Review Article

Access this article online

Quick Response Code:

Website: www.jehp.net

DOI: 10.4103/jehp.jehp_733_22

A review of the challenges of screening for domestic violence against women from the perspective of health professionals

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Received: 28-05-2022
Accepted: 31-07-2022
Published: 30-06-2023

Abstract:

BACKGROUND: Domestic violence has a significant effect on women's reproductive, physical, and mental health, and it is a significant threat to everyone's health, so that, it sometimes leads women to commit suicide. Although many of these women will refer to receive medical care due to domestic violence, few of them are identified by health care providers. The present study aimed to review the challenges of screening for domestic violence against women from the perspective of health professionals.

MATERIALS AND METHOD: This study is a scoping review. The study was performed in five stages, which include (1) designing the research question, (2) searching and extracting research-related studies in national and international databases such as PubMed, Scopus, Web of Science, Embase, Magiran, Scientific Information Database (SID), IranDoc and Google Scholar search engine, from inception to March 2021, (3) selecting related studies, (4) scheduling and summarizing data and information, and (5) reporting the results.

RESULTS: Out of 411 articles reviewed, 10 article met our inclusion criteria and were included. According to the results of the studies, barriers of screening for domestic violence can be classified into three areas, which include barriers related to employees (lack of knowledge and training, lack of time to conduct screening, lack of staff confidence, client judgment, and lack of security and comfort for asking related questions and forgetting employees), barriers related to the client and the prevailing culture in the society (tolerating and not reporting domestic violence, fear of spouse due to high power of men in society, fear of losing children and life, and racial and cultural issues) and barriers related to the organization (lack of necessary support from the organization, lack of funding from the organization, lack of protocol).

CONCLUSION: Considering the high number of barriers of detecting women affected by the domestic violence, this study could be used in program designation, and implementation of effective interventions to remove barriers of domestic violence screening. Health care providers can use the results of this review to prepare educational packages according to their cultural background to improve understanding and women's cooperation in the domestic violence prevention and screening programs.

Keywords:

Attitude of health personnel, domestic violence, Health care provider, intimate partner violence

Introduction

Domestic violence or violence among family members has a long history as human life and is frequently mentioned in religious and historical texts.[1] Domestic violence includes aggressive and repressive behaviors, including physical (bodily), sexual, and psychological attacks, as well as economic pressure exerted by an adult on a person with whom he or she has a

How to cite this article: Purbarrar F, Khani S, Zeydi AE, Cherati JY. A review of the challenges of screening for domestic violence against women from the perspective of health professionals. J Edu Health Promot 2023;12:183.

close relationship.[1,2] Domestic violence is divided into four categories according to the type of behavior including physical violence (such as pushing, throwing, biting, slapping, burning, etc.), psychological violence (such as threats, emotional harassment, Restrictions on traffic, depriving a woman of access to information), sexual violence (sexual intercourse with threats and coercion, requesting sex at an inappropriate time and doing it in a way that is unpleasant for the woman) and economic violence (refusal to pay for traffic, food, clothing, etc.). Among these, psychological violence is more closely related to suicide.[1,3] According to the World Health Organization, the rate of domestic violence in several countries showed a prevalence of 13 to 71 percent.[4,5] In this regard, the results of a systematic review and met analysis indicated a high prevalence (66%) of domestic violence in Iran.[1]

