Women and Birth 38 (2025) 101939

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.sciencedirect.com/journal/women-and-birth

Evaluating knowledge, attitudes and preparedness of health care providers to respond to intimate partner violence in the Western Pacific Region: A scoping review

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ARTICLE INFO

Keywords:
Intimate partner violence
Health care providers
Knowledge
Attitudes
Preparedness
Pregnancy
Western Pacific Region

ABSTRACT

Background: Intimate partner violence (IPV) during pregnancy is a prevalent human rights issue as well as a serious public health issue. Adverse health outcomes of IPV are no longer in doubt; however, there continues to be a lack of acknowledgement of the importance of health sectors response to recognise and support survivors of violence, especially in low- and middle-income countries [7]; Khalil et al., 2016).

Objectives: The aim of the scoping review was to identify, synthesise, appraise, and report on relevant literature in the Western Pacific Region and to identify any gaps in knowledge, attitudes, and preparedness of health care providers towards IPV identification during pregnancy in relation to maternal health service provision.

Method: A scoping review was conducted following the Joanna Briggs Institute guideline**.** A comprehensive search of research databases was conducted across six different databases. The review included peer-reviewed articles published in English from January 2000 to May 2023, with a primary focus on identifying literature conducted within the Western Pacific Region (WPR). Reference lists of included studies were also searched for any relevant literature. Titles and abstracts of the papers retrieved were reviewed by two reviewers. A third reviewer was used to resolve discrepancies using systematic review software. Key characteristics of the included studies were mapped and analysed using content analysis to synthesize and report findings.

Findings: Twelve articles were included in the review. Eight articles were conducted in Australia a high-income country. The remaining four articles were from low- and-middle-income countries (LMIC), China, Philippines, Vietnam, and Malaysia. The findings were grouped into three main themes: (1) 'Lack of healthcare providers knowledge and understanding of IPV as a health issue', (2) 'Lack of health care provider confidence to respond to IPV', and (3) 'Preparedness of healthcare providers to address IPV within the healthcare sector'.

Conclusion and recommendations: Adequate knowledge and awareness of IPV as a prevalent public health issue with detrimental effects on the health of women and children enhance the ability of care providers to respond effectively to IPV within the health sector.

A lack of healthcare provider competence in identifying and responding to IPV results in missed opportunities to address the health and social impacts of IPV. Further research is needed to identify screening practices for IPV in LMICs of the WPR, where the health and social burden is significant.

Statement of Significance

Problem

Failure to identify barriers affecting health care providers' ability to respond to IPV inhibits screening and detection within the health sector.

What is already known

LMICs in the WPR have some of the world's highest IPV rates. However, HCPs are often ill-equipped to detect violence during pregnancy due to insufficient education and training.

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https://doi.org/10.1016/j.wombi.2025.101939
Received 5 November 2024; Received in revised form 5 June 2025; Accepted 7 June 2025
Available online 20 June 2025
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What this paper adds

This review highlights the need for further research in LMICs to develop effective IPV detection and response strategies with emphasis on the importance of a fully prepared health sector to provide support for survivors during pregnancy.

1. Introduction

Intimate partner violence (IPV) is a pervasive public health issue and a violation of women's human rights. Globally, it is estimated one in three women experience IPV during their lifetime [57]. It contributes to the global maternal and neonatal morbidity and mortality rates [30,31,4]. Current research confirms the prevalence of IPV during pregnancy is higher in low- and middle-income countries (LMICs) compared to high income countries (HICs) [55,68,72]. Pregnant women in LMICs are especially at higher risk of experiencing IPV compared to those in HICs [17,72,75]. While pregnancy may act as a protective barrier to violence for some women [11,51], others may endure increased severity, leading to a greater risk of adverse maternal and neonatal outcomes [10,11,4,43]. IPV has been associated with poorer health outcomes, including an increase mental health disorders, preterm birth, and still birth [33,34,65,70]. Studies indicate that between 3 % and 9 % of pregnant women experience violence during pregnancy, linked to factors such as poverty, lack of education, ethnicity, young age, economic stress, and unemployment [25,4,49]. The partner's contextual characteristics including demographic, neighbourhood and community factors, and substance use including drug and alcohol also contribute to relationship violence [15,45,48].

IPV prevalence rates during pregnancy range from 2 % to 35 % globally [74]. The variation in IPV prevalence rates is more pronounced between high-income and low-and-middle-income regions, particularly for past-year prevalence compared to lifetime prevalence. High income regions such as Europe reported the lowest prevalence of IPV compared to low- and middle-income regions of Africa and the WPR [22,58,76]. These disparities, especially during pregnancy, highlight a significant global public health issue affecting, particularly in LMICs ([22,58,75]; Ma et al., 2023).

The World Health Organization recommends all healthcare providers (HCPs) assess patients for exposure to IPV when evaluating conditions that may have be caused or complicated by IPV, in an attempt to improve identification and ensure appropriate management and care [58]. Despite the high prevalence of IPV in LMICs and specific regions such as the WPR, screening rates among HCPs remains low [20,29,60,66,73]. It is critical that HCPs are equipped to identify IPV during pregnancy and implement suitable and appropriate interventions and preventive measures [1]. A widespread barrier to IPV is the lack of knowledge among HCPs, further compounded by insufficient systematic support, protocols, and guidelines [12,2,64]. Effective IPV screening during pregnancy can enable timely interventions and preventive strategies that can reduce violence and improve both maternal and neonatal outcomes [4].

