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Scoping review of healthcare professionals' views on intimate partner violence in the Middle East and North Africa

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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 programmes.

Design Scoping review.

Data sources The scoping review included studies up to December 2023 from PUBMED, Medline, COCHRANE, Cumulative Index of Nursing and Allied Health Literature, 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 were extracted from 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 were analysed using frequency, counts and descriptive content analysis.

Results Of the 1060 articles reviewed, 29 eligible 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, informed 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 made electronically via the web-based programme Rayyan and by two reviewers to reduce bias in relation to the 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 Middle East and North Africa region served as a limitation to the validity of this study.
⇒ A formal bias assessment was not conducted in this study.

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 programmes to provide care and support in a non-judgmental, private and confidential environment.[3 7–9]

The 24 countries of the MENA region include Saudi Arabia, Kuwait, Bahrain, the

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 barriers continue 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 resolved by the religious courts instead of the civil and legal authorities.[3 13 14]

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

Furthermore, findings from recent literature in the MENA region reporting on IPV in the Arab region emphasise the influence of culture, modesty, family solidarity and reputation.[14 15] One study explored attitudes towards 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 healthcare providers (HCPs) for help with IPV due to the cultural stigma of causing a 'scandal'.[17] When a woman does 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%–85% of female respondents.[20 21]

The Arab community has an increased tendency for HCPs to be unwilling to integrate IPV into their practice.[14 22] Cultural stereotypes increase HCPs' reluctance to intervene due to fear for their safety, losing their patients and opposing the norms of their conservative society.[3] With the influence of culture and religion on Arab HCPs, knowledge and attitudes are critical components when developing education and training programmes in 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 programmes.

MATERIALS & METHODS

We have carried out a scoping review; unlike a systematic review, this approach allows researchers to address and summarise 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 and highlight 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, summarising 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 HCPs, including doctors, nurses, policymakers, institutions, organisations, caregivers and health-based students, such as nursing and medical students.

Literature search strategy

FAOAZ and SA developed a search strategy (online supplemental material 1). All publications that target HCPs' views on IPV in the MENA region were included. Key search terms were HCPs, MENA region, IPV, knowledge, attitudes and barriers. The following databases were searched: PUBMED, Medline, PsycINFO, Cumulative Index of Nursing and Allied Health Literature and Cochrane Database of Systematic Reviews. 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 online supplemental file 1 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 and (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 other 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 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

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, 129 full-text studies were