Moreover, the fifth goal of the Millennium Development Goals is gender equality and personal empowerment. Besides, one of the seven priorities for achieving gender equality after 2015 is to try to reduce violence against women and girls.[6] Domestic violence has a significant impact on women's reproductive, physical and mental health as well as marital intimacy, and is a significant threat to everyone's health and sometimes leads people to suicide.[2,7,8] Violence against women, in addition to physical, psychological, and social negative consequences, also imposes a heavy economic burden on society. Domestic violence against women can lead to physical and psychological diseases and reduces their performance in the organization.[3,9] Moreover, women affected by violence have a tendency for smoking, and alcohol, illicit drugs, and substance abuse. Infection, inappropriate weight gain during pregnancy, and severe postpartum depressions could also be seen in them with a higher rate.[2] Many victims of domestic violence disclose this issue to seek help from relatives and acquaintances. However, despite the high prevalence, a large percentage of domestic violence cases are not reported to the health care providers and will remain undiagnosed, which in turn increases the rate of domestic violence.[10] Health care providers are in a unique position to provide services for women affected by violence or exposed to it; as they are recognized as the first level of referrals.[2,10] Though many women will refer to receive medical care due to domestic violence, few of them are identified by health care providers. Therefore, many organizations and experts related to women's health consider screening for domestic violence to be mandatory for all women who visit health centers.[10] In many countries, services provided for women affected by the violence fall into four categories including establishing hotlines for them, counselling, providing support by non-specialists, and providing shelter for women and, if necessary, their children.[11] Most of the women due to their modesty, misconceptions, and traditional pressures that have been regnant of the society for centuries, and fear of being reprimanded or punished by health care providers tends to hide and normalize these spousal abuses.[7] Barriers of screening in a study performed in Iran has been reported as the unpleasantness of the subject, lack of enough effort, time constraints, fear of upsetting the patient, inability in front of patients denial, lack of skills and tactics in managing domestic violence, insufficient knowledge of referral facilities and inability to solve problems.[12] In another study, barriers to domestic violence screening included barriers related to health care staff and patients. Barriers related to health care staff included lack of training regarding domestic violence, lack of time, and lack of appropriate intervention, and barriers related to the patient were only fear of being insulted.[13]

Considering the negative consequences of domestic violence on all aspects of the reproductive, physical, mental, social and emotional health of women, and due to the high number of barriers in the way of health care providers to screen domestic violence, the importance of the subject has been multiplied. Due to the lack of review studies in this field, the present study was performed to review the challenges of screening for domestic violence against women from the perspective of health professionals.

Material and Methods

This study is a scoping review performed in five stages, which include (1) designing the research question, (2) searching and extracting research-related studies, (3) selecting related studies, (4) scheduling and summarizing data and information, and (5) reporting the results.[14] The protocol of this review was not registered in the international prospective register of systematic reviews (PROSPERO) database, because our research questions are not covered by the inclusion criteria of this register. As this study is a scoping review of previously published studies, the need for ethics approval was waived.

Designing the research question

What are the challenges of screening for domestic violence against women from the perspective of health professionals?

Searching and extracting research-related studies

A comprehensive search of literature was performed in national and international databases such as PubMed/MEDLINE, Scopus, Web of Science, Embase, Magiran, Scientific Information Database (SID), Iranian Research Institute for Information Science and Technology (IranDoc) and Google Scholar search engine by two investigators, without any time limit (from inception to January 2021). We updated the search in

March 2021 with the same search terms. The search was limited to English and Persian language articles. The gray literature was not actively searched because they usually do not portray the whole picture of the results, and when fully published, the results may change substantially.

Keywords used to search in the Persian databases were domestic violence, screening, challenges, barriers, limitations, threats, health care providers, health caretakers, health staff, health professionals, nurse, midwife, physician, perspective, and attitude. English keywords were (Domestic violence OR Intimate partner violence OR Violence against women) AND (Screening OR Diagnosis OR early detection) AND (Challenges OR Barriers OR Limitations OR threatens) AND (Health care providers OR Health care services OR Health staff OR Health professionals OR Nurse OR Midwife OR Physician) AND (Attitude OR perspective OR Point of View). All quantitative articles that evaluate the challenges of screening for domestic violence by health care providers, written in Persian or English, and available in full text were included. Any papers which were unrelated to the aim of this study, letters to the editor, case reports and reviews were excluded from the study. The reference list of included studies was manually checked for additional papers.