Pregnancy presents a valuable opportunity for HCPs to screen for current or past exposure of IPV, as most pregnant women have regular contact with HCPs during antenatal, intrapartum, and postnatal care. For some women, antenatal care may be their only interaction with health services. Research indicates when HCPs particularly midwives ask about IPV, women are often willing to disclose their experiences [23,74]. The growing awareness of the presence of IPV during pregnancy emphasises the need for HCPs to identify and refer victims to specialised

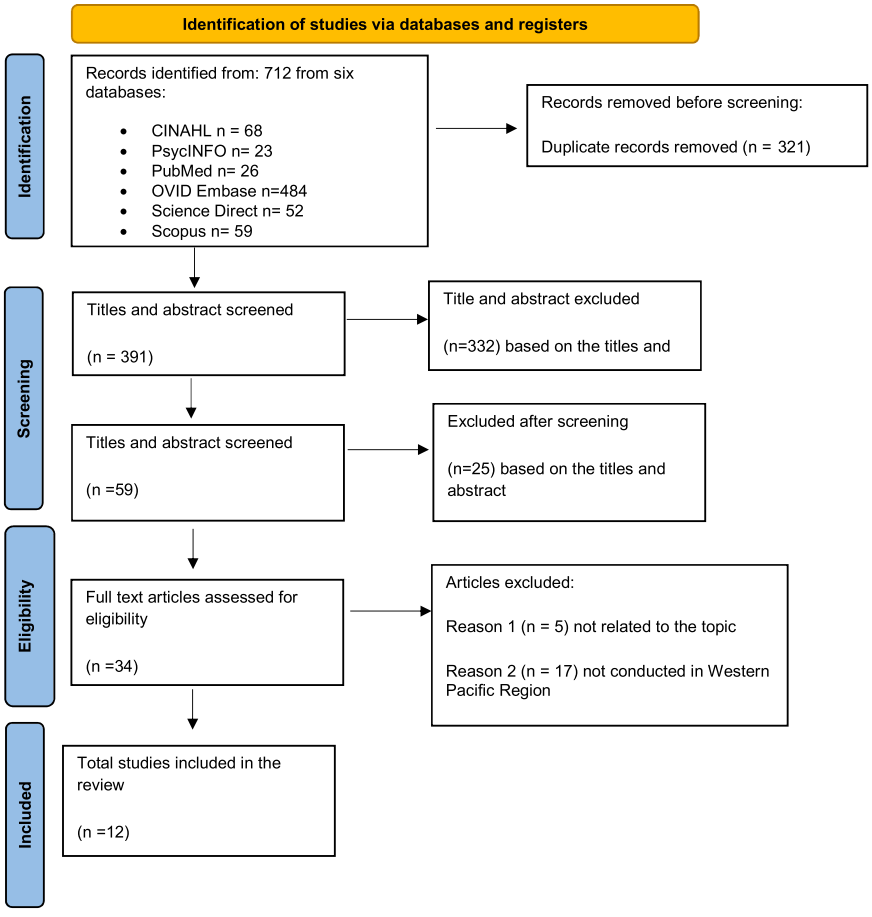

Fig. 1. PRISMA Flowchart of screening and selection process.

Table 1
Search Strategy.

Database	Search	Total
CINAHL	"Healthcare Providers" OR" healthcare workers" OR "Healthcare Professionals" OR "Nurses" OR "Midwives" OR "Doctors"; "Knowledge"; "Attitude/s" OR "Perception" OR "Belief/s"; "Preparedness" OR "Readiness"; "Intimate Partner Violence" OR "Violence Against Women" OR "Domestic Violence"	68
PsycINFO	"Healthcare Providers" OR" healthcare workers" OR "Healthcare Professionals" OR "Nurses" OR "Midwives" OR "Doctors"; "Knowledge"; "Attitude/s" OR "Perception" OR "Belief/s"; "Preparedness" OR "Readiness"; "Intimate Partner Violence" OR "Violence Against Women" OR "Domestic Violence"	23
PubMED	"Healthcare Providers" OR" healthcare workers" OR "Healthcare Professionals" OR "Nurses" OR "Midwives" OR "Doctors"; "Knowledge"; "Attitude/s" OR "Perception" OR "Belief/s"; "Preparedness" OR "Readiness"; "Intimate Partner Violence" OR "Violence Against Women" OR "Domestic Violence"	26
OVID EMBASE	"Healthcare Providers" OR" healthcare workers" OR "Healthcare Professionals" OR "Nurses" OR "Midwives" OR "Doctors"; "Knowledge"; "Attitude/s" OR "Perception" OR "Belief/s"; "Preparedness" OR "Readiness"; "Intimate Partner Violence" OR "Violence Against Women" OR "Domestic Violence"	484
Science Direct	"Healthcare Providers" OR" healthcare workers" OR "Healthcare Professionals" OR "Nurses" OR "Midwives" OR "Doctors"; "Knowledge"; "Attitude/s" OR "Perception" OR "Belief/s"; "Preparedness" OR "Readiness"; "Intimate Partner Violence" OR "Violence Against Women" OR "Domestic Violence"	52
Scopus	"Healthcare Providers" OR" healthcare workers" OR "Healthcare Professionals" OR "Nurses" OR "Midwives" OR "Doctors"; "Knowledge"; "Attitude/s" OR "Perception" OR "Belief/s"; "Preparedness" OR "Readiness"; "Intimate Partner Violence" OR "Violence Against Women" OR "Domestic Violence"	59
Total		712
Duplicates Removed (Endnote then Covidence)		321
Total screened through Covidence		**391**

