	Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA.	Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City (14)	Saudi Arabia	2017	The Egyptian journal of Hospital Medicine	Cross-sectional study	PHCPs	62	– Male HCPs more likely to screen for or diagnose IPV – Married HCPs had higher performances – Lack of knowledge on IPV Lack of knowledge of legal procedures	– N/A	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Insufficient staffing, structures, resources – Heavy workload – Shame/embarrassment in asking questions
15	Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI.	Knowledge of primary care nurses regarding domestic violence (15)	Kuwait	2011	Alexandria Journal of Medicine	Exploratory, attitudinal surveys	nurses	988	– N/A	– N/A	– Lack of IPV training
16	Alsalman Z, Shafey M, Al Ali L.	Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to	Saudi Arabia	2023	International Journal of Women's Health	Cross-sectional study	PHCPs	169	– Lack of knowledge on screening, management, and referral guidelines – Lack of knowledge on IPV	– HCPs fear that screening offends patients,	– Lack of IPV training – Absence of a system that supports directing and helping HCPs to deal with IPV victims – Insufficient resources

		Identify, Screening, and Respond? (16)								
17	Aziz MM, El-Gazzar AF.	Health Care Providers' Perceptions and Practices of Screening for Domestic Violence in Upper Egypt (17)	Upper Egypt (Assiut)	2019	Sexual & Reproductive Healthcare	Mixed Quantitative and Qualitative; Survey and FDGs	doctors and nurses, physicians and nurses in the FDG	122 doctors and 200 nurses returned surveys. 12 Physicians and 10 nurses in the FGDs.	– Lack of knowledge of protocol – Lack of knowledge of legal procedures – Lack of knowledge around necessary skills required	– Believe that IPV is a taboo matter – HCPs perceive IPV to be an ordinary matter within society – HCPs fear that screening offends patients, endangers victims, is distressing to them and causes interference – When screening for IPV, HCPs only manage physical symptoms, not mental 8symptoms, become frustrated when patients don't disclose assault or deny exposure and only refer suicidal cases to a psychiatrist	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Absence of privacy in the clinical setting/OPD – HCPs unable to council cases
18	Ben Natan M, Ben Ari G, Bader T, Hallak M.	Universal screening for domestic violence in a department of obstetrics and gynaecology: A patient and carer perspective (18)	Israel	2011	International Nursing Review	Correlative, cross-sectional design was utilized	physicians, nurses, female patients	100 physicians and nurses, 100 female patients	– Lack of knowledge of protocol – Knowledge about IPV training and protocols on how to deal with cases allowed HCPs to screen IPV victims	– N/A	– Lack of IPV training
19	Boy A, Kulczycki A.	What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women (19)	MENA region	2008	Violence against women	Review article	Not applicable	none	– N/A	– When screening for IPV, HCPs will not intervene beyond medical or physical help i.e., legal	– HCPs unable to identify, help or deal with IPV
20	Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L.	Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory (20)	occupied Palestinian Territory (oPT)	2019	The Oxford Journal on Health Planning and Systems research; Health Policy and planning.	Case Study design using qualitative methods (interviews and a stakeholder meeting)	PHC providers and Stakeholders	23 PHC providers and 19 Stakeholders	– Lack of knowledge of protocol – Lack of knowledge on IPV	– HCPs believe that IPV is a taboo matter – HCPs believe there is limited capacity as IPV is a mental health issue – HCPs become frustrated when patients don't disclose assault or deny exposure – HCPs feel frustrated with the low referral uptakes by patients	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Insufficient staffing, structures, resources No law to protect HCPs
21	Goldblatt H.	Caring for abused women: impact on nurses' professional and personal life experiences (21)	Israel	2009	Journal of Advanced Nursing	A phenomenological study	female Israeli nurses	22	– N/A	– HCPs fear that screening leads to emotional involvement	– Lack of time – Difficult to set boundaries
22	Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al	Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context (22)	Ethiopia	2012	ISRN Nursing	Nursing-led Interdisciplinary project and literature review	NA	NA	– N/A	– HCPs believe that IPV is a taboo matter	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Unclear roles/authority
23	Ibrahim E, Hamed N, Ahmed L.	Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt (23)	Egypt	2021	Eastern Mediterranean health journal	A cross-sectional study	Healthcare Providers	385	– N/A	– HCPs did not want to interfere as they believe IPV is not part of medical practice	– Lack of time – Lack of IPV training – Absence of a system that supports directing and helping HCPs to deal with IPV victims

										– HCPs fear that patients would get angry if screened
24	Natan MB, Rais I.	Knowledge and attitudes of nurses regard-ing domestic violence and their effect on the identification of battered women (24)	Israel	2010	Journal of Trauma nursing	descriptive, quantitative study	hospital- and community-based nurses.	100	– Lack of knowledge of protocol	– Believe that IPV is a taboo matter	– Lack of IPV training
25	Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK.	Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women (25)	Kuwait	2013	Alexandria Journal of Medicine	Cross-sectional Study	Doctors and nurses	210 physicians and 464 nurses (total of 674)	– Male HCPs more likely to screen for or diagnose IPV – Physicians are more likely to screen IPV than nurses More knowledgeable HCPs more likely to screen for IPV	– HCPs fear that screening is not in patients' best interest – Screening reduces rates and effects of violence and improves the quality of life	– N/A
26	Rasoulian M, Shirazi M, Nojomi M.	Primary Health Care Physicians' Approach Toward Domestic Violence in Tehran, Iran (26)	Tehran, Iran	2014	Medical Journal of the Islamic Republic of Iran	Not mentioned	PHCPs	198	– Female HCPs were more likely to document IPV – HCPs believed that patients will disclose IPV if it is severe enough – HCPs believe that IPV is a public health problem. – HCPs think that women should tolerate IPV to keep family's privacy and honour	– HCPs believe that screening endangers victims and is distressing to them	– N/A
27	Usta J, Feder G, Antoun J.	Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners (27)	Lebanon	2014	British Journal of General Practice	Qualitative study	Physicians	70	– Lack of knowledge of protocol	– HCPs believe that IPV is a taboo matter – HCPs do not believe that IPV is a medical issue – HCPs only manage physical symptoms, not mental symptoms	– HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – No law to protect HCPs
28	van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M	The Role of the Healthcare Sector in the Prevention of Sexual Violence Against sub-Saharan Transmigrants in Morocco: A Study of Knowledge, Attitudes and Practices of Healthcare Workers (28)	Morocco	2013	BMC Health Services research	A KAP (Knowledge, Attitudes, Practices) questionnaire, identifying knowledge, attitudes and practices, guided the semi-structured interviews.	Male and Female HCW, Organizations	24 (12 men and 12 women)	Lack of knowledge of legal procedures	– HCPs fear that screening offends patient, is not in patients' best interest and opens up old wounds When screening for IPV, HCPs respect the choice of IPV victims to remain silent	– Absence of a system that supports directing and helping HCPs to deal with IPV victims – Insufficient staffing, structures, resources – HCPs don't feel competent Insufficient awareness amongst HCPs
29	Yousefnia N, Nekuei N, Farajzadegan Z.	The Relationship Between Healthcare Providers' Performance Regarding Women Experiencing Domestic Violence and Their Demographic Characteristics and Attitude Towards Their Management (29)	Iran	2018	Injury & Violence	Cross-sectional study	physicians, 46 midwives, and 212 nurses.	300	– Married HCPs had higher performances – Female HCPs have higher performances – Nurses had higher performances than physicians –	– N/A	N/A
30	Zaher E, Mason R.	Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study (30)	Saudi Arabia	2014	Middle East Journal of Family Medicine	Exploratory, attitudinal surveys	Doctors	30	N/A	N/A	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV

Legend:

*Location is not applicable in one of the included studies as it was a review article and was not based in a specific country.

**Participants are not applicable in review studies that do not have any direct participants

References:

1. AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(3).
2. Ahmed AM, Abdella ME, Yousif E, Elmardi AE. Response of Sudanese doctors to domestic violence. Saudi Medical J. 2003;24(10):1077-80.
3. Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY. Domestic Violence: With Emphasis on International Cultural and Societal Variations. Majmaah Journal of Health Sciences. 2016;216(3771):1-16.
4. Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. BMC Public Health. 2007;7(1):350.
5. Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).
6. Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK. Comparison of Attitude of Primary Health Care Physicians and Nurses Towards Domestic Violence Against Women. Bull Alex Fac Med. 2010;46(4):371-6.
7. Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M. How to screen for domestic violence against women in primary health care centers. Alexandria Journal of Medicine. 2013;49(1):89-94.
8. Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK. Domestic violence screening among primary health care workers in Kuwait. Alexandria Journal of Medicine. 2013;49(2):169-74.
9. Al-Natour A, Gillespie GL, Felblinger D, Wang LL. Jordanian nurses' barriers to screening for intimate partner violence. Violence Against women. 2014;20(12):1473-88.
10. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.
11. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.
12. Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.
13. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(3).
14. Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA. Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City. The Egyptian Journal of Hospital Medicine. 2017;69(8):3058-65.
15. Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI. Knowledge of primary care nurses regarding domestic violence. Alexandria Journal of Medicine. 2011;47(2):173-80.
16. Alsalman Z, Shafey M, Al Ali L. Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to Identify, Screening, and Respond? Int J Womens Health 2023;15:623-33. doi: 10.2147/ijwh.S401606 [Published Online First: 20230418].
17. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sex Reprod Healthc. 2019;20:93-9.
18. Ben Natan M, Ben Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59(1):108-14.
19. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70.
20. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian territory. Health Policy Plan. 2020;35(3):245-56.
21. Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. J Adv Nurs. 2009;65(8):1645-54.
22. Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context. ISRN nursing. 2012;2012.
23. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021 Mar 1;27(3).
24. Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. J Trauma Nurs. 2010;17(2):112-7.
25. Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2013;49(2):181-7.
26. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. Medical Journal of the Islamic Republic of Iran. 2014;28:148.
27. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. The British journal of general practice : the journal of the Royal College of General Practitioners. 2014;64(623):e313-e20.
28. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.
29. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. Inj Violence Res. 2018;10(2):113-8.
30. Zaher E, Mason R. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. World Family Medicine Journal: Incorporating the Middle East Journal of Family Medicine. 2019(1145):1-6.

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	2,3
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	3,4,5
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	N/A
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	6
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	6
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Supplemental Material 1: Search Strategy
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	6
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	N/A
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	N/A

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	N/A
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	7
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	7 Figure 1 PRISMA Flow Chart
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	7,8,9 Supplemental Material 3: Table of KAB of included articles
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	N/A
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	8,9,10
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	8,9,10
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	10,11
Limitations	20	Discuss the limitations of the scoping review process.	12
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	12,13
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	15

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.

BMJ Open

A Scoping Review of healthcare professionals' views on Intimate Partner Violence in the Middle East and North Africa

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2023-079866.R2
Article Type:	Original research
Date Submitted by the Author:	04-Mar-2024
Complete List of Authors:	Al-Salmi, Sabrina ; Royal College of Surgeons in Ireland and Medical University of Bahrain, ; Leicester Royal Infirmary, Aly, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain Najeeb, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain, Alumni Shaikh, Zoya; Royal College of Surgeons in Ireland and Medical University of Bahrain, Zuaiter, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain Doherty, Sally; Royal College of Surgeons in Ireland, Department of Psychology Sefen, Jessica; Royal College of Surgeons in Ireland and Medical University of Bahrain
Primary Subject Heading:	General practice / Family practice
Secondary Subject Heading:	Global health, Medical education and training, Medical publishing and peer review, Public health
Keywords:	Primary Prevention, Primary Health Care, Primary Care < Primary Health Care

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

A Scoping Review of healthcare professionals' views on Intimate Partner Violence in the Middle East and North Africa

Sabrina Al-Salmi[1], Farah W. Aly[1], Farah S.N. Naser[1], Jessica A.N. Sefen[1], Zoya Shaikh[1], Farah A.O.A. Zuaiter[1], Sally Doherty[1]

[1]School of Medicine, Royal College of Surgeons in Ireland, Al-Sayh, Muharraq, Bahrain

*Corresponding Author: Farah A O A Zuaiter

Postal Address:

Royal College of Surgeons in Ireland
Al-Sayh, Muharraq
P.O. Box 15503, Adliya
Kingdom of Bahrain

Email: farahztr@gmail.com

Word Count: 3886 words

ABSTRACT

Objectives

This scoping review aims to charter healthcare providers (HCPs) in the Middle East and North Africa (MENA) about their knowledge, attitudes, and barriers to working with women who experienced Intimate Partner Violence (IPV). The purpose of this review is to map the breadth of available peer-reviewed literature which may inform future educational training programs.

Design

Scoping review.

Data Sources

It involves studies up to December 2023 from PUBMED, Medline, COCHRANE, CINAHL, PsycINFO, and Arabic medical journals.

Eligibility Criteria

We have included articles published in English and Arabic on HCPs' knowledge and views on IPV against women; the MENA region, full-text formats; no date restrictions.

Data Extraction and Synthesis

Studies were on research location, year of publication, type of journal, methodology, design, and participants. Data was extracted 'charted' from all studies to include research location, year of publication, type of journal, methodology, design, participants, knowledge, attitudes, and barriers. Then, the by charting the information into a table and creating a framework, the reviewers were then able to reach multiple outcomes as a result.

Results

Of the 1066 articles reviewed, 30 eligible studies were in this scoping review. HCPs' lack of knowledge about IPV protocol was reported in 27% of the articles, 20% of the articles reported a low level of awareness about IPV. The attitudes of HCPs varied; the dominant attitude reported was a preference to

treat the presenting health complaint and not to engage in discussions about IPV. Finally, 30% of articles stated that the main barrier was the HCPs' lack of training relating to IPV.

Conclusion

Our paper concluded that there is a lack of research in understanding the knowledge, attitudes, and barriers surrounding HCPs in the MENA region and IPV. This scoping review highlights the need for further research, informing interventions, and training for HCPs in the region.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- The methodology of Arksey and O'Malley was used to ensure a consistent framework when drafting the review.
- This study's study selection was done electronically via the web-based program Rayyan and by two reviewers to reduce bias on inclusion and exclusion of articles.
- Language restriction was among the main limitations to the number of studies included in this review.
- The restricted number of domestic violence articles published in the MENA region served as a limitation to the validity of the study.
- A formal bias assessment was not conducted in this study.

KEYWORDS

Intimate Personal Violence, Middle East, Review

BACKGROUND

Intimate Partner Violence (IPV) is a major worldwide public health problem impacting millions of lives (1). IPV is a complex subject, defined in this article in accordance to the Istanbul Convention: *"all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit, or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim"* (2).

Prevalence rates of IPV in Western countries range from 25% to 38%. While prevalence rates in the Middle East and North Africa (MENA) region range from 15% to 85% (1, 2). Those women who experience IPV in their lifetime may suffer from numerous physical and mental health problems such as depression, post-traumatic stress disorder, anxiety disorders, substance abuse, suicidal behaviour, somatising disorders, eating disorders, and chronic pain (3, 4). Undisclosed violence can also lead to feelings of guilt, shame, and worthlessness (5). According to the Global Burden of Disease Study, IPV causes significant morbidity and mortality (6). Healthcare workers need to be aware of the possible signs and symptoms of IPV, have training in the use of screening tools, and refer to community and advocacy programs to provide care and support in a non-judgmental, private, and confidential environment (3, 7-9).

Women who experience IPV will often require more healthcare visits compared to women who do not experience IPV (10). IPV is associated with adverse health outcomes, including depression, anxiety, and substance abuse (11). Therefore, it is crucial to identify healthcare providers' views (HCPs) in the MENA region about their knowledge and attitudes to treating women who experience IPV.