Extracting studies based on inclusion criteria

Using the above-mentioned keywords, 410 studies were identified by searching for sources and one study was identified by manual searching of the references, and therefore a total number of 411 studies were obtained. Studies were reviewed based on inclusion criteria. To manage the data, the results of the database search imported into the EndNote X8 software. After removing the duplicate articles, two authors independently evaluated the title, abstracts, and then the full text of potentially eligible studies. Any disagreements between the investigators were resolved by discussion. Seventy studies were removed because of duplication. The related studies were selected using the following method: first, a list of titles and abstracts of all articles in the databases was prepared by the researchers. Then, with a detailed review of the list, 328 articles were removed due to their irrelevance to the aim of the study. The full text of the articles has been read in the cases that it was not possible to decide on the study based on the title and abstract. By reading the full text of the articles, it was found that three articles did not answer the research question of the present study, and the study of barriers to violence was from the perspective of those referred to medical centers. As a result, these three articles were excluded, too.

Summarizing and tabulation of data

Studies related to the research topic were reviewed and analyzed as shown in Table 1.

Reporting results of the study

After studying the summary and full text of articles related to the research topic, the desired information was extracted. Information required for each study included author name, year, place and type of study, sampling method, data collection tool, and results. Finally, the information obtained from the articles was synthesized and categorized to reveal the most important barriers.

Results

Out of 411 articles reviewed, 10 article met our inclusion criteria and were enrolled in this study. Figure 1 summarized the article selection process.

All included studies had cross-sectional design and their statistical population was health professionals such as physicians, nurses, midwifes, and other health care providers [Table 1].

Data were categorized using the content analysis method. To do this, first, a list of findings of all studies was prepared (according to the study question). Three columns were created in Word software named Health staff-related challenges, client and society/culture-related challenges, and organization-related challenges. Then, the first finding of the list was transferred to the relevant column. The results of the study were reviewed repeatedly and each one was transferred to the relevant column. This work continued until there were no more findings in the initial list of findings.

The three main categories of domestic violence screening challenges in the reviewed studies were: a) barriers related to health staff and health services b) barriers related to the client and the prevailing culture of the society c) barriers related to the organization [Table 2]. Each category consisted of several subcategories.

Barriers related to health staff and health services

Ten studies examined barriers related to health staff and health services. Barriers related to staff were failure to perform screening due to lack of preparation to provide services after recognition of violence,[11,15-19] high workload, and insufficient time to address this issue,[11,16,17,19,21-23] lack of self-confidence,[13,19] client judgment,[13] lack of security and comfort,[16,19] forgetfulness[23] and personal experience.[21,23]

The health staff was not educated enough for screening and identification of women affected by domestic violence. Many of them mentioned that they had not been trained in this field during their work experience[12,15-19] and this reduced their self-confidence and made them unwilling to ask their clients about domestic violence.[23,24]