government and non-government support services [56].

HCPs, particularly midwives, are key to identifying and addressing IPV due to their frequent interactions with women during pregnancy [12,28,3]. Women who experience IPV are more likely to have contact with HCPs, regardless of whether they disclose their experiences, due to the physical injuries and health consequences associated with partner violence [21,74,77,9]. Healthcare settings often offer a degree of privacy that can make women feel safer disclosing experiences of violence, particularly when they are able to attend appointments alone [44].

The World Health Organization groups its Member States into six regions (Africa, America, South-east Asia, Europe, Eastern Mediterranean, and the WPR) [79]. The WPR is home to one of the most populous country in the world (China) and also includes some of the smallest countries in the world [79]. The WPR is one of the most diverse regions in the world with geographic, demographic, sociocultural, and economic differences between and within the 37 countries and areas of the region. IPV prevalence in LMICs within the WPR is the highest globally (39–51 %) far exceeding the global prevalence average rate of 27 % [14,78]. Despite this very little is known about HCPs knowledge, attitudes, and preparedness to address IPV during and after pregnancy.

The aim of this scoping review is to explore and synthesise existing literature on gaps in HCPs knowledge, attitudes, and preparedness to IPV during pregnancy in the WPR. The review addresses the question: "What are the barriers to the knowledge, attitudes and preparedness of HCPs to respond to IPV within healthcare settings in the WPR?" For the purposes of this review, HCPs include gynaecologists, obstetricians, physicians, doctors, medical registrars' medical students, midwives, nurses, community health nurses, and student nurses and midwives.

2. Method

2.1. Approach

The scoping review was conducted following the Khalil framework within Joanna Briggs Institute (JBI) methodology for scoping reviews and presented using the Preferred Reporting Items for Systematic Reviews [53] and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) standards [67]. A review protocol was established as a road map to guide the review process but not published.

The Khalil framework is a more specific application of the broader JBI methodology emphasising the use of the Population Concept and Context framework to structure and guide the five stages of a scoping review [46] within the JBI framework. These include: (a) identifying the research question by clarifying and linking the purpose and research question, (b) identifying the relevant studies (c) selection of the studies using a team approach, (d) charting the data in a tabular and/or narrative format, and (e) collating the results to identify the implications of the study findings for policy, practice, or research [46].

2.2. Search strategy

To address the review question "What are the barriers to the knowledge, attitudes and preparedness of HCPs to respond to IPV within the health settings in the WPR?" a comprehensive, librarian-assisted literature review was conducted across six different electronic databases CINAHL, PsycINFO, PubMed, EMBASE, Science Direct, and Scopus. Key search terms were used to identify relevant literature regarding HCPs knowledge, attitudes, and preparedness to respond to IPV during pregnancy. Keyword searches with alternative terms, keywords of similar origin or with the same meaning are the most commonly method used to guide the process of the literature search and identify relevant literature and research [52].

Key search terms included "Healthcare Providers" OR "healthcare workers" OR "Healthcare Professionals" OR "Nurses" OR "Midwives" OR "Doctors"; "Knowledge"; "Attitude/s" OR "Perception" OR "Belief/s"; "Preparedness" OR "Readiness"; "Intimate Partner Violence" OR "Violence Against Women" OR "Domestic Violence". These keywords were then combined using the databases command called the Boolean operator 'OR' and 'AND' to look for articles that include all the identified keywords and 'OR' was used to look for articles that includes any of the identified keywords across the six databases.

2.3. Eligibility criteria

Articles were eligible for inclusion if they met the following criteria: published in English between January 1, 2000, and May 23, 2023; original peer-reviewed research papers; focused on HCP knowledge, attitudes, and preparedness to respond to IPV within maternal health services in any of the 37 countries in the WPR. Studies using any methodology (qualitative/quantitative/mixed methods) were eligible for inclusion.

2.4. Search outcome

2.4.1. Study selection

All results identified through database searching were imported into the Endnote reference programme [16] and duplicates were removed. The remaining results were then imported into Covidence systematic review software (Version 20) to facilitate the review process, following the Preferred Reporting for Systematic Reviews and Meta-Analysis (PRISMA) guidelines.

2.4.2. Data charting

Data extraction focused on information relevant to the review aim and research question. A data charting form developed by the lead

Table 2
Data Extraction Table.