The twenty-four countries of the MENA region include Saudi Arabia, Kuwait, Bahrain, United Arab Emirate (UAE), Oman, Qatar, Yemen, Lebanon, Syria, Jordan, Palestine, Israel, Turkey, Iran, Iraq, Morocco, Libya, Tunis, Algeria, Egypt, Malta, Djibouti, Ethiopia, and Sudan. These 24 countries represent an approximate population of 725 million (12). Despite diversity across these countries, they tend to share a commonality of culture, religion (mainly Islam), and language (Arabic). While women have achieved parity across many of these countries, there still may exist social, economic, and political equality barriers (13). IPV represents both public health and a human rights problem. The only countries with civil and legal laws to protect women against IPV are Jordan, Lebanon, Tunisia, Morocco, Bahrain, and Saudi Arabia (14). The Supreme Council for Women established a shelter for female family violence victims in Bahrain. Women can receive care and guidance if they experience IPV (15).

IPV is perceived as taboo and not considered a crime in many MENA regions. Often it is a matter for the religious courts to resolve instead of the civil and legal authorities (3, 16, 17).

A recent systematic review of prevalence rates in the Arab region identified 46 datasets from peer-reviewed journals and 11 national surveys across 16 years from 2000 -2016. Results indicated that IPV ranged from 6 to 59% for physical abuse, 3 to 40% for sexual abuse, and 5 to 91% for emotional and

psychological abuse. The authors pointed out the problem was a lack of a homogenous definition of IPV (13).

Findings from recent literature in the MENA region reporting on IPV in the Arab region emphasize the influence of culture, modesty, family solidarity, and reputation (17, 18). Al-Nsour et al. explored attitudes toward IPV in Jordan, discovering that one-third of perpetrators justified 'wife beating' due to the culture in their country (19). Additionally, women do not turn to HCPs for help with IPV due to the cultural stigma of causing a 'scandal' (20). A woman with unexplained injuries and a reluctance to discuss their injury are often because her partner accompanies her to the physician consultation. She may fear the outcomes related to reporting the crime (21). These culturally biased attitudes are the main barriers to seeking help (22). Less than 15% of female patients in the MENA region reported being asked about IPV by their HCPs, in comparison to studies in non-Arabic communities that report 43 to 85% of female respondents (23, 24).

The Arab community has a shared commonality of HCPs unwilling to integrate IPV into their practice (17, 25). Cultural stereotypes increase the HCPs' reluctance to intervene due to fear for their safety, losing their patients, and opposing the norm of their conservative society (3). With the influence of culture and religion on Arab HCPs, knowledge of and attitude to IPV is critical to providing education and training programs (3).

Therefore, the purpose of this review is to map the breadth of available peer-reviewed literature in a specific region to identify research gaps and focus on future research priorities and inform future educational training programs.

MATERIALS & METHODS

We are conducting a scoping review; unlike a systematic review, it allows the researcher to address and summarize a broader range of evidence and topics where multiple study designs are applicable (26). Key concepts in a specific research area describe the wide range of evidence and sources (26). Moreover, it highlights the gaps in the existing literature and is employed due to the lack of literature in a specific area of research (26). The quality of the studies is not assessed in a scoping review. The research question allows for broader non-specific questions to be addressed. In this instance, we are interested in the views

of healthcare providers about IPV. We have included articles that focus on the knowledge, attitudes, and barriers to working with women who experience IPV. The HCPs include doctors, nurses, and midwives, and social workers.

The methods described in this study were adopted by Arksey and O'Malley's methodological framework (26). Their methodological framework for conducting a scoping review consisted of five stages. The following stages include identifying a research question, identifying relevant peer-reviewed studies, study selection, charting the data, and finally collating, summarizing, and reporting the results (26).

Our aim is investigating "what is known about the knowledge attitudes, and barriers of HCPs on IPV in the MENA region?" This scoping review is conducted for IPV advocates, IPV victims, their representatives, researchers, and healthcare providers, including doctors, nurses, policymakers, institutions, organizations, caregivers, and health-based students, such as nursing and medical students.

Literature search strategy

FAOAZ and SA did a search strategy [Supplemental Material 1]. All publications that target HCPs' views on IPV in the MENA Region were included. Key search terms were Healthcare providers, MENA region, IPV, knowledge, attitudes, and barriers. The following databases were searched: PUBMED, Medline, PsycINFO, Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Cochrane Database of Systematic Reviews (CDSR). All searches were performed up to the date of December 2023 with no date restriction. In addition, the references from all key papers were manually reviewed. A hand search of relevant articles in the Arabic Medical Journals was also conducted. A sample of the search strategy is available for review in the document labelled as Figure 1.

Eligibility Criteria

For this scoping review, we included articles based on a broad eligibility criterion. This criterion contains articles: [1] published in English and Arabic; [2] focused on IPV against women; [3] Included HCPs' views on IPV; [4] in the MENA region; [5] in full-text formats; [6] no date restrictions. Articles that did not meet this inclusion criterion or with abstracts and full texts that could not be obtained were excluded.

Data Extraction

Based on the review's research question, a data extraction template was developed in the form of a table by two reviewers, JANS and ZS. They extracted or 'charted' the data focusing on the following categories: Study characteristics, which includes but is not limited to research location, year of publication, type of journal, methodology, study design and participants; knowledge, attitudes, barriers, and any factors that fall under these categories. As seen in other Scoping reviews (26), determining what fell under each category differed per paper and there was a difference in the definition and understanding of each concept throughout the studies.

Data Synthesis

By charting the information into a table and creating a framework, the reviewers were then able to reach multiple outcomes as a result. The framework additionally allowed us to identify gaps in the research and describe the outcomes on each of the categories: Knowledge, Attitudes and Barriers.

Patient and Public Involvement

We did not include patients or members of the public in the research, as this was beyond the study's scope.

RESULTS

Article Identification & Selection

Our search strategy resulted in a total of 1060 articles [Figure 1]. Of these articles, 146 came from the databases, 481 from references, and 433 from the hand search of Arabic Medical Journals. We did not encounter any papers with only Arabic abstract or full text. Of these, 99 were duplicated and removed before title screening. Therefore, 961 underwent title review, and the reviewers found that 353 abstracts were potentially eligible. After screening the abstracts, 129 full text studies were reviewed. However, only 30 studies were included in the scoping review [Supplemental Material 2]. The remaining articles were excluded as they did not mention knowledge, attitudes or barriers of HCPs towards IPV. All article screening and selection were completed using the web-based program Rayyan (27).

Figure 1: PRISMA Flow Chart

Study Characteristics

There was a total of 30 papers in this scoping review (5, 18, 28-54). The majority came from Kuwait (n = 9) followed by three studies from Israel and three from Jordan (23, 28, 32-40, 42, 45, 47, 50). Three studies were each conducted in Saudi Arabia, and two were done in Morocco, and Iran (41, 43, 51, 53, 54). One study was conducted in each of the occupied Palestine Territory (oPT), Egypt, Ethiopia, Lebanon, Turkey, and Sudan (5, 29, 31, 44, 46, 48, 49, 52). One study involved the entire MENA region (n = 1, 3.3%) (18). The final study included is a review that had no mention of the actual country; hence it is classified as 'not mentioned/not applicable' under location in the Knowledge, Attitudes, and Beliefs table [Supplemental Material 3] (30).

Study Designs

There were twelve different types of study designs in the 30 articles reviewed. Of these, the majority were cross-sectional studies (n=14, 46.7%), 3 were review articles (10%), 3 were qualitative studies (10%), 2 were Phenomenological studies (6.75%), and mixed as well as quantitative designs were each present in one study (3.3%) (18, 23, 30-41, 43-47, 49, 50, 52, 53). The table in supplemental material 3 fully outlines the 12 study designs and the type as well as number of participants. The range of participants in these studies ranged from 12 (37, 38) to 1,553 (28, 32, 33, 40) participants. Three review studies are literature based and hence don't directly involve any participants (18, 30, 48).

Some studies involved both doctors and nurses (n = 11, 36.7%) (23, 28, 31, 33-35, 39, 40, 44, 45, 53). A few studies included either doctors (n = 6, 20%) or nurses (n = 6, 20%) (29, 36-38, 42, 47, 50, 52, 54). One study included doctors, nurses, and midwives (53), and another included doctors, nurses, and female patients (45). Health Care Providers were included in three studies, this is a separate row on the table as the title 'HCP' does not specify the professional (ie. nurse/doctor) [Supplemental Material 3] (41, 43, 51). One study even included social workers (49). Two included other participants besides HCPs; one included HCP and stakeholders, (46) and the other targeted key HCPs and organizations in the community to recruit as participants (5).

Studies that do not specify what kind of healthcare worker participated (ie. nurse or doctor or other) were just left as 'HCPs'.

Outcomes

This study reviews 30 articles in the Arabic and English literature on the views of HCPs about IPV in the MENA region. We did not assess the quality of these studies as this does not fall under the claim of a scope review. Fewer studies were published in North Africa (n=3) relative to the Middle East (n=25) (5, 23, 28, 29, 31-54). There was an increasing trend in the number of papers published from 2000-2005 (n=1, 3.3%), 2006-2010 (n=5, 16.7%), and finally 2011-2015 (n=16, 53.3%) (5, 18, 23, 28, 29, 31-37, 39, 40, 42, 45, 47, 48, 50-54). However, there was a relative decline in the number of studies published between 2016 and 2023 (n=8, 26.7%) (30, 38, 41, 44, 46, 49, 53).

The main research question referred to the views of HCPs in the MENA region to IPV. Several themes of HCP's knowledge, attitudes, and barriers in relation to IPV were uncovered across the 30 articles. Knowledge refers to the statements made by HCPs about IPV, I think, I know, I do, while attitudes are distilled from the literature, I feel, I want, I would. Attitude statements were associated with feelings, whereas knowledge statements were associated with facts, information, or skills.

General views and knowledge

The most notable difference between HCPs was that male HCPs were more likely to screen for or diagnose IPV, evidenced in 3 articles (n=3, 10%) (23, 35, 41). Next, two articles concluded that married HCPs had higher performances regarding assessing, intervening, documenting, referring, and following up with IPV cases (n=2, 6.7%) (41, 53). Two articles identified that family physicians were more likely to have a good knowledge of IPV than general practitioners and were therefore more likely to screen for IPV (n=1, 3.3%) (29). It was noted that female HCPs have more knowledge (n=4, 13.3%), saw IPV as a genuine health problem, were more likely to document IPV and were also more likely to interfere (n=1, 3.3%) (29, 31, 32, 35, 51, 53). Also, HCPs who had more work experience showed more IPV knowledge (n=1, 3.3%) (29).

The most contributing factor to assessing and managing IPV by HCPs was a lack of availability or understanding of best practice protocols (n=10, 33.3%) followed by a lack of knowledge on IPV, i.e., the full definition (n=8, 26.7%) (5, 29-33, 35, 37, 38, 41, 43-46, 50, 52). 4 articles identified that HCPs were

unaware of the legal procedure (10%) (5, 31, 41, 44). 1 article proved that knowledge about IPV training and protocols on how to deal with IPV cases, allowed HCPs to screen IPV victims (3.3%), and another stated that more knowledgeable HCPs are more likely to screen for IPV (3.3%) (29, 45).

Attitudes

The most common attitude was that HCPs believed that IPV is taboo, did not discuss or intervene (n=10, 33.3%), perceived IPV to be an ordinary matter within society and that women should tolerate IPV to keep their family's privacy and honour (n=1, 3.3%) (18, 30, 33, 35, 38, 40, 44, 46, 48, 50-52). HCPs feared that screening is an invasion of privacy (n=1, 3.3%), would not be in the victims' best interest (n=2, 6.7%), leads to an emotional environment (n=1, 3.3%) and that it would have several negative impacts such as offending patients (n=5, 16.7%), angering patients (n=1, 3.3%), endangering victims (n=2, 6.7%) and distressing victims (n=2, 6.7%) (5, 23, 36, 37, 43, 44, 47, 51). Some HCPs wouldn't screen for IPV even if they suspected violence (n=1, 3.3%) (38). HCPs felt frustrated with the low referral uptakes by patients (n=1, 3.3%) (38). Some HCPs felt shame/embarrassment in asking questions regarding IPV (n=1, 3.3%) (40, 41).

When screening for IPV, HCPs only managed physical symptoms (n=3, 10%) and would not intervene beyond physical or medical help (n=2, 6.7%) (18, 29, 38, 44, 52). HCPs would only refer suicidal cases to psychiatrists and believed there is limited capacity as IPV is a mental health issue (n=1, 3.3%) and is not part of medical practice (n=1, 3.3%) (29, 49). When HCPs did screen, they would become frustrated when their patients did not disclose or deny IPV (n=3, 10%), believed that patients will disclose IPV if it is severe enough and would respect the choice of IPV victims to remain silent (n=1, 3.3%) (5, 36, 38, 44). HCPs also feared endless legal procedures (n=1, 3.3%) (29).

Barriers

The most prevalent barrier was the lack of IPV training and experience, which spanned 19 articles contributing to 63.3% of the articles (28-31, 33, 37-46, 48-50, 54). The next barrier was personal safety; 10 articles reported HCPs were afraid of redirected violence to themselves; therefore, they did not want to intervene (33.3%) (29, 33, 36, 40, 41, 44, 46, 48, 52, 54). Lack of time was reported in 10 articles (33.3%) (29, 33, 36, 37, 40, 44, 46, 47, 49, 52). HCPs declared that they deemed themselves unfit to identify, help or deal with IPV victims (n=8, 26.7%) (18, 31, 33, 36, 40, 44, 46, 54). Moreover, there was also a common

theme amongst 11 articles (36.7%) of the absence of systems that support directing and helping HCPs deal with IPV victims, such as support and referral services (5, 35-37, 40, 43, 44, 46, 49, 54). Some HCPs claimed that there was an absence of privacy in the clinical setting (n=4, 13.3%) (34, 37, 40, 44). HCPs also were unsure about their roles or the authority they had in IPV cases (n=3, 10%) and claimed that there was insufficient awareness amongst HCPs (n=2, 6.7%) (5, 37, 38, 40). Another barrier identified was the heavy workload (n=2, 6.7%) (40, 41).

DISCUSSION

There are several noteworthy findings from this review concerning the quantity and focus of the articles; we see a significant number of articles discussing a lack of time and training, which are common in the international literature. However, specific to the MENA region are articles relating to a lack of knowledge about protocols and systems of support, the role of the law, unclear professional roles, fear for safety, managing misconceptions, and a lack of privacy in the consultation.

The most reported statement and barrier was that HCPs perceive IPV as taboo, i.e., social, religious, or private. HCPs would, as a result, refrain from screening or asking questions regarding IPV if suspected. The second most prevalent attitude indicated that IPV is not a medical issue, which causes an obstacle for IPV victims who choose to disclose their experience to HCPs.

In comparison to the MENA region, a recent study published by Hudspeth et al. outlines the barriers to identification of IPV across various countries (55). These were found to be similar to the MENA region and included both environmental and social barriers. In the MENA region, the most common barrier was found to be lack of IPV training. However, in the study by Hudspeth et al, the largest barrier was the HCPs' healthcare environment and the impact it had on their interaction with patients (55).

This scoping review of the IPV literature reveals a gap in the knowledge, attitudes, and management of patients who present with injuries from IPV in the MENA region. This discovery highlights the urgent need to educate, train, and provide a safe environment to report IPV. The barriers highlighted in this review are universally recognized but require a bespoke culturally relevant education program for health care workers. International best practice paired with culturally relevant training is the ideal scenario. As

HCP working in this region, it is essential to seek and build awareness of the barriers to working with women who experience IPV.