Table 1: Studies related to the research topic

Author/Year/Country	Title	Study type	Sample size	Study tool	Results
MahrokhDolatian/2012/ Iran	Barriers of Domestic Violence Screening from the Perspective of Health Care providers Working in Clinics and Hospitals Under the auspices of Shahid Beheshti University of Medical Sciences and Health Services	Descriptive	100 health and medical staff (midwives, gynecologists, doctors, and nurses)	Demographic Characteristics Questionnaire - Assessing Barriers to domestic Violence Screening from the perspective of health and medical staff of Gotmanis	Lack of proper training for staff, lack of sufficient time to perform screening, and lack of support resources are among the known barriers in this study.
Elham Saberi/2017/ Australia	Ready, willing, and able? A survey of clinicians' perceptions about domestic violence screening in a regional hospital emergency	Cross-sectional	76 health care providers	Demographic Characteristics Questionnaire - Assessing domestic Violence Screening from the perspective of health care providers (DVHPS)	Many physicians considered screening necessary. Lack of proper protocol, lack of comfort for screening, and lack of required training are known to be the most important barriers.
AhlamAl-natour/2014/ Jordan	Jordanian Nurses' Barriers to Screening for Intimate Partner Violence	Cross-sectional	125 nurses	Demographic questionnaire - Assessing domestic Violence Screening from the perspective of health care providers (DVHCPS)	Barriers to domestic violence include low employee confidence, employee judgment, lack of system support, and lack of a sense of security for employees.
Mican I. Deboer/2013/ USA	What Are Barriers to Nurses Screening for Intimate Partner Violence?	Cross-sectional	494 nurses	Demographic questionnaire-Researcher-made domestic violence questionnaire from the perspective of health care providers	86% of nurses provided care to two or fewer people in a domestic violence setting, last year. 81% said they had enough time to do the screening, 60% said they considered their work environment appropriate to do screening, and 56% said they had been trained for this situation. 77% of employees felt comfortable doing the screening.
Iman Y. Alotaby/2013/ Kuwait	Barriers for domestic violence screening in primary health care centers	Cross-sectional	366 doctors and nurses	Demographic questionnaire-Researcher-made domestic violence questionnaire from the perspective of health care providers	Lack of sufficient time, personal experience of employees in this field, the high workload of employees, tolerance of domestic violence and non-reporting by the victim, lack of necessary support from the organization and officials, fear of spouse, and fear of losing children and life due to high power of Men in the society were among the barriers associated with screening in this study.
Heather M. Shearer/2006/Canada	Chiropractor's Perception About Intimate Partner Violence: A Cross-Sectional Survey	Cross-sectional	93 Experimental chiropractors	Demographic questionnaire-Researcher-made domestic violence questionnaire from the perspective of health care providers	General information about domestic violence was found among experimental chiropractors to be at a high percentage, but knowledge of clinical indicators, management, and guidance of victims was very poor. Lack of information and knowledge on this topic, discomfort to speak and time limitation were all mentioned as barriers to IPV screening.

Contd...

Table 1: Contd...

Author/Year/Country	Title	Study type	Sample size	Study tool	Results
Jana J. Ortiz/2005/ USA	Existence of Staff Barriers to Partner Violence Screening and Screening Practices in Military Prenatal Settings	Cross-sectional	74 health care providers	Demographic questionnaire-Researcher-made domestic violence questionnaire from the perspective of health care providers	Staff at military-affiliated health centers had enough awareness of domestic violence. Lack of time and enough training, staff inconvenience for screening, lack of proper protocol, and support from the organization were the main barriers to domestic violence screening for medical staff.
JUDYC. CHANG/2003/ USA	Helping Women with Disabilities and Domestic Violence: Strategies, Limitations, and Challenges of Domestic Violence Programs and Services	Cross-sectional	85 health staff	Demographic questionnaire-Researcher-made domestic violence questionnaire from the perspective of health care providers	Lack of funding, lack of proper education, and lack of support, and limitations of service facilities were identified as barriers to domestic violence screening.
Lorrie Elliot/2002/USA	Barriers to Screening for Domestics Violence	Cross-sectional	2400 doctors	Demographic questionnaire-Researcher-made domestic violence questionnaire from the perspective of health care providers	Low staff confidence, concern about patients' anger when asking relevant questions, forgetting staff to do screening, lack of time, and personal staff experience of domestic violence are some of the barriers to screening.
Linda Chamberlain/2002/ USA	The Impact of Perceived Barriers on Primary Care Physicians' Screening Practices for Female Partner Abuse	Cross-sectional	297 specialist and general practitioners	Demographic questionnaire-Researcher-made domestic violence questionnaire from the perspective of health care providers	Half of the participants did not know the time limit as one of the major barriers to domestic violence screening. More than three-quarters of staff agreed with the screening, and 70% of participants felt comfortable doing screening for domestic violence.