Citation/ Country	Title	Major Focus/ Concept	Study Design	Population	Aim	Results
[6] Australia and United Kingdom	Preparedness of Australian and British Nurses and midwives about domestic violence and abuse	Evaluate Knowledge, Opinions and Preparedness of Nurses and midwives	Cross Sectional Study Design Data was collected using the Physician Readiness to Manage Intimate Partner Violence (PREMIS) survey.	Nurses and Midwives n = 368 (n = 130 Australia n = 238 UK)	To measure current levels of knowledge, opinions and preparedness of registered nurses and midwives in Australia and UK	**Knowledge** Minimal Knowledge and skills to support women experiencing DVA. **Attitude** They have a positive attitude towards women experiencing DVA. **Preparedness** Most participants were unprepared to ask relevant questions about DVA and had inadequate knowledge about available resources.
[61] Australia	Asking the hard questions: Improving midwifery students' confidence with Domestic Violence screening in pregnancy	Student Midwives confidence and knowledge, attitudes, and preparedness to respond to respond to IPV before and after training	Mixed Method Study- Survey data were collected for the quantitative data and the survey data with open ended question was used for the qualitative data.	Midwifery students n = 174	To increase midwifery students' confidence in screening for, and responding to, disclosure of domestic violence in maternity services	**Knowledge** Both Midwives and students often feel unprepared to work with women in this important area of midwifery practice. **Attitudes and Preparedness** Due to its emotional component, midwives and student midwives struggle to develop competence and confidence to respond to IPV
[12] Australia	An exploration of Australian Midwives knowledge of intimate partner violence against women during pregnancy	Midwives' knowledge of intimate partner violence	Quantitative Study -online survey link was distributed using the Australia College of Midwives.	Midwives n = 152	To investigate midwives' knowledge of intimate partner violence against women during pregnancy.	**Knowledge** Most midwives do not know about the risks and signs of IPV. Some midwives do not know about the risks associated with Intimate partner violence indicating lack of knowledge. Midwives held misconceptions about risks and characteristics of perpetrators of violence
[19] Philippines	Knowledge, attitude, and practices of healthcare providers in intimate partner violence screening in a private tertiary hospital.	Obstetrics and Gynaecologist knowledge, attitudes, and practices	Descriptive study and Quantitative -Data were collected using the Physician readiness to Manage Intimate Partner Violence Survey (PREMIS) tool.	Obstetricians and Gynaecologist n = 123	To assess the level of knowledge, attitudes and practices of obstetricians and gynaecologist on screening for intimate partner violence in a private tertiary hospital using the PREMIS tool.	Participants did not have adequate knowledge on IPV. Lack of awareness on IPV as a health issue. **Attitudes** Inappropriate attitude to address IPV. **Preparedness** Participants were not fully prepared and equipped to handle patients who are victims of IPV which they were unable to routinely screen for IPV.
[24] Australia	Australian Nursing and Midwifery student beliefs and attitudes about domestic violence:	Nursing and Midwifery students' beliefs, attitudes about domestic violence	Quantitative- multi-site cross sectional survey study was conducted.	Nurses and Midwives n = 603	To explore Australian Nursing and Midwifery student's attitudes and beliefs about domestic violence	**Knowledge** Many students understood the nature and consequences of IPV but have very limited understanding of IPV. Some students had stereotypical and gendered attitudes that normalized violence within intimate relationships and sustain victim blaming attitudes. Settings of practice also contributes to their attitudes towards IPV. Midwifery students were knowledgeable about IPV than the nursing students.

(*continued on next page*)

Table 2 (*continued*)