This review additionally aims to recognize and identify the need for HCPs education programs that target not only lack of training and knowledge of HCPs but also their attitudes and beliefs. A review by Sprague et al, aims to identify the components of educational programs that have the greatest positive impact on identifying and managing IPV (56). They found that programs that were delivered by IPV educators/experts or physicians, included specific treatment protocols and patient resources, and finally programs with an online training component and lasting for more than 5 sessions yielded the best results (56). It is important to highlight that although literature exists on the effectiveness of various training programmes for HCPs, the effectiveness of these programmes on the attitudes and behaviours of physicians is lacking worldwide (57). Additionally, many countries in the MENA region still lack appropriate IPV legal policies and support services for victims. Therefore, many victims and HCPs do not have the necessary IPV laws, hospital policies, and services to sufficiently support them (13). This is only one of the many barriers to developing efficient training programs in the MENA region. Therefore, suggesting an ideal training program for HCPs in the MENA region is impossible without further research that explores the barriers and efficiency of training programs both in the MENA region and worldwide.

Strength and Limitations

This scoping review included a wide range of strengths; initially, two reviewers performed the study selection and review process twice. Our eligibility criteria included studies published in both Arabic and English Journals, giving readers a broader scope of the literature and a deeper insight into IPV in the region. We additionally chose not to include an end date in our eligibility criteria, as the MENA region has a limited number of studies on HCPs' perspectives regarding IPV.

As with all research, our review also faced some limitations. The first was that our search was only limited to literature that was already published. As a result, publication bias may be an issue as studies reporting any negative results in the region may remain unpublished. While we included articles in English and Arabic, we excluded articles that were conducted in French, Turkish, and any other language within the region. Therefore, we limited our number of studies and did not include findings that present in some of the countries in the region. This, we believe, is one of the first scoping reviews in MENA, where IPV has

been comprehensively discussed. Another limitation in this study is that the articles included in this study only discussed the negative but not the positive attitudes and beliefs of HCPs towards IPV. Perhaps adding positive attitudes and beliefs or enablers to managing and screening for IPV would have facilitated an understanding of possible solutions to addressing IPV in the MENA region.

CONCLUSION

In conclusion, this scoping review was undertaken to understand the knowledge, attitudes, and barriers of HCPs towards IPV. It highlights the main obstacles that need to be addressed in order to assist IPV victims in the MENA region. These obstacles include lack of knowledge about the IPV protocol, fear factors that are embedded in the HCP due to certain cultural beliefs, and HCPs viewing IPV as a taboo matter. The most important way to overcome these obstacles is to implement a mandatory and culturally relevant training program to educate HCPs about detecting, supporting, and treating IPV victims to help improve and potentially save their lives.

Implications

This scoping review draws attention to the knowledge, attitudes, and beliefs of HCPs towards IPV. Now that this paper identified some of the barriers to screening and managing IPV in the MENA region, it highlights the need for further studies to investigate the means and components of an effective education and training program in the MENA region. This training programme should be one that tackles not only the knowledge of HCPs but also their attitudes and beliefs. In addition to studies that investigate the effectiveness of these education programs in the region, it would be beneficial if further literature is done to address the positive attitudes and enablers to managing and screening for IPV within HCPs in the MENA region.

LIST OF ABBREVIATIONS

CINAHL - Cumulative Index of Nursing and Allied Health Literature

CDSR – Cochrane Database of Systematic Reviews

IPV – Intimate Partner Violence

MENA – Middle East and North Africa

SOS-DoC – Support, Options, Strength – Document of observation, assessment & plans, and continuity

HCP – Health Care Practitioners

UAE – United Arab Emirates

oPT – Occupied Palestine Territory

CBPR – Community Based Participatory Research

MDT – Multidisciplinary Training

OPD – Outpatient Department

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable.

CONSENT FOR PUBLICATION

Not applicable.

AVAILABILITY OF DATA AND MATERIALS

Not applicable.

COMPETING INTERESTS

None declared.

FUNDING

This review received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

AUTHOR CONTRIBUTIONS

FSNN and FWA researched and worked on the background. FAOAZ and SA worked on the literature search strategy. JANSS extracted the data regarding the study characteristics. ZS analysed and interpreted the patient data where she performed descriptive statistics of the study sample to describe the sample study characteristics, design, and HCPs' views regarding IPV. SA and SD were significant contributors in writing the manuscript. All authors read and approved the final manuscript.

ACKNOWLEDGEMENTS

Not applicable

REFERENCES

1. Violence against women World Health Organization [Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women.

2. Maziak W, Asfar T. Physical abuse in low-income women in Aleppo, Syria. Health Care Women Int. 2003;24(4):313-26.

3. Usta J, Taleb R. Addressing domestic violence in primary care: what the physician needs to know. Libyan J Med. 2014;9:23527.

4. Taherkhani S, Negarandeh R, Simbar M, Ahmadi F. Barriers to seeking help among abused Iranian women. The Journal of Adult Protection. 2017;19(5):261-73.

5. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.

6. Kyu HH, Abate D, Abate KH, Abay SM, Abbafati C, Abbasi N, et al. Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. The Lancet. 2018;392(10159):1859-922.

7. Cronholm PF, Fogarty CT, Ambuel B, Harrison SL. Intimate partner violence. American family physician. 2011;83(10):1165-72.

8. AlJuhani S, AlAteeq M. Intimate partner violence in Saudi Arabia: A topic of growing interest. J Family Med Prim Care. 2020;9(2):481-4.

9. Schrier MW, Rougas SC, Schrier EW, Elisseou S, Warrie S. Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals. MedEdPORTAL. 2017;13:10622-.

10. Rivara FP, Anderson ML, Fishman P, Bonomi AE, Reid RJ, Carrell D, et al. Healthcare Utilization and Costs for Women with a History of Intimate Partner Violence. American Journal of Preventive Medicine. 2007;32(2):89-96.

11. Bacchus LJ, Ranganathan M, Watts C, Devries K. Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies. BMJ open. 2018;8(7):e019995.

12. United Nations DoEaSA. World Population Prospects 2019: Highlights. 2019;ST/ESA/SER.A/423.

13. Elghossain T, Bott S, Akik C, Obermeyer CM. Prevalence of intimate partner violence against women in the Arab world: a systematic review. BMC International Health and Human Rights. 2019;19(1):29.

14. Ending Violence against Women and Girls.

15. Consideration of reports submitted by States Parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women 2007.

16. Douki S, Nacef F, Belhadj A, Bouasker A, Ghachem R. Violence against women in Arab and Islamic countries. Arch Womens Ment Health. 2003;6(3):165-71.

17. Usta J, Antoun J, Ambuel B, Khawaja M. Involving the health care system in domestic violence: what women want. Ann Fam Med. 2012;10(3):213-20.

18. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70.

19. Al-Nsour M, Khawaja M, Al-Kayyali G. Domestic Violence against Women in Jordan: Evidence from Health Clinics. Journal of Family Violence. 2009;24:569-75.

20. Lenze J, Klasen S. Does Women's Labor Force Participation Reduce Domestic Violence? Evidence from Jordan. Feminist Economics. 2017;23(1):1-29.

21. Ahmad I, Ali PA, Rehman S, Talpur A, Dhingra K. Intimate partner violence screening in emergency department: a rapid review of the literature. J Clin Nurs. 2017;26(21-22):3271-85.

22. Kposowa AJ, Aly Ezzat D. Religiosity,Conservatism, and Acceptability of Anti-Female Spousal Violence in Egypt. J Interpers Violence. 2019;34(12):2525-50.

23. Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2013;49(2):181-7.

24. Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. BMJ. 2002;325(7359):314-.

25. Niaz U, Hassan SU-N, Tariq Q. Situational Analysis of Intimate Partner Violence Interventions in South Asian and Middle Eastern Countries. Partner Abuse. 2017;8:47 - 88.

26. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. International Journal of Social Research Methodology. 2005;8(1):19-32.

27. Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan—a web and mobile app for systematic reviews. Systematic Reviews. 2016;5(1):210.

28. AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(1).

29. Ahmed AM, Abdella ME, Yousif E, Elmardi AE. Response of Sudanese doctors to domestic violence. Saudi Med J. 2003;24(10):1077-80.

30. Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY. Domestic Violence: With Emphasis on International Cultural and Societal Variations. Majmaah Journal of Health Sciences. 2016;216(3771):1-16.

31. Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. BMC Public Health. 2007;7(1):350.

32. Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).

33. Alkhabaz A, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly M. Comparison of attitude of primary health care physicians and nurses towards domestic violence against women. Bull Alex Fac Med. 2010;46(4):371-6.

34. Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M. How to screen for domestic violence against women in primary health care centers. Alexandria Journal of Medicine. 2013;49(1):89-94.

35. Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK. Domestic violence screening among primary health care workers in Kuwait. Alexandria Journal of Medicine. 2013;49(2):169-74.

36. Al-Natour A, Gillespie GL, Felblinger D, Wang LL. Jordanian nurses' barriers to screening for intimate partner violence. Violence Against Women. 2014;20(12):1473-88.

37. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.

38. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.

39. Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.

40. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(4).

41. Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA. Barriers that impede primary health care physicians from screening women for domestic violence at Makkah ALmukarramah City. The Egyptian Journal of Hospital Medicine. 2017;69(8):3058-65.

42. Alsafy NN, Kamel M. Knowledge of primary care nurses regarding domestic violence. Alexandria Journal of Medicine. 2011;47(2).

43. Alsalman Z, Shafey M, Al Ali L. Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to Identify, Screening, and Respond? Int J Womens Health. 2023;15:623-33.

44. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sex Reprod Healthc. 2019;20:93-9.

45. Natan MB, Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59:108-14.

46. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health Policy Plan. 2020;35(3):245-56.

47. Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. J Adv Nurs. 2009;65(8):1645-54.

48. Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the ethiopian context. ISRN Nurs. 2012;2012:307271.

49. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021;27(3).

50. Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. J Trauma Nurs. 2010;17(2):112-7.

51. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. Med J Islam Repub Iran. 2014;28:148-.

52. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. Br J Gen Pract. 2014;64(623):e313-20.

53. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. J Inj Violence Res. 2018;10(2):113-8.

54. Zaher E. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. From the Editor. 2014;7(10).

55. Hudspeth N, Cameron J, Baloch S, Tarzia L, Hegarty K. Health practitioners' perceptions of structural barriers to the identification of intimate partner abuse: a qualitative meta-synthesis. BMC Health Services Research. 2022;22(1):96.

56. Sprague S, Swaminathan A, Slobogean GP, Spurr H, Arseneau E, Raveendran L, et al. A scoping review of intimate partner violence educational programs for health care professionals. Women Health. 2018;58(10):1192-206.

57. Arora S, Rege S, Bhate-Deosthali P, Thwin SS, Amin A, García-Moreno C, et al. Knowledge, attitudes and practices of health care providers trained in responding to violence against women: a pre- and post-intervention study. BMC Public Health. 2021;21(1):1973.

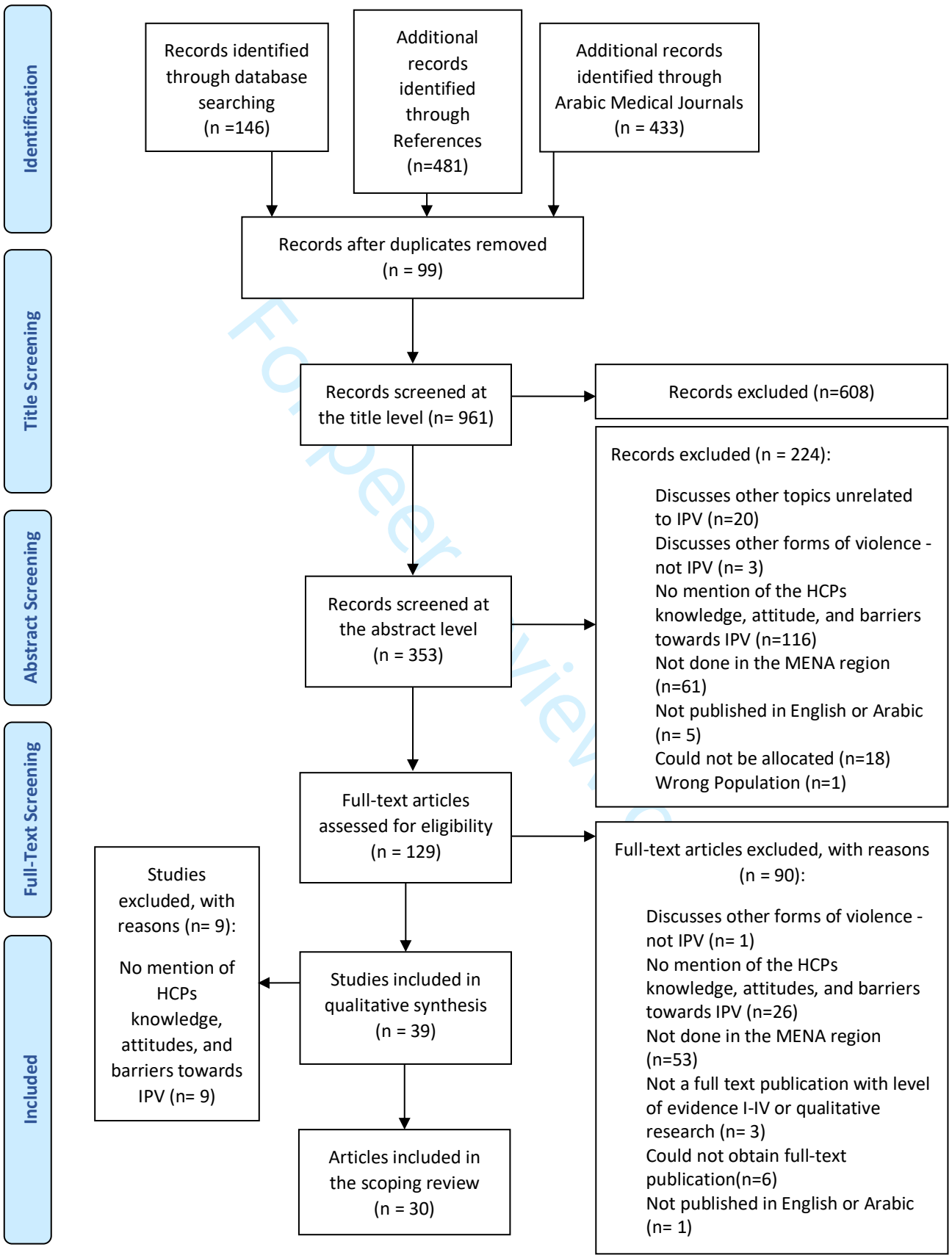
Supporting information

Figure 1. PRISMA Flow Chart (.pdf)

Supplemental Material 1 [Search Strategy] (.pdf)

Supplemental Material 2 [A List of Articles Included in the Scoping Review] (.pdf)

Supplemental Material 3 [Table on the Knowledge, Attitudes, and Beliefs of Included Articles] (.pdf)



Search Strategy (e.g. MEDLINE, CINAHL, APA Psychinfo)

Database: EBSCO MEDLINE, Pyshcinfo, CINAHL.