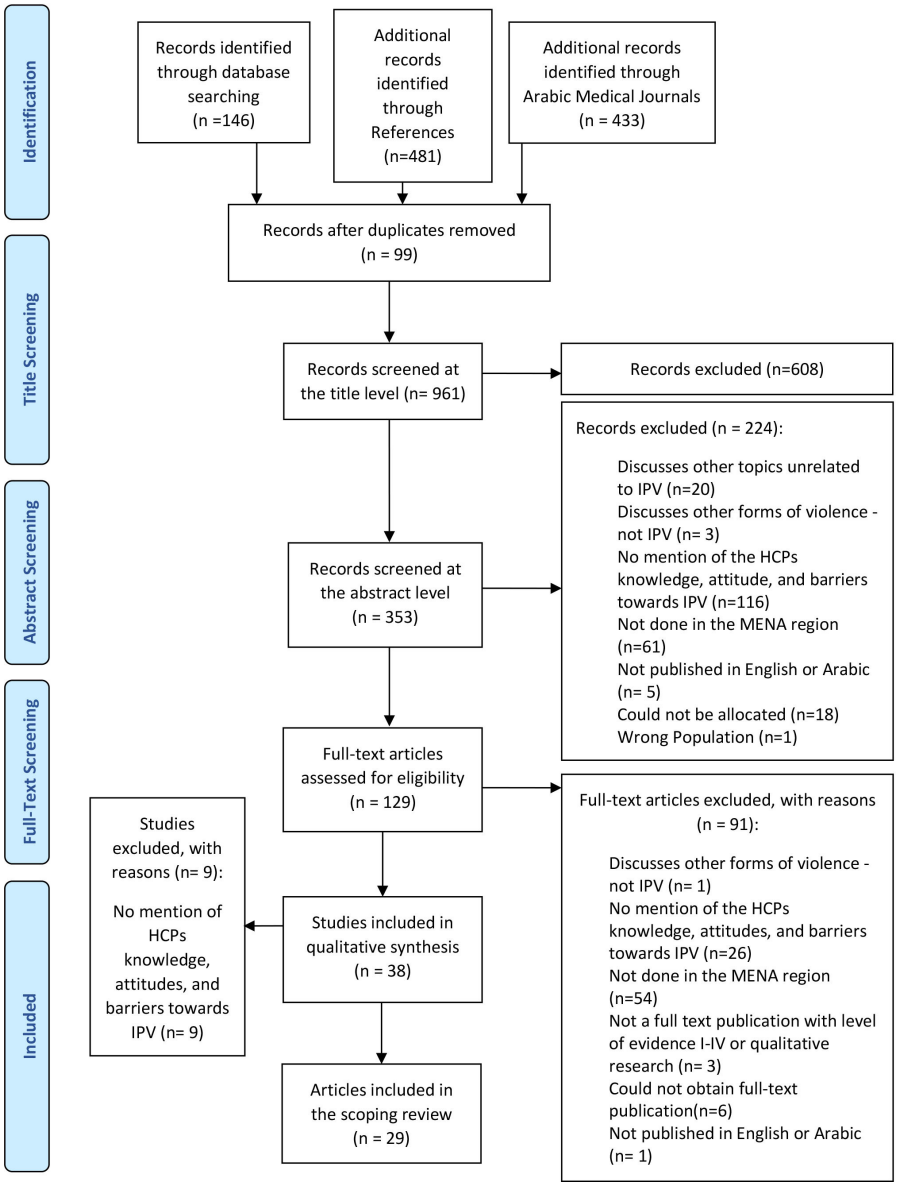

Figure 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow chart. HCPs, healthcare providers; MENA, Middle East and North Africa.

reviewed. However, only 29 studies were included in the scoping review (online supplemental material 2). The remaining articles were excluded as they did not mention the knowledge, attitudes or barriers of HCPs towards IPV. All article screening and selection were completed using the web-based programme Rayyan.[24]

Study characteristics

There were 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 in Iran.[38 40 48 50 51] The occupied Palestinian territories, Egypt, Ethiopia, Lebanon, Turkey, Morocco and Sudan were each studied.[5 26 28 41 43 45 46 49] One study involved the entire MENA region (n=1, 3.4%).[15]

Study designs

There were 12 different types of study designs in the 2×9 articles reviewed. Of these, the majority were cross-sectional studies (n=14, 48.3%), two were review articles (6.9%), three were qualitative studies (10.3%), two were phenomenological studies (6.9%), and mixed and quantitative designs were each present in one study (3.4%).[15 20 27–38 40–44 46 47 49 50] The table in online supplemental file 3 fully outlines the 12 study designs and the type and number of participants. Participants in these studies ranged from 12[34 35] to 1553[25 37 39] participants. Three review studies are literature based and do not directly involve any participants.[15 27 45]

Some studies involved doctors and nurses (n=11 370.9%).[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] HCPs were included in three studies; this is a separate row on the table as the title 'HCP' does not specify the professional (ie, nurse or doctor) (online supplemental file 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 organisations in the community to recruit as participants.[5]

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

Outcomes

We have included 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, 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 to 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 three 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, that is, 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, allowing 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 was 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%), would lead to an emotional environment (n=1, 3.4%) and 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 would not screen for IPV even if they suspected violence (n=1, 3.4%).[35] HCPs felt frustrated with the low referral uptake by patients (n=1, 3.4%).[38] Some HCPs felt shame

or embarrassment when 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 was 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 redirecting 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 10 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 were also unsure about their roles or authority in IPV cases (n=3, 10.3%) and claimed insufficient awareness among HCPs (n=2, 6.9%).[5 34 35 37] Another barrier identified was the heavy workload (n=2, 6.9%).[37 38]

DISCUSSION

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 consultation.

The most commonly reported statement and barrier was the HCPs' perception of IPV as a taboo subject, that is, 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 with 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 recognised but require a bespoke, culturally relevant education programme 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 recognise and identify the need for HCP education programmes 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 programmes that have the most significant positive impact on identifying and managing IPV.[53] They found that the programmes that IPV educators/experts or physicians delivered included specific treatment protocols and patient resources, and programmes 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 programmes in the MENA region. Therefore, suggesting an ideal training programme for HCPs in the MENA region is only possible with further research that explores the barriers and efficiency of training programmes both in the MENA region and worldwide.

Strengths 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. First, 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 programme 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 effective education and training programme in the MENA region. This training programme should tackle not only the knowledge of HCPs but also their attitudes and beliefs. In addition to investigating the effectiveness of these education programmes in the region, it would be beneficial if further literature addressed the positive attitudes and enablers of managing and screening for IPV within HCPs in the MENA region.

Contributors FSNN and FWA researched and worked on the background. FAOAZ and SA-S 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 on the study sample to describe the sample study characteristics, design and HCPs' views regarding IPV. SA-S and SD were significant contributors to writing the manuscript. SD is the guarantor of this paper. All authors read and approved the final manuscript.

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