Citation/ Country	Title	Major Focus/ Concept	Study Design	Population	Aim	Results
						Program of study and clinical learning contributes to the development of student attitude towards IPV, content taught.
[27] Australia	Midwives' experiences of routine enquiry for intimate partner violence in pregnancy.	Identifying facilitators and barriers to routine enquiry of intimate partner violence.	Qualitative descriptive design – In-depth telephone interview was conducted.	Midwives n = 35	To explore midwives' experiences of routine enquiry, perceptions of facilitators and barriers, and suggested strategies to improve practice.	**Attitudes** Continuous commitment from organisation. Midwives perceive that routine enquiry is an important midwifery role. **Preparedness** Lack of Professional development not prepared and lack of workplace support. Lack of time and lack of privacy Presence of partners
[40] Australia	Maternal and Child Health Nurse's preparedness to respond to women and children experiencing intimate partner violence:	Assessing Preparedness of maternal and child health nurses to address IPV	A cross-sectional study= Online survey was used for the data collection.	Nurses and Midwives n = 1125	To assess the level of Maternal and Child Health nurse intimate partner violence training and nurse preparedness to address partner violence. To compare group differences in preparedness by nurse location, role and level of training	**Preparedness** Nurses were well prepared to complete IPV practice although there were differences with preparedness across group. Rural nurses were less prepared than their urban colleagues especially when conducting safety assessments and documentation. Nurses with greater and recent training report being more prepared for IPV
[47] Vietnam	IPV: Forms, consequences, and preparedness to act as perceived by healthcare staff and district in northern	Knowledge and preparedness to respond to address IPV	Qualitative Study – Focus group discussion	Nurses n = 40	To describe how female and male healthcare workers and elected representatives of the district and community organisation in a rural part of Vietnam perceive violence against women in intimate relationship.	**Knowledge** Health professionals were uninformed about the prevalence rates and reluctant to intervene. Lack of understanding that IPV is a issue. **Preparedness** Health professionals were not prepared to address IPV as a health issue.
[69] Australia	Exploration of barriers to screening for domestic violence in the perinatal period using an ecological framework	Perspectives of HCPs on factors influencing disclosure and screening of IPV	Qualitative study – In-depth semi-structured interview were used to enquire about participants perspectives on domestic violence screening, their screening practices and how they deal with positive disclosures.	Healthcare providers n = 12	To explore Australian HCP perspectives on factors that influence disclosure and domestic violence screening through the lens of Heise's (1998) integrated ecological framework.	**Knowledge** HCP not knowing what to do: Fear of opening a can of worms. Lacking knowledge and awareness.' Education's a huge thing Ethnic consideration **Attitude** HCP not knowing what to do: Fear of opening a can of worms. Lacking knowledge and awareness.' Education's a huge thing Ethnic consideration **Preparedness** Time constraints: Lacking physical resources and emotional support.
[18] Malaysia	"I feel it is not enough." Health providers' perspectives on services for victims of intimate partner violence	Views and attitudes of HCPs towards IPV	Qualitative Study- Descriptive case study approach were the data was collected using an in-depth interview	Healthcare providers n = 54	To explore the views and attitudes of HCP towards IPV and abused women and to investigate their impacts on the provision and the quality of OSCC integrated services in Malaysia	**Knowledge** HCPs were aware that IPV causes both physical and emotional harm to the woman this indicate their knowledge of IPV. In one part of Malaysia people refereed to IPV as

(*continued on next page*)

Table 2 (*continued*)

Citation/ Country	Title	Major Focus/ Concept	Study Design	Population	Aim	Results
						causing both physical and psychological harm, unlike in another state respondents referred primarily to hitting and beating and any physical injury. **Attitude** About 75 % of the HCP interviewed perceived IPV was something that should not be tolerated. Majority of all the healthcare respondents said that no form of violence by the husband or partner was acceptable. Despite majority of the participants intolerant views towards IPV, there were still a small minority of medical officers and staff nurses at the district and more specialized hospital who accepted it or minimised it, referring to physical abuse as a small thing. One medical officer stated that if violence was severe and frequent, he thought it should be tackled. Among a minority of providers who accepted violence as a normal part of married life, a nurse offered a different kind of advice to women. She would tell them to be patient and stay their husband – because of the children – or advise them not to divorce. **Preparedness** Malaysia department of Health developed the One-Stop Crisis Centre to offer medical and health services to domestic and sexual violence survivors.
[62] China	Management of Domestic Violence by Primary Care Physicians in Hong Kong: Association With Barriers, Attitudes, Training, and Practice Background	Knowledge, Attitudes and Preparedness as Barriers to respond to IPV	Mixed Method Study Qualitative and quantitative approach was adopted – Qualitative data collected using the four focus group interviews of 7–10 participants exploring their opinions towards DV while the Quantitative data were collected by the administration of structured questionnaire.	Primary Care physicians n = 504	To investigate the barriers of Hong Kong Primary care physicians towards managing DV, including barriers of recognition, management, and referrals of these patients.	**Knowledge** Primary care physicians (PCPs) acknowledge they lack knowledge as to make the final diagnosis but confirms the diagnosis only when the survivor disclosed the exposure. PCPs want knowledge exchange on handling DV encounters and Lack of knowledge on DV from preservice training. **Attitude** Hesitant to intervene in domestic affairs of clients. Negative attitude towards screening for IPV Blaming victims of taking the responsibility to report the exposure to violence. **Preparedness** Facility setting was not ready. The screening took place with no privacy.

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Table 2 (*continued*)

Citation/ Country	Title	Major Focus/ Concept	Study Design	Population	Aim	Results
						Time constraints and no training specifically for the management of violence therefore PCP were reluctant to inquire. Main barriers: • Lack of experience in handling positive cases. • Lack of guidelines for DV management accessible for clinicians to follow. • Lack of access to services for referral • Lengthy process, no one-stop-shop to manage violence which causes clients not to trust the system. Proposed solution: • Create clear referral pathway or roadmap between different service providers.
[20] Australia	Australian Hospital Staff perceptions of barriers and enablers of domestic and family violence screening and response	Preparedness of hospital staffs towards IPV	A cross-sectional survey was developed from staff questionnaires routinely used at the study sites and a review of the current and existing literature.	Healthcare providers n = 615	To determine staff perceptions of barriers and enablers of Domestic and Family Violence screening and response	Less than 50 % of staff indicated to be well prepared to conduct screening for domestic violence.

author (C.P.) was used to summarise key findings, organised according to the inclusion criteria and guided by the Population, Concept, and Context framework. Once completed this was reviewed by two of the co-authors (K.B., H.R.). The data extraction included all data relevant to inform the aim and the scoping review question including data on HCP knowledge, attitudes, and preparedness to respond to IPV during pregnancy in the WPR. Any disagreements during data extraction were discussed and resolved collaboratively. The data extraction table captured key characteristics and provided a descriptive summary of each study, highlighting barriers that may hinder HCPs from screening for IPV. Following the review process 12 studies were considered appropriate for inclusion.