Search ID#	Search Terms	Results
S1	Domestic Abuse OR Domestic violence OR Domestic assault OR Intimate partner violence OR partner violence OR interpersonal violence OR spouse abuse OR family violence OR sexual violence OR dating violence OR partner abuse	90,205
S2	Primary healthcare OR Primary Healthcare Physician OR Physicians, General Practitioners OR Family Physicians OR Healthcare providers OR Patient Focused Care OR General Practice OR Care OR Primary Health OR Health Care Primary OR Primary Care OR Patient Centered Care	1,396,187
S3	Kuwait OR Bahrain OR United Arab Emirates OR Oman OR Qatar OR Saudi Arabia OR Lebanon OR Syria OR Palestine OR Israel OR Turkey OR Jordan	929,659
S4	Iran OR Iraq OR Yemen OR Morocco OR Libya OR Tunisia OR Algeria OR Egypt OR Malta OR Djibouti OR Ethiopia OR Sudan	476,267
S5	S3 OR S4	1,374,139
S6	Knowledge OR Understanding OR Ability OR Awareness OR Education OR Expertise OR Familiarity OR Grasp OR Grip OR Insight OR Intelligence OR Judgement	7,457,100
S7	Observation OR Recognition OR Comprehension OR Command OR Apprehension OR Skill OR Proficiency OR Capacity OR Capability OR Consciousness	3,348,600
S8	S6 OR S7	9,630,887
S9	Attitude OR Approach OR opinion OR Perspective OR Point of view OR Position OR Prejudice OR Stance OR Reaction OR Sensibility OR Stand OR Temperament	7,530,678
S10	View OR Inclination OR Leaning OR Predilection OR Disposition OR Headset OR Standpoint OR Frame of mind OR Mental state OR Proclivity OR Angle	1,258,559
S11	Reaction OR Ideas OR Conviction OR Orientation OR Feelings OR Thoughts OR Interpretation	3,872,651
S12	S9 OR S10 OR S11	9,436,742
S13	Barriers OR Boundary OR Boundaries OR Limit OR Limitations OR Impediment OR Obstacle OR Fortification OR Hurdle OR Hindrance OR Drawback OR Complication	5,653,834
S14	Difficulty OR Problem OR Disadvantage	2,421,074
S15	S13 OR S14	7,648,623
S16	S1 AND S2 AND S5 AND S8 AND S12 AND S15	8

Additional File 2: Articles Included in the Scoping Review (n=29)

1. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.
2. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70
3. Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2013;49(2):181-7.
4. AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(1).
5. Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).
6. Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK. Domestic violence screening among primary health care workers in Kuwait. Alexandria Journal of Medicine. 2013;49(2):169-74.
7. Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI. Knowledge of primary care nurses regarding domestic violence. Alexandria Journal of Medicine. 2011;47(2):173-80.
8. Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M. How to screen for domestic violence against women in primary health care centers. Alexandria Journal of Medicine. 2013;49(1):89-94.
9. Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.
10. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(4).
11. Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK. Comparison of Attitude of Primary Health Care Physicians and Nurses Towards Domestic Violence Against Women. Bull Alex Fac Med. 2010;46(4):371-6.
12. Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. J Adv Nurs. 2009;65(8):1645-54.
13. Ben Natan M, Ben Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59(1):108-14.
14. Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. J Trauma Nurs. 2010;17(2):112-7.
15. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.
16. Al-Natour A, Gillespie GL, Felblinger D, Wang LL. Jordanian nurses' barriers to screening for intimate partner violence. Violence Against women. 2014;20(12):1473-88.
17. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.
18. Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. BMC Public Health. 2007;7(1):350.
19. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. J Inj Violence Res. 2018;10(2):113-8.
20. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. Medical Journal of the Islamic Republic of Iran. 2014;28:148.

21. Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA. Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City. The Egyptian Journal of Hospital Medicine. 2017;69(8):3058-65.
22. Zaher E, Mason R. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. World Family Medicine Journal: Incorporating the Middle East Journal of Family Medicine. 2014;99(1145):1-6.
23. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health Policy Plan. 2020;35(3):245-56.
24. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sex Reprod Healthc. 2019;20:93-9.
25. Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context. ISRN nursing. 2012;2012.
26. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. The British journal of general practice : the journal of the Royal College of General Practitioners. 2014;64(623):e313-e20.
27. Ahmed AM, Abdella ME, Yousif E, Elmardi AE. Response of Sudanese doctors to domestic violence. Saudi Medical J. 2003;24(10):1077-80.
28. Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY. Domestic Violence: With Emphasis on International Cultural and Societal Variations. Majmaah Journal of Health Sciences. 2016;216(3771):1-16.
29. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021 Mar 1;27(3).
30. Alsalman Z, Shafey M, Al Ali L. Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to Identify, Screening, and Respond? Int J Womens Health 2023;15:623-33. doi: 10.2147/ijwh.S401926 [published Online First: 20230418]

Table on the Knowledge, Attitudes, and Beliefs of Included Articles

No.	Author	Study Name	Location	Year of Publication	Type of Journal	Study Design	Participants	Number of participants	Knowledge	Attitudes	Barriers
1	AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI	Knowledge and perception of domestic violence among primary care physicians and nurses: a comparative study (1)	Kuwait	2012	Alexandria Journal of medicine	A comparative study	physician and nurses	565 physicians and 988 nurses (total of 1553)	– N/A	– N/A	– Lack of IPV training
2	Ahmed AM, Abdella ME, Yousif E, Elmardi AE.	Response of Sudanese doctors to domestic violence (2)	Khartoum, Sudan	2003	Saudi Medical Journal	Not mentioned	Doctors	102	– Female HCPs see IPV as a genuine health problem – Female HCPs were more likely to interfere – Female HCPs have more knowledge about violence (ie. knowledge or definition of IPV, clinical presentation/findings/characteristic of IPV victims) – Lack of knowledge on IPV – HCPs with more work experience had more knowledge	– HCPs believe that IPV is a taboo matter – HCPs will not intervene beyond medical or physical help i.e., legal	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – HCPs have a fear of endless legal procedures
3	Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY.	Domestic Violence : With Emphasis on International Cultural and Societal Variations (3)	Not Applicable *	2016	Majmaah Journal of Health Sciences,	Review Article	NA **	NA **	N/A	– N/A	– Lack of IPV training
4	Aksan HAD, Aksu F.	The Training needs of turkish emergency department personnel regarding intimate partner violence (4)	Turkey	2007	BMC Public Health	A cross-sectional study	Nurses and physicians	215	– Lack of knowledge of legal procedures Female HCPs have more knowledge about violence (ie. knowledge or definition of IPV, clinical presentation/findings/characteristic of IPV victims)	– N/A	– Lack of IPV training – HCPs unable to identify, help or deal with IPV
5	Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK.	Gender difference of knowledge and attitude of primary health care staff towards domestic violence (5)	Kuwait	2011	Alexandria Journal of Medicine	observational cross-sectional study	health care workers	1553	– Female HCPs have more knowledge about violence (ie. knowledge or definition of IPV, clinical presentation/findings/characteristic of IPV victims)	– N/A	– N/A
6	Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK	Comparison of the attitude of primary health care physicians and nurses towards domestic violence against women (6)	Kuwait	2010	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	1553	– Lack of knowledge on IPV	– HCPs believed that IPV is a taboo matter	– Lack of IPV training – Personal safety (if violence was redirected to HCPs) – Lack of time – HCPs unable to identify, help or deal with IPV
7	Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M.	How to screen for domestic violence against women in primary health care centers (7)	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians, and nurses	210 physicians and 464 nurses (total of 674)	– N/A	– N/A	– Absence of privacy in the clinical setting/OPD – IPV victims don't disclose to HCPs of the opposite sex
8	Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK	Domestic violence screening among primary health care workers in Kuwait (8)	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	210 physicians and 464 nurses (total of 674)	– Male HCPs more likely to screen for or diagnose IPV – Physicians are more likely to screen IPV than nurses – Lack of knowledge on IPV Female HCPs have more knowledge about violence	– HCPs believe that IPV is a taboo matter	– Absence of a system that supports directing and helping HCPs to deal with IPV victims
9	Al-Natour A, Gillespie GL, Felblinger D, Wang LL.	Jordanian nurses barriers to screening for intimate partner violence (9)	Jordan	2014	Violence against women	Cross-sectional Study	Jordanian nurses.	125	– N/A	– HCPs do not believe that IPV is a medical issue – HCPs fear that screening offends patients – HCPs fear that screening endangers victims – HCPs fear that screening angers patients – HCPs fear that screening is an invasion of privacy	– Personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – HCPs don't feel competent

										– HCPs don't think it's their business if patients don't disclose IPV	
10	Al-Natour A, Qandil A, Gillespie GL.	Intimate Partner Violence screening barriers as perceived by Jordanian nurses: qualitative descriptive study (10)	Jordan	2015	Journal of Nursing and Practice	qualitative descriptive study	nurses	12	– Lack of knowledge of protocol – HCPs fear that screening offends patients	– N/A	– Lack of IPV training – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – Unclear roles/authority – Absence of privacy in the clinical setting/OPD – Insufficient awareness amongst HCPs – IPV victims don't disclose to HCPs of the opposite sex
11	Al-Natour A, Qandil A, Gillespie GL.	Nurses' roles in screening for intimate partner violence: a phenomenological Study (11)	Jordan	2016	International Nursing Review	A phenomenological study	male and female Jordanian nurses	12	– Lack of knowledge of protocol Lack of knowledge on IPV	– HCPs believed that IPV is a taboo matter – Don't screen for IPV even if they suspect violence – Only manage physical symptoms, not mental symptoms – Become frustrated when patients don't disclose assault or deny exposure	– Lack of IPV training – Unclear roles/authority
12	Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M.	Barriers for domestic violence screening in primary health care centers (12)	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	210 physicians and 464 nurses (total of 674)	N/A	– N/A	Lack of IPV training – Lack of experience
13	Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK	Barriers for administering primary health care services to battered women: perception of physician and nurses (13)	Kuwait	2011	Alexandria Journal of Medicine	Observational cross-sectional study	physicians and nurses.	1553	N/A	– HCPs believed that IPV is a taboo matter	– Lack of IPV training – Personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Insufficient staffing, structures, resources – Absence of privacy in the clinical setting/OPD – Heavy workload – Shame/embarrassment in asking questions – Lack of legal arrangements
14	Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA.	Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City (14)	Saudi Arabia	2017	The Egyptian journal of Hospital Medicine	Cross-sectional study	PHCPs	62	– Male HCPs more likely to screen for or diagnose IPV – Married HCPs had higher performances – Lack of knowledge on IPV Lack of knowledge of legal procedures	– N/A	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Insufficient staffing, structures, resources – Heavy workload – Shame/embarrassment in asking questions
15	Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI.	Knowledge of primary care nurses regarding domestic violence (15)	Kuwait	2011	Alexandria Journal of Medicine	Exploratory, attitudinal surveys	nurses	988	– N/A	– N/A	– Lack of IPV training
16	Alsalman Z, Shafey M, Al Ali L.	Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to	Saudi Arabia	2023	International Journal of Women's Health	Cross-sectional study	PHCPs	169	– Lack of knowledge on screening, management, and referral guidelines – Lack of knowledge on IPV	– HCPs fear that screening offends patients,	– Lack of IPV training – Absence of a system that supports directing and helping HCPs to deal with IPV victims – Insufficient resources

		Identify, Screening, and Respond? (16)								
17	Aziz MM, El-Gazzar AF.	Health Care Providers' Perceptions and Practices of Screening for Domestic Violence in Upper Egypt (17)	Upper Egypt (Assiut)	2019	Sexual & Reproductive Healthcare	Mixed Quantitative and Qualitative; Survey and FDGs	doctors and nurses, physicians and nurses in the FDG	122 doctors and 200 nurses returned surveys. 12 Physicians and 10 nurses in the FGDs.	– Lack of knowledge of protocol – Lack of knowledge of legal procedures – Lack of knowledge around necessary skills required	– Believe that IPV is a taboo matter – HCPs perceive IPV to be an ordinary matter within society – HCPs fear that screening offends patients, endangers victims, is distressing to them and causes interference – When screening for IPV, HCPs only manage physical symptoms, not mental 8symptoms, become frustrated when patients don't disclose assault or deny exposure and only refer suicidal cases to a psychiatrist	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Absence of privacy in the clinical setting/OPD – HCPs unable to council cases
18	Ben Natan M, Ben Ari G, Bader T, Hallak M.	Universal screening for domestic violence in a department of obstetrics and gynaecology: A patient and carer perspective (18)	Israel	2011	International Nursing Review	Correlative, cross-sectional design was utilized	physicians, nurses, female patients	100 physicians and nurses, 100 female patients	– Lack of knowledge of protocol – Knowledge about IPV training and protocols on how to deal with cases allowed HCPs to screen IPV victims	– N/A	– Lack of IPV training
19	Boy A, Kulczycki A.	What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women (19)	MENA region	2008	Violence against women	Review article	Not applicable	none	– N/A	– When screening for IPV, HCPs will not intervene beyond medical or physical help i.e., legal	– HCPs unable to identify, help or deal with IPV
20	Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L.	Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory (20)	occupied Palestinian Territory (oPT)	2019	The Oxford Journal on Health Planning and Systems research; Health Policy and planning.	Case Study design using qualitative methods (interviews and a stakeholder meeting)	PHC providers and Stakeholders	23 PHC providers and 19 Stakeholders	– Lack of knowledge of protocol – Lack of knowledge on IPV	– HCPs believe that IPV is a taboo matter – HCPs believe there is limited capacity as IPV is a mental health issue – HCPs become frustrated when patients don't disclose assault or deny exposure – HCPs feel frustrated with the low referral uptakes by patients	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Insufficient staffing, structures, resources No law to protect HCPs
21	Goldblatt H.	Caring for abused women: impact on nurses' professional and personal life experiences (21)	Israel	2009	Journal of Advanced Nursing	A phenomenological study	female Israeli nurses	22	– N/A	– HCPs fear that screening leads to emotional involvement	– Lack of time – Difficult to set boundaries
22	Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al	Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context (22)	Ethiopia	2012	ISRN Nursing	Nursing-led Interdisciplinary project and literature review	NA	NA	– N/A	– HCPs believe that IPV is a taboo matter	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Unclear roles/authority
23	Ibrahim E, Hamed N, Ahmed L.	Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt (23)	Egypt	2021	Eastern Mediterranean health journal	A cross-sectional study	Healthcare Providers	385	– N/A	– HCPs did not want to interfere as they believe IPV is not part of medical practice	– Lack of time – Lack of IPV training – Absence of a system that supports directing and helping HCPs to deal with IPV victims

										– HCPs fear that patients would get angry if screened
24	Natan MB, Rais I.	Knowledge and attitudes of nurses regard-ing domestic violence and their effect on the identification of battered women (24)	Israel	2010	Journal of Trauma nursing	descriptive, quantitative study	hospital- and community-based nurses.	100	– Lack of knowledge of protocol	– Believe that IPV is a taboo matter	– Lack of IPV training
25	Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK.	Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women (25)	Kuwait	2013	Alexandria Journal of Medicine	Cross-sectional Study	Doctors and nurses	210 physicians and 464 nurses (total of 674)	– Male HCPs more likely to screen for or diagnose IPV – Physicians are more likely to screen IPV than nurses More knowledgeable HCPs more likely to screen for IPV	– HCPs fear that screening is not in patients' best interest – Screening reduces rates and effects of violence and improves the quality of life	– N/A
26	Rasoulian M, Shirazi M, Nojomi M.	Primary Health Care Physicians' Approach Toward Domestic Violence in Tehran, Iran (26)	Tehran, Iran	2014	Medical Journal of the Islamic Republic of Iran	Not mentioned	PHCPs	198	– Female HCPs were more likely to document IPV – HCPs believed that patients will disclose IPV if it is severe or fatal – HCPs believe that IPV is a public health problem. – HCPs think that women should tolerate IPV to keep family's privacy and honour	– HCPs believe that screening endangers victims and is distressing to them	– N/A
27	Usta J, Feder G, Antoun J.	Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners (27)	Lebanon	2014	British Journal of General Practice	Qualitative study	Physicians	70	– Lack of knowledge of protocol	– HCPs believe that IPV is a taboo matter – HCPs do not believe that IPV is a medical issue – HCPs only manage physical symptoms, not mental symptoms	– HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – No law to protect HCPs
28	van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M	The Role of the Healthcare Sector in the Prevention of Sexual Violence Against sub-Saharan Transmigrants in Morocco: A Study of Knowledge, Attitudes and Practices of Healthcare Workers (28)	Morocco	2013	BMC Health Services research	A KAP (Knowledge, Attitudes, Practices) questionnaire, identifying knowledge, attitudes and practices, guided the semi-structured interviews.	Male and Female HCW, Organizations	24 (12 men and 12 women)	Lack of knowledge of legal procedures	– HCPs fear that screening offends patient, is not in patients' best interest and opens up old wounds When screening for IPV, HCPs respect the choice of IPV victims to remain silent	– Absence of a system that supports directing and helping HCPs to deal with IPV victims – Insufficient staffing, structures, resources – HCPs don't feel competent Insufficient awareness amongst HCPs
29	Yousefnia N, Nekuei N, Farajzadegan Z.	The Relationship Between Healthcare Providers' Performance Regarding Women Experiencing Domestic Violence and Their Demographic Characteristics and Attitude Towards Their Management (29)	Iran	2018	Injury & Violence	Cross-sectional study	physicians, 46 midwives, and 212 nurses.	300	– Married HCPs had higher performances – Female HCPs have higher performances – Nurses had higher performances than physicians –	– N/A	N/A
30	Zaher E, Mason R.	Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study (30)	Saudi Arabia	2014	Middle East Journal of Family Medicine	Exploratory, attitudinal surveys	Doctors	30	N/A	N/A	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV

Legend:

*Location is not applicable in one of the included studies as it was a review article and was not based in a specific country.