2.4.3. Synthesis

Content analysis was used to synthesise findings from the 12 eligible studies, following data extraction and mapping of the key characteristics, concepts, and content [46]. This approach was appropriate for a scoping review as it allowed for the summarisation of findings and identification of research gaps. A systematic content analysis approach was used to identify common themes.

2.4.4. Methodological quality review

The reviewers conducted a methodological quality assessment of the twelve included studies using the Mixed Method Appraisal Tool (MMAT) [38]. The MMAT has five specific criteria to assess the quality of each quantitative and qualitative studies; whereas; the mixed method has 15 criteria to assess against for the quality of each study instead of five [38]. Therefore, the overall quality of a combination cannot exceed the quality of its weakest component. The lowest score of the study component is the overall quality score of the mixed method study. The authors of the MMAT revised version (2018) advise against using an overall numerical score to reflect the quality of the studies. They believe it provides insufficient information about the ratings reflecting the quality of the studies included in the review [38]. Therefore, this scoping review quality assessment of the included studies was made against each criterion out of five, scored as 'Yes', 'No' 'Can't tell' and presenting the score with the descriptor star (*). The studies are ranked as high if five of five criteria are met with five stars (*****) and medium if four criteria are met (****), whereas studies with three or fewer criteria met were rated as low.

The 12 included studies assessed using the MMAT [37] indicated that five studies rated high in fulfilling all of five criteria, six were rated medium quality fulfilling four criteria, and one study met few criteria and was rated as low quality. All 12 studies responded 'yes' to both MMAT screening questions confirming the tool's appropriateness for independently appraising the quality of each study.

2.4.5. Study characteristics

Of the 12 included studies, four used qualitative methods to collect the data ([18]; J. [27,47,69]), two utilised a mixed method methods [61, 63] and the remaining six studies used quantitative methods [12,19,20, 24,40,5].

The 12 included studies had a broad geographical distribution within the WPR with eight from Australia one from China, one from the Philippines, one from Vietnam and one from Malaysia. Eight of the twelve studies [12,20,24,28,40,61,6,69] were conducted in high-income countries, two [18,62] in upper-income countries, and two [19,47] in lower-middle-income countries.

Nine studies investigated the knowledge, attitudes, and preparedness of HCPs to respond to IPV within the healthcare sector [12,18,19,20,24, 47,63,6,69] identifying a lack of knowledge a key barrier. Additionally, 11 of the 12 studies [24,28,41,5,61] reported unpreparedness due to insufficient support and confidence, which resulted in HCPs not being fully equipped or prepared to respond to IPV. Two papers did not include any reference to the attitudes of HCP towards IPV [40,47]. However, they emphasised the differences in the preparedness to screen for IPV across various groups of HCPs and indicated that a lack of knowledge about IPV impedes screening practices by HCPs.

The findings of the scoping review, which aimed to assess the knowledge, attitudes, and preparedness of HCPs in responding to IPV in

Table 3
Quality Appraisal.

Category of Study Design	Ali et al., [5]	Smith et al., [61]	Baird et al., [12]	Cortes, Quinio [19]	Doran et al., [24]	Eustace et al., [27]	Hooker et al., [40]	Krantz et al., [47]	Usanov et al., [69]	Colombini et al., [18]	Sun et al., [63]	([20] b)
S1 Are there clear research Questions?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
S2 Do the collected data allow to address the research question?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Qualitative 1.1	NA	Yes*	NA	NA	NA	Yes *	NA	Yes *	Yes *	Yes *	Yes *	NA
1.2	NA	Yes*	NA	NA	NA	Yes *	NA	Yes *	Yes *	Yes *	Yes *	NA
1.3	NA	Yes *	NA	NA	NA	Yes *	NA	Yes *	Yes *	Yes *	Yes *	NA
1.4	NA	Yes *	NA	NA	NA	Yes *	NA	Yes *	Yes *	Yes *	Yes *	NA
1.5	NA	Yes *	AN	NA	NA	Yes *	NA	Yes *	Yes *	Yes *	Yes *	NA
Quantitative Descriptive 4.1 Is the sampling strategy relevant to address the research question?	Yes*	Yes *	Yes *	Yes *	Yes*	NA	Yes *	NA	NA	NA	Can't tell −0	Yes *
4.2 Is the sample representative of the target population?	NO −0	NO −0	Yes *	Yes *	Yes *		Yes *				NO −0	NO −0
4.3 Are the measurements appropriate?	Yes *	Yes *	Yes *	Yes *	Yes *		Yes*				Yes *	Yes *
4.4 Is the risk of nonresponse bias low?	Yes *	Yes *	Yes *	Can't tell −0	Can't tell −0		NO −0				Yes *	Can't tell −0
4.5 Is the statistical analysis appropriate to answer the research question?	Yes *	Can't tell −0	Yes *	Yes *	Yes *		Yes *				Yes *	Yes *
Mixed Methods 5.1		Yes*									Can't tell	
5.2		Yes *									Yes *	
5.3		Yes *									Yes *	
5.4		Yes *									Yes *	
5.5		Yes*									Yes *	
Quality Assessment	4**** Medium	4*** Medium	5***** High	4**** Medium	4**** Medium	5***** High	4**** Medium	5***** High	5***** High	5***** High	4**** Medium	3*** Low

the WPR, identified several factors that hinder screening. The review highlighted the necessity for future research in LMICs of the WPR, as nearly 70 % of the included studies were conducted in high- and upper-income countries. The majority of the studies discussed and identified substantial barriers and challenges, such as insufficient resources, lack of knowledge, inadequate preparation and a lack of confidence among HCPs, all which impede effective IPV screening.

2.5. Findings

Findings are presented under three main themes identified from the review: (1) HCP lack of knowledge as a barrier to respond to IPV, (2) HCP negative attitudes towards IPV a barrier to respond to IPV, and (3) HCP unpreparedness towards IPV is a barrier to respond to IPV. Each theme will be discussed independently.

2.5.1. HCP lack of knowledge as a barrier to respond to IPV

HCPs often lack of knowledge about IPV, hindering their ability to effectively screen and manage cases, effectively leading to missing opportunities for support and intervention. Understanding the health impact of IPV is crucial for HCPs. Proper training increases knowledge and boosts confidence in identifying, providing support and referring cases onto appropriate support agencies ultimately leading to better outcomes [61].

Nine of the included studies explored HCP knowledge and their response to IPV [12,18,20,24,47,5,63,69]. Baird et al. [12] found that almost two thirds of the participants (midwives) were unaware of the risks and signs of IPV. Similarly, Krantz et al. [47] reported that HCPs lacked education about IPV prevalence and were therefore reluctant to ask women about a history about IPV. Usanov et al. [69] also identified a reluctance among HCPs to ask clients about a history of IPV, citing their limited knowledge of how to respond safely and effectively to a positive disclosure as a barrier. A lack of knowledge was consistently found to be a major barrier to both identifying and responding to IPV. Several studies indicated that many HCPs did not view violence against women as a health problem, but rather as a social issue that negatively influenced their willingness to engage with screening [47,69].

Overall, most studies found that HCPs, including nurses, midwives, doctors, and medical students did not perceive themselves to be knowledgeable about IPV [12,18,20,61,6,69]. This lack of knowledge often prevented them from inquiring about a clients history of IPV or referring women to support services for support and advice [12,19,6].

2.6. HCPs attitude towards IPV is a barrier to respond to IPV

HCP attitudes influence their ability and willingness to identify and respond to IPV, while gaps in knowledge and awareness can hinder effective care [18]. Participants from across the included studies regardless of their roles reported the need for support in responding to IPV disclosures [18,62]. Three studies reported that limited prior training on IPV hindered the HCP confidence and ability to screen for IPV, leading to missed opportunities for the identification and safe response to IPV [12,24,5]. In contrast, Smith et al. [61] found that students who received training in their undergraduate programs felt more confidence in attending to women exposed to violence and were more likely to respond positively to women exposed to violence.

Several system barriers also influence HCP responses to IPV. These include insufficient resources, lack of time, and inadequate referral pathways [69]. HCPs who have experienced violence themselves are less likely to address IPV among their clients, potentially due to them normalising IPV or feeling uncomfortable to addressing IPV leading to reduced screening and support for their clients [69]. Additionally, some HCPs hesitate to engage with what they perceive as clients' private matters, affecting their willingness to respond to IPV disclosures [62].

The working environment plays a significant role in shaping HCPs attitudes and practices towards screening. Structural barriers such as limited time, lack of private consultation space and insufficient institutional support can hinder effective screening and response to IPV [62]. Additionally, the lack of privacy within healthcare emerges as a critical barrier, In resource-limited settings, the lack of privacy and constrained physical environments further exacerbate HCPs reluctance for screening during pregnancy [62]. To improve HCPs ability to provide support to IPV victims and surviours, comprehensive education, enhanced communication skills, and a shift in mindset and attitudes are essential. These efforts are critical to ensuring women exposed to IPV receive safe appropriate support.

2.7. HCP preparedness towards IPV is a barrier to respond to IPV

HCP preparedness to respond to IPV is a critical factor influencing their decision to intervene. Key barriers include inadequate education, limited clinical experience as well as insufficient organisational support [61,6]. Variations in preparedness are linked to differences in training, educational programs, and geographical location [24,39,40]. For example, nurses and midwives working in urban settings appear to be better prepared for IPV screening than those in rural settings. Additionally, recent comprehensive training has been shown to improve readiness and preparedness for screening compared to outdated or minimal training. Hooker, Taft [39,41]. Knowledge, attitudes, and preparedness are interrelated and to respond and should not be considered in isolation. Adequate knowledge positively influences HCP attitudes towards addressing IPV, and a positive attitude, combined with a supportive environment, enhances their preparedness to respond effectively [19,28]. Key factors that support HCP preparedness include standardised screening guideline, accessible referral pathways, private consultation spaces for screening, adequate appointment times, and comprehensive training for all HCPs [40,62].