**Participants are not applicable in review studies that do not have any direct participants

References:

1. AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(3).
2. Ahmed AM, Abdella ME, Yousif E, Elmardi AE. Response of Sudanese doctors to domestic violence. Saudi Medical J. 2003;24(10):1077-80.
3. Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY. Domestic Violence: With Emphasis on International Cultural and Societal Variations. Majmaah Journal of Health Sciences. 2016;216(3771):1-16.
4. Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. BMC Public Health. 2007;7(1):350.
5. Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).
6. Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK. Comparison of Attitude of Primary Health Care Physicians and Nurses Towards Domestic Violence Against Women. Bull Alex Fac Med. 2010;46(4):371-6.
7. Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M. How to screen for domestic violence against women in primary health care centers. Alexandria Journal of Medicine. 2013;49(1):89-94.
8. Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK. Domestic violence screening among primary health care workers in Kuwait. Alexandria Journal of Medicine. 2013;49(2):169-74.
9. Al-Natour A, Gillespie GL, Felblinger D, Wang LL. Jordanian nurses' barriers to screening for intimate partner violence. Violence Against women. 2014;20(12):1473-88.
10. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.
11. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.
12. Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.
13. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(2).
14. Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA. Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City. The Egyptian Journal of Hospital Medicine. 2017;69(8):3058-65.
15. Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI. Knowledge of primary care nurses regarding domestic violence. Alexandria Journal of Medicine. 2011;47(2):173-80.
16. Alsalman Z, Shafey M, Al Ali L. Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to Identify, Screening, and Respond? Int J Womens Health 2023;15:623-33. doi: 10.2147/ijwh.S401606 [Published Online First: 20230418].
17. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sex Reprod Healthc. 2019;20:93-9.
18. Ben Natan M, Ben Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59(1):108-14.
19. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70.
20. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian territory. Health Policy Plan. 2020;35(3):245-56.
21. Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. J Adv Nurs. 2009;65(8):1645-54.
22. Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context. ISRN nursing. 2012;2012.
23. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021 Mar 1;27(3).
24. Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. J Trauma Nurs. 2010;17(2):112-7.
25. Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2013;49(2):181-7.
26. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. Medical Journal of the Islamic Republic of Iran. 2014;28:148.
27. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. The British journal of general practice : the journal of the Royal College of General Practitioners. 2014;64(623):e313-e20.
28. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.
29. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. Inj Violence Res. 2018;10(2):113-8.
30. Zaher E, Mason R. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. World Family Medicine Journal: Incorporating the Middle East Journal of Family Medicine. 2019;17(9(1145):1-6.

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	2,3
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	3,4,5
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	N/A
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	6
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	6
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Supplemental Material 1: Search Strategy
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	6
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	N/A
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	N/A

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	N/A
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	7
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	7 Figure 1 PRISMA Flow Chart
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	7,8,9 Supplemental Material 3: Table of KAB of included articles
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	N/A
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	8,9,10
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	8,9,10
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	10,11
Limitations	20	Discuss the limitations of the scoping review process.	12
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	12,13
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	15

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.

BMJ Open

A Scoping Review of healthcare professionals' views on Intimate Partner Violence in the Middle East and North Africa

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2023-079866.R3
Article Type:	Original research
Date Submitted by the Author:	23-Apr-2024
Complete List of Authors:	Al-Salmi, Sabrina ; Royal College of Surgeons in Ireland and Medical University of Bahrain, ; Leicester Royal Infirmary, Aly, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain Najeeb, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain, Alumni Shaikh, Zoya; Royal College of Surgeons in Ireland and Medical University of Bahrain, Zuaiter, Farah; Royal College of Surgeons in Ireland and Medical University of Bahrain Doherty, Sally; Royal College of Surgeons in Ireland, Department of Psychology Sefen, Jessica; Royal College of Surgeons in Ireland and Medical University of Bahrain
Primary Subject Heading:	General practice / Family practice
Secondary Subject Heading:	Global health, Medical education and training, Medical publishing and peer review, Public health
Keywords:	Primary Prevention, Primary Health Care, Primary Care < Primary Health Care

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

A Scoping Review of healthcare professionals' views on

Intimate Partner Violence in the Middle East and North Africa

Sabrina Al-Salmi[1], Farah W. Aly[1], Farah S.N. Naser[1], Jessica A.N. Sefen[1], Zoya Shaikh[1],

Farah A.O.A. Zuaiter[1],Sally Doherty[1]

[1]School of Medicine, Royal College of Surgeons in Ireland, Al-Sayh, Muharraq, Bahrain

*Corresponding Author: Farah A O A Zuaiter

Postal Address:

Royal College of Surgeons in Ireland
Al-Sayh, Muharraq
P.O. Box 15503, Adliya
Kingdom of Bahrain

Email: farahztr@gmail.com

Word Count: 3886 words

ABSTRACT

Objectives

This scoping review aims to survey healthcare providers (HCPs) in the Middle East and North Africa (MENA) about their knowledge, attitudes, and barriers to working with women who have experienced Intimate Partner Violence (IPV). This review aims to map the breadth of available peer-reviewed literature that may inform future educational training programs.

Design

Scoping review.

Data Sources

The scoping review included studies up to December 2023 from PUBMED, Medline, COCHRANE, CINAHL, PsycINFO, and Arabic medical journals.

Eligibility Criteria

Selected articles were restricted to those carried out in the MENA region, available in full-text, and with no date restrictions.

Data Extraction and Synthesis

Data was extractedfrom all studies to include research location, year of publication, type of journal, methodology, design, participants, knowledge, attitudes, and barriers.By charting the information into a table, the data wasanalysedusing frequency and counts and descriptive content analysis.

Results

Of the 1066 articles reviewed, 29eligible studies were included in this scoping review. 27% of the articles reported HCPs' lack of knowledge about IPV protocols. The dominant attitude reported was a preference to treat the presenting health complaint and avoid discussing IPV. Finally, 30% of articles reported HCPs' lack of training as the main barrier.

Conclusion

Our paper concluded that there is a lack of research in understanding the knowledge, attitudes, and barriers surrounding HCPs in the MENA region and IPV. This scoping review highlights the need for further research, informing interventions, and training for HCPs in the region.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- Arksey and O'Malley's methodology ensured a consistent framework when drafting the review.
- The study selection was done electronically via the web-based program Rayyan and by two reviewers to reduce bias in relation tothe inclusion and exclusion of articles.
- Language restriction (to English and Arabic only) was one of the main limitations on the comprehensiveness of this review.
- The restricted number of domestic violence articles published in the MENA region served as a limitation to the validity of this study.
- A formal bias assessment was not conducted in this study.

KEYWORDS

Intimate Personal Violence, Middle East, Review

BACKGROUND

Intimate Partner Violence (IPV) is a major worldwide public health problem impacting millions of lives (1). In this article, it is defined in accordance with the Istanbul Convention as: *"all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit, or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim."*(2)

Prevalence rates of IPV in Western countries range from 25% to 38%,while prevalence rates in the Middle East and North Africa (MENA) region range from 15% to 85%(1, 2). Women who experience IPV in their lifetime may suffer from numerous physical and mental health problems such as depression, post-traumatic

stress disorder, anxiety disorders, substance abuse, suicidal behaviour, somatising disorders, eating disorders, and chronic pain (3, 4). Undisclosed violence can also lead to feelings of guilt, shame, and worthlessness (5). According to the Global Burden of Disease Study, IPV causes significant morbidity and mortality (6). Healthcare workers must be aware of the signs and symptoms of IPV, complete the necessary IPV training, and refer to community and advocacy programs to provide care and support in a non-judgmental, private, and confidential environment (3, 7-9).

The twenty-four countries of the MENA region include Saudi Arabia, Kuwait, Bahrain, United Arab Emirate (UAE), Oman, Qatar, Yemen, Lebanon, Syria, Jordan, Palestine, Israel, Turkey, Iran, Iraq, Morocco, Libya, Tunis, Algeria, Egypt, Malta, Djibouti, Ethiopia, and Sudan. These 24 countries represent an approximate population of 725 million (10). Despite diversity across these countries, they tend to share a commonality of culture, religion (mainly Islam), and language (Arabic). IPV represents both a public health and human rights problem. While women have achieved parity across many of these countries, social, economic, and political equality barrierscontinue to exist(11). The only countries with civil and legal laws to protect women against IPV are Jordan, Lebanon, Tunisia, Morocco, Bahrain, and Saudi Arabia (12).

IPV is perceived as taboo and not considered a crime in many MENA regions. It is a matter often resolvedbythe religious courts instead of the civil and legal authorities (3, 13, 14).

IPV prevalence rates in the Arab region identified 46 datasets from peer-reviewed journals and 11 national surveys across 16 years from 2000 -2016. Results indicated that IPV ranged from 6 to 59% for physical abuse, 3 to 40% for sexual abuse, and 5 to 91% for emotional and psychological abuse (11).

Furthermore, findings from recent literature in the MENA region reporting on IPV in the Arab region emphasize the influence of culture, modesty, family solidarity, and reputation (14, 15). One study explored attitudes toward IPV in Jordan, discovering that one-third of perpetrators justified 'wife beating' due to the culture in their country (16). Some data also suggests that women do not turn to HCPs for help with IPV due to the cultural stigma of causing a 'scandal' (17).When a womandoes sustain severe injuries secondary to the IPV, she is often reluctant and unable to discuss the cause of her injuries due to the presence of her partner during the physician consultation. In such situations, women might also fear the outcomes secondary to reporting the crime (18). These culturally biased attitudes are the main barriers to seeking

help (19). Less than 15% of female patients in the MENA region reported being asked about IPV by their HCPs, in comparison to studies in non-Arabic communities that report 43 to 85% of female respondents (20-21).

The Arab community has an increased tendency of HCPsto be unwilling to integrateIPV into their practice (14, 22). Cultural stereotypes increase an HCPs' reluctance to intervene due to fear for their safety, losing their patients, and opposing the norm of their conservative society (3). With the influence of culture and religion on Arab HCPs, knowledge of and attitudesare criticalcomponents whendeveloping education and training programsin the region(3).

Therefore, this review aims to map the breadth of available peer-reviewed literature in the MENA region to identify research gaps, focus on future research priorities, and inform future educational training programs.

MATERIALS & METHODS

We have carried out a scoping review; unlike a systematic review, this approach allows researchers to address and summarize a broader range of evidence and topics where multiple study designs are applicable (23). It does not assess the quality of studies but, in turn, allows for key concepts in a specific research area to describe the wide range of evidence and sources andhighlight any gaps that may be present(23). Moreover, the research question in a scoping review allows for broader, non-specific questions to be addressed. In this instance, we are interested in HCPs' views about IPV. We have included articles focusing on the knowledge, attitudes, and barriers to working with women who experience IPV. The HCPs include doctors, nurses, midwives, and social workers.

Arksey and O'Malley's methodological framework adopted the methods described in this study(23). Their methodological framework for conducting a scoping review consisted of five stages. The following stages include identifying a research question, relevant peer-reviewed studies, study selection, charting the data, and finally, collating, summarizing, and reporting the results (23).

We aimed to investigate "what is known about the knowledge, attitudes, and barriers of HCPs on IPV in the MENA region?" This scoping review is conducted to inform the work of IPV advocates, IPV victims,

their representatives, researchers, and healthcare providers, including doctors, nurses, policymakers, institutions, organizations, caregivers, and health-based students, such as nursing and medical students.

Literature search strategy

FAOAZ and SA developed a search strategy [Supplemental Material 1]. All publications that target HCPs' views on IPV in the MENA Region were included. Key search terms were Healthcare providers, MENA region, IPV, knowledge, attitudes, and barriers. The following databases were searched: PUBMED, Medline, PsycINFO, Cumulative Index of Nursing and Allied Health Literature (CINAHL), and Cochrane Database of Systematic Reviews (CDSR). All searches were performed up to the date of December 2023with no date restriction. In addition, the references from all key papers were manually reviewed. A hand search of relevant articles in the Arabic Medical Journals was also conducted. A sample of the search strategy is available for review in the document labelledSupplemental Material 1 [search strategy].

Eligibility Criteria

We included articles based on a broad eligibility criterion for this scoping review. This criterion includes articles [1] published in English and Arabic; [2] focused on IPV against women; [3] Including HCPs' views on IPV; [4] in the MENA region; [5] in full-text formats; [6] with no date restrictions. Articles that did not meet this inclusion criterion or could not be obtained for any reason were excluded.

Data Extraction

Based on the review's research question, a data extraction template was developed in the form of a table by two reviewers, JANS and ZS. They extracted the data focusing on the following categories: study characteristics, which include but are not limited to research location, year of publication, type of journal, methodology, study design and participants, knowledge, attitudes, barriers, and any factors that fall under these categories. As seen in other scoping reviews (23), determining what fell under each category differed per paper, and there was a difference in the definition and understanding of each concept throughout the studies.

Data Synthesis

Then, by charting the information into a table, the reviewers were then able to analyse the data quantitatively using frequency and counts. Data extracted from qualitative studies will be analysed using descriptive content analysis. This, in turn, allowed us to identify gaps in the research.

Patient and Public Involvement

We did not include patients or members of the public in the research, as this was beyond the study's scope.

RESULTS

Article Identification & Selection

Our search strategy resulted in a total of 1060 articles [Figure 1]. Of these articles, 146 came from the databases, 481 from references, and 433 from the hand search of Arabic Medical Journals. We did not encounter any papers with only Arabic abstracts or full text. Of these, 99 were duplicated and removed before title screening. Therefore, 961 underwent title review, and the reviewers found that 353 abstracts were potentially eligible. After screening the abstracts, 129full-text studies were reviewed. However, only 29 studies were included in the scoping review [Supplemental Material 2]. The remaining articles were excluded as they did not mention knowledge, attitudes, or barriers of HCPs towards IPV. All article screening and selection were completed using the web-based program Rayyan (24).