HCP level of training, location of employment, and professional roles all contribute to their preparedness to respond to IPV [24,61]. Hooker et al. [40] compared rural nurses with urban nurses revealing that rural nurses were less prepared to respond to IPV than their urban counterparts. Additionally, nurses who had received recent IPV training were more prepared to conduct screening than those with without training [39], highlighting that both the level and recency of training significantly influenced the preparedness of HCPs to conduct screening.

3. Discussion

HCPs willingness to screen for IPV in pregnancy is influenced and shaped by their knowledge, attitudes, and level of preparedness. This review also highlighted several external factors that significantly hindered effective screening, including insufficient training and education programs, geographical location, ethnic and cultural influences, insufficient policy directives and resources, and a lack managerial support significantly [12,20,24,40,63,6].

Interventions must be tailored and context specific, reflecting the distinct needs and realities of different healthcare settings. While models developed in high- and upper-income countries may offer valuable frameworks, they are often not directly applicable in LMICs due to the variations in resource allocation, training systems, resource and infrastructure availability, cultural norms and geographical challenges, educational and training frameworks, and economic conditions. Consequently, intervention strategies must grounded in a nuanced understanding of local contexts considering the diverse socio-economic and cultural landscapes of each country and health service. This approach not only improves the practical and sustainable implementation of IPV screening programs but also supports equitable and contextually appropriate care across diverse health systems in the WPR and other low resource income settings.

Most studies in this review were from HICs with only two from LMICs, despite IPV being most prevalent in LMICs [32,75,8,76]. As previously discussed, the contextual and resource factors of each country will have an influence and impact on the effectiveness of an intervention. Many interventions or recommendations that have been shown to be effective in HICs have not been as effective when delivered to a population in LMICs indicating that one size does not fit all [13,26]. There are many contextual factors that have significant bearing on the effectiveness of an intervention and on which outcomes are most important, including social, cultural, infrastructure, health profile, and economic characteristic [50].

Overall, HCPs' knowledge of IPV remains limited compared to their attitudes and preparedness to respond to it. While many HCPs recognise and acknowledge the presence and prevalence of IPV among women of reproductive age and condemn such violence, significant barriers continue to hinder effective screening and identification of violence within healthcare settings significant [36,42,8]. In many countries, the lack of formal education, ultimately preventing survivors from accessing support services and increasing their risk of adverse health outcomes [47]. Enhancing and improving HCP understanding of the various forms, impacts, and health consequences of IPV are essential for the development of effective context specific training programs. These programs must go beyond raising awareness, aiming to build practical skills and confidence in addressing IPV in healthcare settings [54]. Without this foundation, efforts to integrate IPV screening into routine care will remain inconsistent and inadequate in low to middle income settings.

Healthcare systems in LMICs face tremendous resource limitations yet the burden of diseases resulting from IPV remains significant. Identifying solutions to address their limitations is crucial [50]. Evidence-based strategies are needed to guide and prioritise resource allocation of scarce resources, to achieve desired health outcomes [71]. This scoping review affirms that LMICs around the world including those within the WPR severely lack substantial evidence and research studies to inform cost efficient and cost-effective interventions and approaches to strengthening the health sectors response to address IPV during pregnancy.

The high prevalence of IPV among women of reproductive age in LMICs within the WPR places additional strain and burden on already limited resources. This reinforces the urgent need for an immediate and systematic healthcare response [75]. While IPV prevention is recognised as a global priority for the health care sector this scoping review reveals a critical gap in the regions most identified by IPV [58]. Addressing this gap is essential to inform the development of cost-effective strategies and interventions. The lack of research evaluating HCPs knowledge, attitudes, and preparedness to respond to IPV in high-prevalence,

resource-limited settings may hinder the design and implementation of context-specific, cost-effective interventions within the health sector [35,59]. Moreover, while HICs have developed structured training curricula, instructional resources, policies and guidelines, and teaching methodologies to support HCPs in addressing IPV, these approaches may be impractical or culturally inappropriate for LMIC contexts due to workforce shortages and differing health system structures [59,71].

4. Conclusion

Preventing IPV remains a global priority due to its significant and widespread prevalence and immense health burden. This review highlights the importance of evaluating the knowledge, attitudes and preparedness of HCPs to respond to IPV in LMICs within the WPR. Despite its significant public health implications, IPV is still frequently viewed as a social or legal issue leading to it marginalisation within health priorities. Improving HCP competence in recognising and addressing IPV is crucial for facilitating disclosure, supporting survivours and ensuring timely intervention. A lack of training and preparedness results in missed opportunities to mitigate both the health and social impacts of IPV, particularly in resource limited settings. This underscores the urgent need for targeted, context-specific interventions and capacity-building initiatives. Additionally, further research is critical to uncover the systemic, cultural, and educational barriers that shape the healthcare response to IPV in LMICs and to inform effective, sustainable solutions.(Fig. 1 and Tables 1–3)

Funding

No funding was received for this scoping review. However, one of the authors conducted the review with support from an Australia Awards Scholarship.

Declaration of Competing Interest

The authors declare that there is no conflict of interest relating to this scoping review.

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