Figure 1: PRISMA Flow Chart

Study Characteristics

There was a total of 29 papers in this scoping review(5, 15, 25-51). The majority came from Kuwait (n = 9), followed by three studies from Israel and three from Jordan(20, 25, 29-37, 39, 42, 44, 47). Three studies were conducted in Saudi Arabia, and two were done inIran(38, 40, 48, 50, 51). The occupied Palestine Territories (OPT), Egypt, Ethiopia, Lebanon, Turkey, Morocco, and Sudanwere each conducted in one study(5, 26, 28, 41, 43, 45, 46, 49). One study involved the entire MENA region (n = 1, 3.4%) (15).

Study Designs

There were twelve different types of study designs in the 2x9 articles reviewed. Of these, the majority were cross-sectional studies (n=14, 48.3%), 2 were review articles (6.9%), 3 were qualitative studies (10.3%), 2 were Phenomenological studies (6.9%), and mixed as well as quantitative designs were each present in one study (3.4%)(15, 20, 27-38, 40-44, 46, 47, 49, 50). The table in supplemental material three fully outlines the 12 study designs and the type and number of participants. Participants in these studies ranged from 12 (34, 35) to 1,553 (25, 39, A, 37) participants. Three review studies are literature-based and don't directly involve any participants (15, 27, 45).

Some studies involved doctors and nurses (n = 11,37.9%)(20, 25, 28, 30-32, 36, 37, 41, 42, 50). A few studies included doctors (n = 6, 20.7%) or nurses (n = 6, 20.7%) (26, 33-35, 39, 44, 47, 49, 51). One study included doctors, nurses, and midwives (50); another included doctors, nurses, and female patients (42). Health Care Providers were included in three studies; this is a separate row on the table as the title 'HCP' does not specify the professional (i.e., nurse/doctor)[Supplemental Material 3](38,40,48). One study even included social workers (46). Two included other participants besides HCPs; one included HCPs and stakeholders (43), and the other targeted key HCPs and organizations in the community to recruit as participants(5).

Studies that do not specify what kind of healthcare worker participated (e.g., nurse, doctor, or other) were just left as 'HCPs.'

Outcomes

We have included29 articles in the Arabic and English literature on the views of HCPs about IPV in the MENA region. We did not assess the quality of these studies as this does not fall under the usual methods of a scoping review. Fewer studies were published in North Africa (n=3) relative to the Middle East (n=25) (5, 20, 25, 26, 28-51). There was an increasing trend in the number of papers published from 2000-2005 (n=1, 3.4%), 2006-2010 (n=5, 17.2%), and finally, 2011-2015 (n=16, 55.1%) (5, 15, 20, 25, 26, 28-34, 36, 37, 39, 42, 44, 45, 47-51). However, there was a relative decline in the number of studies published between 2016 and 2023 (n=7, 24.1%) (27, 35, 38, 41, 43, 46, 50).

The main research question referred to the views of HCPs in the MENA region on IPV. Several themes of HCPs' knowledge, attitudes, and barriers in relation to IPV were uncovered across the 29 articles. Knowledge refers to the statements made by HCPs about IPV: I think, I know, I do, while attitudes are distilled from the literature: I feel, I want, I would. Attitude statements were associated with feelings, whereas knowledge statements were associated with facts, information, or skills.

General views and knowledge

The most notable difference between HCPs was that male HCPs were more likely to screen for or diagnose IPV, as evidenced in 3 articles (n=3, 10.3%)(20, 32, 38). Next, two articles concluded that married HCPs had higher performances regarding assessing, intervening, documenting, referring, and following up with IPV cases (n=2, 6.9%) (38,50).Two articles identified that family physicians were more likely to have a good knowledge of IPV than general practitioners and were, therefore, more likely to screen for IPV (n=1, 3.4%) (29).It was noted that female HCPs have more knowledge (n=4, 13.3%), saw IPV as a genuine health problem (n=1, 3.4%), were more likely to document IPV, and were also more likely to interfere (n=1, 3.4%)(26, 28, 29, 32, 48, 50). Also, HCPs with more work experience showed more IPV knowledge (n=1, 3.4%) (26).

The most contributing factor to assessing and managing IPV by HCPs was a lack of availability or understanding of best practice protocols (n=10, 34.5%) followed by a lack of knowledge of IPV, i.e., the full definition (n=7, 24.1%)(5, 26-30, 32, 34, 35, 38, 40-43, 47, 49). Four articles identified that HCPs were unaware of the legal procedure (13.8%)(5, 28, 38, 41).One article proved that there is a lack of knowledge about IPV training and protocols on how to deal with IPV cases, allowed HCPs to screen IPV victims (3.4%), and another stated that more knowledgeable HCPs are more likely to screen for IPV (3.4%) (26,42).

Attitudes

The most common attitude was that HCPs believed that IPV is taboo and preferred not to discuss or intervene in the matter (n=10, 34.5%)(15, 27, 30, 32, 35, 37, 41, 43, 45, 47, 49). Some studies perceived IPV to be an ordinary matter within society and that women should tolerate IPV to keep their family's privacy and honour (n=1, 3.4%) (48).HCPs feared that screening is an invasion of privacy (n=1, 3.4%), would not be in the victims' best interest (n=2, 6.9%), lead to an emotional environment (n=1, 3.4%), and

that it would have several negative impacts such as offending patients (n=5, 17.2%), angering patients (n=1, 3.4%), endangering victims (n=2, 6.9%) and distressing victims (n=2, 6.9%)(5, 20, 33, 34, 40, 41, 44, 48). Some studies reported that HCPs wouldnot screen for IPV even if they suspected violence (n=1, 3.4%) (35).HCPs felt frustrated with the low referral uptakes by patients (n=1, 3.4%) (38).Some HCPs felt shame/embarrassment in asking questions regarding IPV (n=2, 6.9%) (37,38).

When screening for IPV, HCPs only managed physical symptoms (n=3, 10.3%) and would not intervene beyond physical or medical help (n=2, 6.9%)(15, 26, 35, 41, 49).HCPs would only refer suicidal cases to psychiatrists and believed there is limited capacity as IPV is a mental health issue (n=1, 3.4%) and is not part of medical practice (n=1, 3.4%) (26, 46). When HCPs did screen, they would become frustrated when their patients did not disclose or deny IPV (n=3, 10.3%), believed that patients would disclose IPV if it is severe enough, and would respect the choice of IPV victims to remain silent (n=1, 3.4%)(5, 33, 35, 41). Furthermore, they feared endless legal procedures (n=1, 3.4%) (26).

Barriers

The most prevalent barrier was the lack of IPV training and experience, reported in 18 articles, contributing to 62.1% of our included articles(25-28, 30, 34-43, 45-47, 51). The next most commonly reported barrier was personal safety; 10 articles reported that HCPs were afraid of redirected violence to themselves; therefore, they did not want to intervene (34.5%)(26, 30, 33, 37, 38, 41, 43, 45, 49, 51). Lack of time was reported in 10 articles (34.5%)(26, 30, 33, 34, 37, 41, 43, 44, 46, 49). HCPs declared that they deemed themselves unfit to identify, help, or deal with IPV victims (n=8, 27.6%)(15, 28, 30, 33, 37, 41, 43, 51).Moreover, there was also a common theme among ten articles (34.5%) of the absence of systems that support directing and helping HCPs deal with IPV victims, such as support and referral services(5, 32-34, 37, 40, 41, 43, 46, 51). Some HCPs claimed that there was an absence of privacy in the clinical setting (n=4, 13.8%) (31, 34, 37, 41). HCPs also were unsure about their roles or authority in IPV cases (n=3, 10.3%) and claimed insufficient awareness amongst HCPs (n=2, 6.9%)(5, 34, 35, 37). Another barrier identified was the heavy workload (n=2, 6.9%) (37, 38).

DISCUSSION

[removal of a paragraph]

This review has several noteworthy findings concerning the quantity and focus of the articles; we see a significant number of articles discussing a need for more time and training, which is common in the international literature.However, studies in the MENA region discuss a need for more knowledge about protocols and systems of support, the role of the law, unclear professional roles, fear for safety, managing misconceptions, and a lack of privacy in the consultation.

[removal of two paragraphs]

The most commonly reported statement and barrier was the HCPs' perception of IPV as a taboo subject, i.e., social, religious, or private. HCPs would, as a result, refrain from screening or asking questions regarding IPV if suspected. The second most prevalent attitude indicated that IPV is not a medical issue, which causes an obstacle for IPV victims who choose to disclose their experience to HCPs.

Compared to the MENA region, a recent study has outlined the barriers to identifying IPV across various countries(52). These were found to be similar to the MENA region and included both environmental and social barriers. In the MENA region, the most common barrier was the lack of IPV training. However, in the same study, the most significant barrier was the HCPs' healthcare environment and its impact on their interaction with patients (52).

This scoping review of the IPV literature reveals a gap in the knowledge, attitudes, and management of patients who present with injuries from IPV in the MENA region. This discovery highlights the need to educate, train, and provide a safe environment to report IPV. The barriers highlighted in this review are universally recognized but require a bespoke culturally relevant education program for healthcare workers. International best practice paired with culturally relevant training is the ideal scenario. As HCPs working in this region, seeking and building awareness of the barriers to working with women who experience IPV is essential.

This review aims to recognize and identify the need for HCP education programs that target not only the lack of training and knowledge of HCPs but also their attitudes and beliefs. A preview review aims to identify the components of educational programs that have the most significant positive impact on identifying and managing IPV (53). They found that the programs that IPV educators/experts or physicians delivered included specific treatment protocols and patient resources, and programs with an online training component lasting for more than five sessions yielded the best results(53). It is essential to highlight that

although literature exists on the effectiveness of various training programmes for HCPs, the efficacy of these programmes on the attitudes and behaviours of physicians is lacking worldwide (54). Additionally, many countries in the MENA region still lack appropriate IPV legal policies and support services for victims. Therefore, many victims and HCPs do not have the necessary IPV laws, hospital policies, and services to support them sufficiently(11). This is only one of the many barriers to developing efficient training programs in the MENA region. Therefore, suggesting an ideal training program for HCPs in the MENA region is only possible with further research that explores the barriers and efficiency of training programs both in the MENA region and worldwide.

Strength and Limitations

This scoping review included a wide range of strengths; initially, two reviewers performed the study selection and review process twice. Our eligibility criteria included studies published in both Arabic and English Journals, giving readers a broader scope of the literature and a deeper insight into IPV in the region. We additionally chose not to include an end date in our eligibility criteria, as the MENA region has a limited number of studies on HCPs' perspectives regarding IPV.

As with all research, our review also includes some limitations. Firstly, our search was limited to the literature that had been published. As a result, publication bias may be an issue, as studies reporting negative results in the region may remain unpublished. While we included articles in English and Arabic, we excluded articles conducted in French, Turkish, and any other excluded languages within the region. This has, therefore,limited the number of studies included in this study. Furthermore, the articles included in this study only examined the negative attitudes and beliefs of HCPs towards IPV. Adding positive attitudes and beliefs or enablers to managing and screening for IPV would have perhaps facilitated an understanding of possible solutions to addressing IPV in the MENA region.

CONCLUSION

In conclusion, this scoping review was undertaken to understand the knowledge, attitudes, and barriers of HCPs towards IPV. It highlights the main obstacles that must be addressed to assist IPV victims in the MENA region. These obstacles include a lack of knowledge about the IPV protocol, fear factors that are embedded in the HCP due to certain cultural beliefs, and HCPs viewing IPV as a taboo matter. The most

important way to overcome these obstacles is to implement a mandatory and culturally relevant training program to educate HCPs about detecting, supporting, and treating IPV victims to help improve and potentially save their lives.

Implications

This scoping review draws attention to the knowledge, attitudes, and beliefs of HCPs towards IPV. Now that this paper has identified some barriers to screening and managing IPV in the MENA region, it highlights the need for further studies to investigate the means and components of an effectiveeducation and training programin the MENA region. This training programme should tackle not only the knowledge of HCPs but also their attitudes and beliefs. In additionto investigating the effectiveness of these education programs in theregion,it would be beneficial if further literature addresses the positive attitudes and enablers to managing and screening for IPV within HCPs in the MENA region.

LIST OF ABBREVIATIONS

CINAHL - Cumulative Index of Nursing and Allied Health Literature

CDSR – Cochrane Database of Systematic Reviews

IPV – Intimate Partner Violence

MENA – Middle East and North Africa

SOS-DoC – Support, Options, Strength – Document of observation, assessment & plans, and continuity

HCP – Health Care Practitioners

UAE – United Arab Emirates

oPT – Occupied Palestine Territory

CBPR – Community-Based Participatory Research

MDT – Multidisciplinary Training

OPD – Outpatient Department

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable.

CONSENT FOR PUBLICATION

Not applicable.

AVAILABILITY OF DATA AND MATERIALS

Extra data can be accessed via the Dryad data repository at http://datadryad.org/ with the doi:10.5061/dryad.kkwh70sc5

COMPETING INTERESTS

None declared.

FUNDING

This review received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

AUTHOR CONTRIBUTIONS

FSNN and FWA researched and worked on the background. FAOAZ and SA worked on the literature search strategy. JANSS extracted the data regarding the study characteristics. ZS analysed and interpreted the patient data and performed descriptive statistics of the study sample to describe the sample study characteristics, design, and HCPs' views regarding IPV. SA and SD were significant contributors in writing the manuscript. All authors read and approved the final manuscript.

ACKNOWLEDGEMENTS

Not applicable

REFERENCES

1. Violence against women World Health Organization [Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women.

2. Maziak W, Asfar T. Physical abuse in low-income women in Aleppo, Syria. Health Care Women Int. 2003;24(4):313-26.

3. Usta J, Taleb R. Addressing domestic violence in primary care: what the physician needs to know. Libyan J Med. 2014;9:23527.

4. Taherkhani S, Negarandeh R, Simbar M, Ahmadi F. Barriers to seeking help among abused Iranian women. The Journal of Adult Protection. 2017;19(5):261-73.

5.van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.

6.Kyu HH, Abate D, Abate KH, Abay SM, Abbafati C, Abbasi N, et al. Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. The Lancet. 2018;392(10159):1859-922.

7.Cronholm PF, Fogarty CT, Ambuel B, Harrison SL. Intimate partner violence. American family physician. 2011;83(10):1165-72.

8.AlJuhani S, AlAteeq M. Intimate partner violence in Saudi Arabia: A topic of growing interest. J Family Med Prim Care. 2020;9(2):481-4.

9.Schrier MW, Rougas SC, Schrier EW, Elisseou S, Warrie S. Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals. MedEdPORTAL. 2017;13:10622-.

10.United Nations DoEaSA. World Population Prospects 2019: Highlights. 2019;ST/ESA/SER.A/423.

11.Elghossain T, Bott S, Akik C, Obermeyer CM. Prevalence of intimate partner violence against women in the Arab world: a systematic review. BMC International Health and Human Rights. 2019;19(1):29.

12.Ending Violence against Women and Girls.

13.Douki S, Nacef F, Belhadj A, Bouasker A, Ghachem R. Violence against women in Arab and Islamic countries. Arch Womens Ment Health. 2003;6(3):165-71.

14.Usta J, Antoun J, Ambuel B, Khawaja M. Involving the health care system in domestic violence: what women want. Ann Fam Med. 2012;10(3):213-20.

15.Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70.

16.Al-Nsour M, Khawaja M, Al-Kayyali G. Domestic Violence against Women in Jordan: Evidence from Health Clinics. Journal of Family Violence. 2009;24:569-75.

17.Lenze J, Klasen S. Does Women's Labor Force Participation Reduce Domestic Violence? Evidence from Jordan. Feminist Economics. 2017;23(1):1-29.

18.Ahmad I, Ali PA, Rehman S, Talpur A, Dhingra K. Intimate partner violence screening in emergency department: a rapid review of the literature. J Clin Nurs. 2017;26(21-22):3271-85.

19.Kposowa AJ, Aly Ezzat D. Religiosity,Conservatism, and Acceptability of Anti-Female Spousal Violence in Egypt. J Interpers Violence. 2019;34(12):2525-50.

20.Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2013;49(2):181-7.

21.Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. BMJ. 2002;325(7359):314-.

22.Niaz U, Hassan SU-N, Tariq Q. Situational Analysis of Intimate Partner Violence Interventions in South Asian and Middle Eastern Countries. Partner Abuse. 2017;8:47 - 88.

23.Arksey H, O'Malley L. Scoping studies: towards a methodological framework. International Journal of Social Research Methodology. 2005;8(1):19-32.

24.Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan—a web and mobile app for systematic reviews. Systematic Reviews. 2016;5(1):210.

25.AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(1).

26.Ahmed AM, Abdella ME, Yousif E, Elmardi AE. Response of Sudanese doctors to domestic violence. Saudi Med J. 2003;24(10):1077-80.

27.Ahmed AM, Abdelrahman NHA, Aedh AI, Al-Omer KA, Mohamed EY. Domestic Violence: With Emphasis on International Cultural and Societal Variations. Majmaah Journal of Health Sciences. 2016;216(3771):1-16.

28.Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. BMC Public Health. 2007;7(1):350.

29.Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).

30.Alkhabaz A, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly M. Comparison of attitude of primary health care physicians and nurses towards domestic violence against women. Bull Alex Fac Med. 2010;46(4):371-6.

31.Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M. How to screen for domestic violence against women in primary health care centers. Alexandria Journal of Medicine. 2013;49(1):89-94.

32.Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK. Domestic violence screening among primary health care workers in Kuwait. Alexandria Journal of Medicine. 2013;49(2):169-74.

33.Al-Natour A, Gillespie GL, Felblinger D, Wang LL. Jordanian nurses' barriers to screening for intimate partner violence. Violence Against Women. 2014;20(12):1473-88.

34.Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.

35.Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.

36.Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.

37.Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(4).

38.Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA. Barriers that impede primary health care physicians from screening women for domestic violence at Makkah ALmukarramah City. The Egyptian Journal of Hospital Medicine. 2017;69(8):3058-65.

39.Alsafy NN, Kamel M. Knowledge of primary care nurses regarding domestic violence. Alexandria Journal of Medicine. 2011;47(2).

40.Alsalman Z, Shafey M, Al Ali L. Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to Identify, Screening, and Respond? Int J Womens Health. 2023;15:623-33.

41.Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sex Reprod Healthc. 2019;20:93-9.

42.Natan MB, Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59:108-14.

43.Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health Policy Plan. 2020;35(3):245-56.

44.Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. J Adv Nurs. 2009;65(8):1645-54.

45.Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the ethiopian context. ISRN Nurs. 2012;2012:307271.

46.Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021;27(3).

47.Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. J Trauma Nurs. 2010;17(2):112-7.

48.Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. Med J Islam Repub Iran. 2014;28:148-.

49.Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. Br J Gen Pract. 2014;64(623):e313-20.

50.Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. J Inj Violence Res. 2018;10(2):113-8.

51.Zaher E. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. From the Editor. 2014;7(10).

52.Hudspeth N, Cameron J, Baloch S, Tarzia L, Hegarty K. Health practitioners' perceptions of structural barriers to the identification of intimate partner abuse: a qualitative meta-synthesis. BMC Health Services Research. 2022;22(1):96.

53.Sprague S, Swaminathan A, Slobogean GP, Spurr H, Arseneau E, Raveendran L, et al. A scoping review of intimate partner violence educational programs for health care professionals. Women Health. 2018;58(10):1192-206.

54.Arora S, Rege S, Bhate-Deosthali P, Thwin SS, Amin A, García-Moreno C, et al. Knowledge, attitudes and practices of health care providers trained in responding to violence against women: a pre- and post-intervention study. BMC Public Health. 2021;21(1):1973.

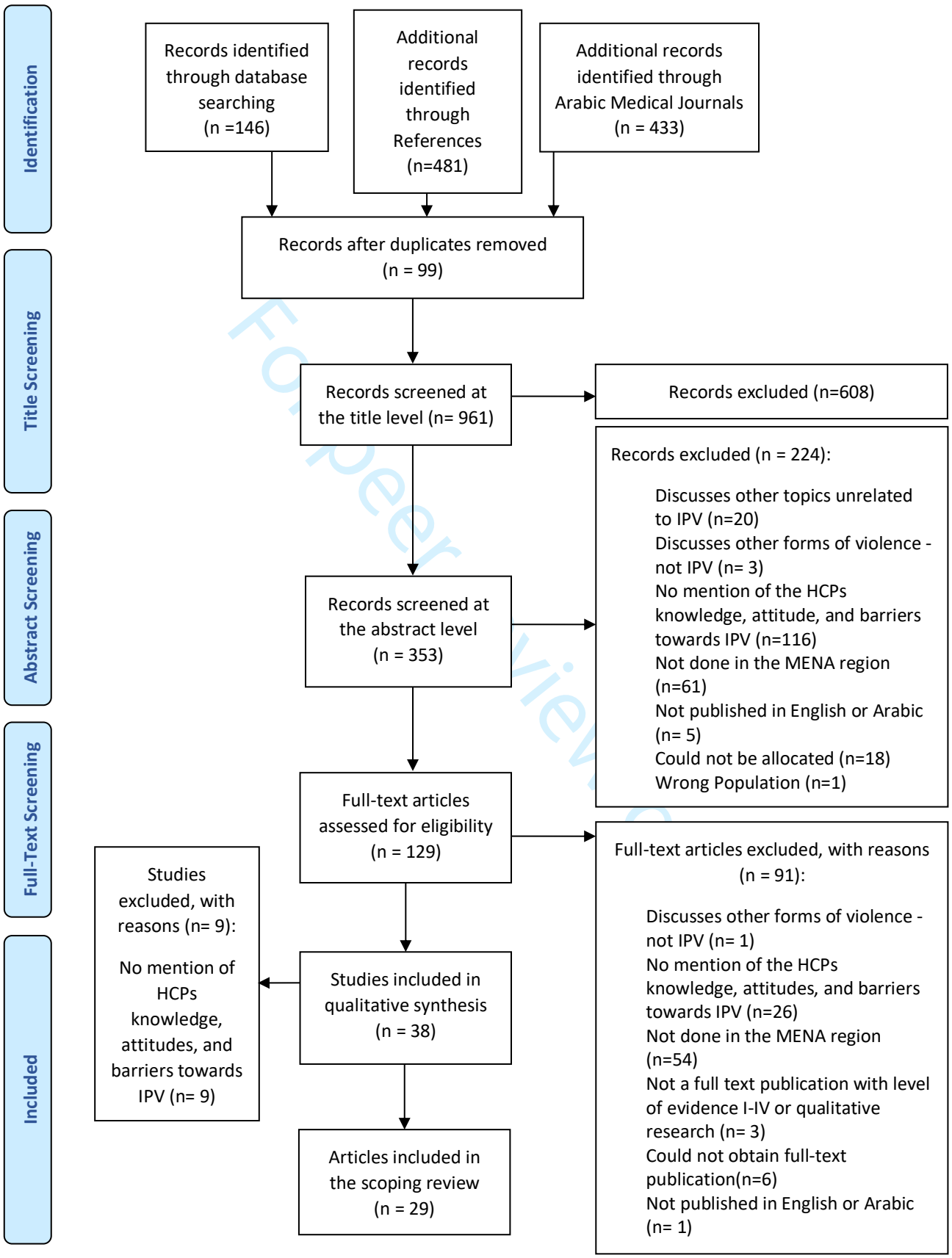
Supporting information

Figure 1. PRISMA Flow Chart (.pdf)

Supplemental Material 1 [Search Strategy] (.pdf)

Supplemental Material 2 [A List of Articles Included in the Scoping Review] (.pdf)

Supplemental Material 3 [Table on the Knowledge, Attitudes, and Beliefs of Included Articles] (.pdf)



Search Strategy (e.g. MEDLINE, CINAHL, APA Psychinfo)

Database: EBSCO MEDLINE, Pyshcinfo, CINAHL.

Search ID#	Search Terms	Results
S1	Domestic Abuse OR Domestic violence OR Domestic assault OR Intimate partner violence OR partner violence OR interpersonal violence OR spouse abuse OR family violence OR sexual violence OR dating violence OR partner abuse	90,205
S2	Primary healthcare OR Primary Healthcare Physician OR Physicians, General Practitioners OR Family Physicians OR Healthcare providers OR Patient Focused Care OR General Practice OR Care OR Primary Health OR Health Care Primary OR Primary Care OR Patient Centered Care	1,396,187
S3	Kuwait OR Bahrain OR United Arab Emirates OR Oman OR Qatar OR Saudi Arabia OR Lebanon OR Syria OR Palestine OR Israel OR Turkey OR Jordan	929,659
S4	Iran OR Iraq OR Yemen OR Morocco OR Libya OR Tunisia OR Algeria OR Egypt OR Malta OR Djibouti OR Ethiopia OR Sudan	476,267
S5	S3 OR S4	1,374,139
S6	Knowledge OR Understanding OR Ability OR Awareness OR Education OR Expertise OR Familiarity OR Grasp OR Grip OR Insight OR Intelligence OR Judgement	7,457,100
S7	Observation OR Recognition OR Comprehension OR Command OR Apprehension OR Skill OR Proficiency OR Capacity OR Capability OR Consciousness	3,348,600
S8	S6 OR S7	9,630,887
S9	Attitude OR Approach OR opinion OR Perspective OR Point of view OR Position OR Prejudice OR Stance OR Reaction OR Sensibility OR Stand OR Temperament	7,530,678
S10	View OR Inclination OR Leaning OR Predilection OR Disposition OR Headset OR Standpoint OR Frame of mind OR Mental state OR Proclivity OR Angle	1,258,559
S11	Reaction OR Ideas OR Conviction OR Orientation OR Feelings OR Thoughts OR Interpretation	3,872,651
S12	S9 OR S10 OR S11	9,436,742
S13	Barriers OR Boundary OR Boundaries OR Limit OR Limitations OR Impediment OR Obstacle OR Fortification OR Hurdle OR Hindrance OR Drawback OR Complication	5,653,834
S14	Difficulty OR Problem OR Disadvantage	2,421,074
S15	S13 OR S14	7,648,623
S16	S1 AND S2 AND S5 AND S8 AND S12 AND S15	8

Additional File 2: Articles Included in the Scoping Review (n=29)

1. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.
2. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70
3. Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2013;49(2):181-7.
4. AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(1).
5. Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).
6. Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK. Domestic violence screening among primary health care workers in Kuwait. Alexandria Journal of Medicine. 2013;49(2):169-74.
7. Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI. Knowledge of primary care nurses regarding domestic violence. Alexandria Journal of Medicine. 2011;47(2):173-80.
8. Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M. How to screen for domestic violence against women in primary health care centers. Alexandria Journal of Medicine. 2013;49(1):89-94.
9. Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.
10. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(4).
11. Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK. Comparison of Attitude of Primary Health Care Physicians and Nurses Towards Domestic Violence Against Women. Bull Alex Fac Med. 2010;46(4):371-6.
12. Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. J Adv Nurs. 2009;65(8):1645-54.
13. Ben Natan M, Ben Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59(1):108-14.
14. Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. J Trauma Nurs. 2010;17(2):112-7.
15. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.
16. Al-Natour A, Gillespie GL, Felblinger D, Wang LL. Jordanian nurses' barriers to screening for intimate partner violence. Violence Against women. 2014;20(12):1473-88.
17. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.
18. Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. BMC Public Health. 2007;7(1):350.
19. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. J Inj Violence Res. 2018;10(2):113-8.
20. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. Medical Journal of the Islamic Republic of Iran. 2014;28:148.

21. Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA. Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City. The Egyptian Journal of Hospital Medicine. 2017;69(8):3058-65.
22. Zaher E, Mason R. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. World Family Medicine Journal: Incorporating the Middle East Journal of Family Medicine. 2014;99(1145):1-6.
23. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health Policy Plan. 2020;35(3):245-56.
24. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sex Reprod Healthc. 2019;20:93-9.
25. Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context. ISRN nursing. 2012;2012.
26. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. The British journal of general practice : the journal of the Royal College of General Practitioners. 2014;64(623):e313-e20.
27. Ahmed AM, Abdella ME, Yousif E, Elmardi AE. Response of Sudanese doctors to domestic violence. Saudi Medical J. 2003;24(10):1077-80.
28. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021 Mar 1;27(3).
29. Alsalman Z, Shafey M, Al Ali L. Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to Identify, Screening, and Respond? Int J Womens Health 2023;15:623-33. doi: 10.2147/ijwh.S401926 [published Online First: 20230418]

Table on the Knowledge, Attitudes, and Beliefs of Included Articles

No.	Author	Study Name	Location	Year of Publication	Type of Journal	Study Design	Participants	Number of participants	Knowledge	Attitudes	Barriers
1	AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI	Knowledge and perception of domestic violence among primary care physicians and nurses: a comparative study (1)	Kuwait	2012	Alexandria Journal of medicine	A comparative study	physician and nurses	565 physicians and 988 nurses (total of 1553)	– N/A	– N/A	– Lack of IPV training
2	Ahmed AM, Abdella ME, Yousif E, Elmardi AE.	Response of Sudanese doctors to domestic violence (2)	Khartoum, Sudan	2003	Saudi Medical Journal	Not mentioned	Doctors	102	– Female HCPs see IPV as a genuine health problem – Female HCPs were more likely to interfere – Female HCPs have more knowledge about violence (ie. knowledge of definition of IPV, clinical presentation/findings/characteristics of IPV victims) – Lack of knowledge on IPV – HCPs with more work experience had more knowledge	– HCPs believe that IPV is a taboo matter – HCPs will not intervene beyond medical or physical help i.e., legal	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – HCPs have a fear of endless legal procedures
3	Aksan HAD, Aksu F.	The Training needs of turkish emergency department personnel regarding intimate partner violence (4)	Turkey	2007	BMC Public Health	A cross-sectional study	Nurses and physicians	215	– Lack of knowledge of legal procedures Female HCPs have more knowledge about violence (ie. knowledge of definition of IPV, clinical presentation/findings/characteristics of IPV victims)	– N/A	– Lack of IPV training – HCPs unable to identify, help or deal with IPV
4	Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK.	Gender difference of knowledge and attitude of primary health care staff towards domestic violence (5)	Kuwait	2011	Alexandria Journal of Medicine	observational cross-sectional study	health care workers	1553	– Female HCPs have more knowledge about violence (ie. knowledge of definition of IPV, clinical presentation/findings/characteristics of IPV victims)	– N/A	– N/A
5	Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK	Comparison of the attitude of primary health care physicians and nurses towards domestic violence against women (6)	Kuwait	2010	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	1553	– Lack of knowledge on IPV	– HCPs believed that IPV is a taboo matter	– Lack of IPV training – Personal safety (if violence was redirected to HCPs) – Lack of time – HCPs unable to identify, help or deal with IPV
6	Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M.	How to screen for domestic violence against women in primary health care centers (7)	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians, and nurses	210 physicians and 464 nurses (total of 674)	– N/A	– N/A	– Absence of privacy in the clinical setting/OPD – IPV victims don't disclose to HCPs of the opposite sex
7	Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK	Domestic violence screening among primary health care workers in Kuwait (8)	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	210 physicians and 464 nurses (total of 674)	– Male HCPs more likely to screen for or diagnose IPV – Physicians are more likely to screen IPV than nurses – Lack of knowledge on IPV Female HCPs have more knowledge about violence	– HCPs believe that IPV is a taboo matter	– Absence of a system that supports directing and helping HCPs to deal with IPV victims
8	Al-Natour A, Gillespie GL, Felblinger D, Wang LL.	Jordanian nurses barriers to screening for intimate partner violence (9)	Jordan	2014	Violence against women	Cross-sectional Study	Jordanian nurses.	125	– N/A	– HCPs do not believe that IPV is a medical issue – HCPs fear that screening offends patients – HCPs fear that screening endangers victims – HCPs fear that screening angers patients – HCPs fear that screening is an invasion of privacy – HCPs don't think it's their business if patients don't disclose IPV	– Personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – HCPs don't feel competent

9	Al-Natour A, Qandil A, Gillespie GL.	Intimate Partner Violence screening barriers as perceived by Jordanian nurses: qualitative descriptive study (10)	Jordan	2015	Journal of Nursing and Practice	qualitative descriptive study	nurses	12	– Lack of knowledge of protocol – HCPs fear that screening offends patients	– N/A	– Lack of IPV training – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – Unclear roles/authority – Absence of privacy in the clinical setting/OPD – Insufficient awareness amongst HCPs – IPV victims don't disclose to HCPs of the opposite sex
10	Al-Natour A, Qandil A, Gillespie GL.	Nurses' roles in screening for intimate partner violence: a phenomenological Study (11)	Jordan	2016	International Nursing Review	A phenomenological study	male and female Jordanian nurses	12	– Lack of knowledge of protocol Lack of knowledge on IPV	– HCPs believed that IPV is a taboo matter – Don't screen for IPV even if they suspect violence – Only manage physical symptoms, not mental symptoms – Become frustrated when patients don't disclose assault or deny exposure	– Lack of IPV training – Unclear roles/authority
11	Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M.	Barriers for domestic violence screening in primary health care centers (12)	Kuwait	2013	Alexandria Journal of Medicine	observational cross-sectional study	physicians and nurses	210 physicians and 464 nurses (total of 674)	N/A	– N/A	Lack of IPV training – Lack of experience
12	Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK	Barriers for administering primary health care services to battered women: perception of physician and nurses (13)	Kuwait	2011	Alexandria Journal of Medicine	Observational cross-sectional study	physicians and nurses.	1553	N/A	– HCPs believed that IPV is a taboo matter	– Lack of IPV training – Personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Insufficient staffing, structures, resources – Absence of privacy in the clinical setting/OPD – Heavy workload – Shame/embarrassment in asking questions – Lack of legal arrangements
13	Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA.	Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City (14)	Saudi Arabia	2017	The Egyptian journal of Hospital Medicine	Cross-sectional study	PHCPs	62	– Male HCPs more likely to screen for or diagnose IPV – Married HCPs had higher performances – Lack of knowledge on IPV Lack of knowledge of legal procedures	– N/A	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Insufficient staffing, structures, resources – Heavy workload – Shame/embarrassment in asking questions
14	Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI.	Knowledge of primary care nurses regarding domestic violence (15)	Kuwait	2011	Alexandria Journal of Medicine	Exploratory, attitudinal surveys	nurses	988	– N/A	– N/A	– Lack of IPV training
15	Alsalman Z, Shafey M, Al Ali L.	Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to Identify, Screening, and Respond? (16)	Saudi Arabia	2023	International Journal of Women's Health	Cross-sectional study	PHCPs	169	– Lack of knowledge on screening, management, and referral guidelines – Lack of knowledge on IPV	– HCPs fear that screening offends patients,	– Lack of IPV training – Absence of a system that supports directing and helping HCPs to deal with IPV victims – Insufficient resources
16	Aziz MM, El-Gazzar AF.	Health Care Providers'	Upper Egypt (Assiut)	2019	Sexual & Reproductive Healthcare	Mixed Quantitative and Qualitative; Survey and FDGs	doctors and nurses, physicians and nurses in the FDG	122 doctors and 200 nurses returned surveys.	– Lack of knowledge of protocol – Lack of knowledge of legal procedures	– Believe that IPV is a taboo matter	– Lack of IPV training

		Perceptions and Practices of Screening for Domestic Violence in Upper Egypt (17)						12 Physicians and 10 nurses in the FGDs.	– Lack of knowledge around necessary skills required	– HCPs perceive IPV to be an ordinary matter within society – HCPs fear that screening offends patients, endangers victims, is distressing to them and causes interference – When screening for IPV, HCPs only manage physical symptoms, not mental 8symptoms, become frustrated when patients don't disclose assault or deny exposure and only refer suicidal cases to a psychiatrist	– HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Absence of privacy in the clinical setting/OPD – HCPs unable to council cases
17	Ben Natan M, Ben Ari G, Bader T, Hallak M.	Universal screening for domestic violence in a department of obstetrics and gynaecology: A patient and carer perspective (18)	Israel	2011	International Nursing Review	Correlative, cross-sectional design was utilized	physicians, nurses, female patients	100 physicians and nurses, 100 female patients	– Lack of knowledge of protocol – Knowledge about IPV training protocols on how to deal with cases allowed HCPs to screen victims	– N/A	– Lack of IPV training
18	Boy A, Kulczycki A.	What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women (19)	MENA region	2008	Violence against women	Review article	Not applicable	none	– N/A	– When screening for IPV, HCPs will not intervene beyond medical or physical help i.e., legal	– HCPs unable to identify, help or deal with IPV
19	Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L.	Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory (20)	occupied Palestinian Territory (oPT)	2019	The Oxford Journal on Health Planning and Systems research; Health Policy and planning.	Case Study design using qualitative methods (interviews and a stakeholder meeting)	PHC providers and Stakeholders	23 PHC providers and 19 Stakeholders	– Lack of knowledge of protocol – Lack of knowledge on IPV	– HCPs believe that IPV is a taboo matter – HCPs believe there is limited capacity as IPV is a mental health issue – HCPs become frustrated when patients don't disclose assault or deny exposure – HCPs feel frustrated with the low referral uptakes by patients	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV – Unclear roles/authority – Insufficient staffing, structures, resources No law to protect HCPs
20	Goldblatt H.	Caring for abused women: impact on nurses' professional and personal life experiences (21)	Israel	2009	Journal of Advanced Nursing	A phenomenological study	female Israeli nurses	22	– N/A	– HCPs fear that screening leads to emotional involvement	– Lack of time – Difficult to set boundaries
21	Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al	Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context (22)	Ethiopia	2012	ISRN Nursing	Nursing-led Interdisciplinary project and literature review	NA	NA	– N/A	– HCPs believe that IPV is a taboo matter	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Unclear roles/authority
22	Ibrahim E, Hamed N, Ahmed L.	Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt (23)	Egypt	2021	Eastern Mediterranean health journal	A cross-sectional study	Healthcare Providers	385	– N/A	– HCPs did not want to interfere as they believe IPV is not part of medical practice	– Lack of time – Lack of IPV training – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs fear that patients would get angry if screened

23	Natan MB, Rais I.	Knowledge and attitudes of nurses regard-ing domestic violence and their effect on the identification of battered women (24)	Israel	2010	Journal of Trauma nursing	descriptive, quantitative study	hospital- and community-based nurses.	100	– Lack of knowledge of protocol	– Believe that IPV is a taboo matter	– Lack of IPV training
24	Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK.	Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women (25)	Kuwait	2013	Alexandria Journal of Medicine	Cross-sectional Study	Doctors and nurses	210 physicians and 464 nurses (total of 674)	– Male HCPs more likely to screen for or diagnose IPV – Physicians are more likely to screen IPV than nurses More knowledgeable HCPs more likely to screen for IPV	– HCPs fear that screening is not in patients' best interest – Screening reduces rates and effects of violence and improves the quality of life	– N/A
25	Rasoulian M, Shirazi M, Nojomi M.	Primary Health Care Physicians' Approach Toward Domestic Violence in Tehran, Iran (26)	Tehran, Iran	2014	Medical Journal of the Islamic Republic of Iran	Not mentioned	PHCPs	198	– Female HCPs were more likely to document IPV – HCPs believed that patients will disclose IPV if it is severe enough – HCPs believe that IPV is a medical health problem. – HCPs think that women should tolerate IPV to keep family's privacy and honour	– HCPs believe that screening endangers victims and is distressing to them	– N/A
26	Usta J, Feder G, Antoun J.	Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners (27)	Lebanon	2014	British Journal of General Practice	Qualitative study	Physicians	70	– Lack of knowledge of protocol	– HCPs believe that IPV is a taboo matter – HCPs do not believe that IPV is a medical issue – HCPs only manage physical symptoms, not mental symptoms	– HCPs fear personal safety (if violence was redirected to HCPs) – Lack of time – No law to protect HCPs
27	van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M	The Role of the Healthcare Sector in the Prevention of Sexual Violence Against sub-Saharan Transmigrants in Morocco: A Study of Knowledge, Attitudes and Practices of Healthcare Workers (28)	Morocco	2013	BMC Health Services research	A KAP (Knowledge, Attitudes, Practices) questionnaire, identifying knowledge, attitudes and practices, guided the semi-structured interviews.	Male and Female HCW, Organizations	24 (12 men and 12 women)	Lack of knowledge of legal procedures	– HCPs fear that screening offends patient, is not in patients' best interest and opens up old wounds When screening for IPV, HCPs respect the choice of IPV victims to remain silent	– Absence of a system that supports directing and helping HCPs to deal with IPV victims – Insufficient staffing, structures, resources – HCPs don't feel competent Insufficient awareness amongst HCPs
28	Yousefnia N, Nekuei N, Farajzadegan Z.	The Relationship Between Healthcare Providers' Performance Regarding Women Experiencing Domestic Violence and Their Demographic Characteristics and Attitude Towards Their Management (29)	Iran	2018	Injury & Violence	Cross-sectional study	physicians, 46 midwives, and 212 nurses.	300	– Married HCPs had higher performances – Female HCPs have higher performances – Nurses had higher performances than physicians –	– N/A	N/A
29	Zaher E, Mason R.	Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study (30)	Saudi Arabia	2014	Middle East Journal of Family Medicine	Exploratory, attitudinal surveys	Doctors	30	N/A	N/A	– Lack of IPV training – HCPs fear personal safety (if violence was redirected to HCPs) – Absence of a system that supports directing and helping HCPs to deal with IPV victims – HCPs unable to identify, help or deal with IPV

Legend:

*Location is not applicable in one of the included studies as it was a review article and was not based in a specific country.

**Participants are not applicable in review studies that do not have any direct participants

References:

1. AbuTaleb NI, Dashti TA, Alasfour SM, Elshazly M, Kamel MI. Knowledge and perception of domestic violence among primary care physicians and nurses: A comparative study. Alexandria Journal of Medicine. 2012;48(1).

2. Ahmed AM, Abdella ME, Yousif E, Elmardi AE. Response of Sudanese doctors to domestic violence. Saudi Medical J. 2003;24(10):1077-80.
3. Aksan HAD, Aksu F. The training needs of Turkish emergency department personnel regarding intimate partner violence. BMC Public Health. 2007;7(1):350.
4. Alazmy SF, Alotaibi DM, Atwan AA, Kamel MI, El-Shazly MK. Gender difference of knowledge and attitude of primary health care staff towards domestic violence. Alexandria Journal of Medicine. 2011;47(4).
5. Alkhabaz AA, Hammadi TA, Alnoumas SR, Ghayath TA, Kamel MI, El-Shazly MK. Comparison of Attitude of Primary Health Care Physicians and Nurses Towards Domestic Violence Against Women. Bull Alex Fac Med, 2010;46(4):371-6.
6. Almutairi GD, Alrashidi MR, Almerri AT, Kamel MI, El-Shazly M. How to screen for domestic violence against women in primary health care centers. Alexandria Journal of Medicine. 2013;49(1):89-94.
7. Almutairi M, Alkandari AM, Alhouli H, Kamel MI, El-Shazly MK. Domestic violence screening among primary health care workers in Kuwait. Alexandria Journal of Medicine. 2013;49(2):169-74.
8. Al-Natour A, Gillespie GL, Felblinger D, Wang LL. Jordanian nurses' barriers to screening for intimate partner violence. Violence Against women. 2014;20(12):1473-88.
9. Al-Natour A, Qandil A, Gillespie GL. Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. Journal of Nursing Education and Practice. 2015;5(9):11-6.
10. Al-Natour A, Qandil A, Gillespie GL. Nurses' roles in screening for intimate partner violence: a phenomenological study. Int Nurs Rev. 2016;63(3):422-8.
11. Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly M. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.
12. Alsabhan EH, Al-Mutairi MM, Al-Kandari WA, Kamel MI, El-Shazly MK. Barriers for administering primary health care services to battered women: Perception of physician and nurses. Alexandria Journal of Medicine. 2011;47(4).
13. Alsaedi JA, Elbarrany WG, AL Majnon WA, Al-Namankany AA. Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City. The Egyptian Journal of Hospital Medicine. 2017;69(8):3058-65.
14. Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI. Knowledge of primary care nurses regarding domestic violence. Alexandria Journal of Medicine. 2011;47(2):173-80.
15. Alsalman Z, Shafey M, Al Ali L. Intimate Partner Violence; Are Saudi Physicians in Primary Health Care Setting Ready to Identify, Screening, and Respond? Int J Womens Health 2023;15:623-33. doi: 10.2147/ijwh.S401726 [published Online First: 20230418].
16. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sex Reprod Healthc. 2019;20:93-9.
17. Ben Natan M, Ben Ari G, Bader T, Hallak M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. International Nursing Review. 2012;59(1):108-14.
18. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008;14(1):53-70.
19. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health Policy Plan. 2020;35(3):245-56.
20. Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. J Adv Nurs. 2009;65(8):1645-54.
21. Guruge S, Bender A, Aga F, Hyman I, Tamiru M, Hailemariam D, et al. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context. ISRN nursing. 2012;2012.
22. Ibrahim E, Hamed N, Ahmed L. Views of primary health care providers of the challenges to screening for intimate partner violence, Egypt. Eastern Mediterranean health journal. 2021 Mar 1;27(3).
23. Natan MB, Rais I. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. J Trauma Nurs. 2010;17(2):112-7.
24. Qasem HD, Hamadah FA, Qasem KD, Kamel MI, El-Shazly MK. Knowledge and attitude of primary health care staff screening and not screening for domestic violence against women. Alexandria Journal of Medicine. 2011;47(1):81-7.
25. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians' approach toward domestic violence in Tehran, Iran. Medical Journal of the Islamic Republic of Iran. 2014;28:148.
26. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: a qualitative study of primary care practitioners. The British journal of general practice : the journal of the Royal College of General Practitioners. 2014;64(623):e313-e20.
27. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC Health Services Research. 2013;13(1):77.
28. Yousefnia N, Nekuei N, Farajzadegan Z. The relationship between healthcare providers' performance regarding women experiencing domestic violence and their demographic characteristics and attitude towards their management. Inj Violence Res. 2018;10(2):113-8.
29. Zaher E, Mason R. Saudi Family-Medicine Residents' Readiness to Manage Intimate Partner Violence: A Needs Assessment Study. World Family Medicine Journal: Incorporating the Middle East Journal of Family Medicine. 2021;19(1145):1-6.

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	2,3
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	3,4,5
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	N/A
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	6
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	6
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Supplemental Material 1: Search Strategy
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	6
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	N/A
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	N/A

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	N/A
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	7
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	7 Figure 1 PRISMA Flow Chart
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	7,8,9 Supplemental Material 3: Table of KAB of included articles
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	N/A
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	8,9,10
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	8,9,10
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	10,11
Limitations	20	Discuss the limitations of the scoping review process.	12
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	12,13
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	15

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.