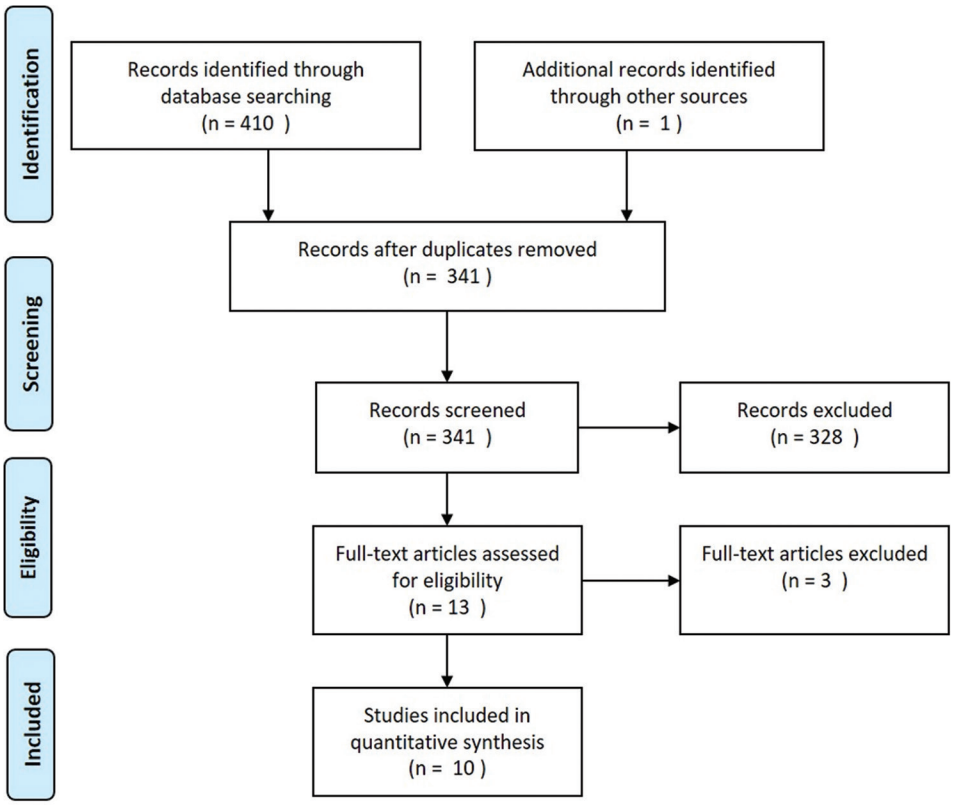

Figure 1: Flow diagram of the included studies

Table 2: Domestic violence screening challenges

Barriers related to health professionals and health services
No screening due to lack of preparation to provide services after the diagnosis of violence[12,14-18]
Not having enough time[12,15,16,18-21]
High workload[20]
Lack of self-confidence[19,22]
Judging the client[22]
Not having a sense of security and comfort[15-18]
Forgetfulness[19]
Personal experience[19,20]
Barriers related to the client according to the prevailing culture of the society
Tolerance of domestic violence[20]
Fear of spouse[20]
Fear of losing children and life[20]
Racial and cultural differences[23]
Barriers related to the organization
Lack of required support[11,13,14,16]
Lack of protocol[16,17]
Lack of suitable environment[15,23]
Lack of budget[14]

Regarding the sensitivity of this issue, many staff said that judging and labelling abused women should be avoided, but in practice, they had little ability to deal with this inner feeling and sometimes inadvertently judged the patient.[13] The increasing number of clients in health centers and medical services for different reasons, caused them to pay more attention to in-person clients due to the fixed working hours. Besides, the high workload caused staff to forget to do screening.[21] As a result, they are not identified due to lack of time.[12,16,17,19,21-23] It should be said that some health staff cannot establish an appropriate relationship with clients and this problem makes them uncomfortable to ask questions in this regard. There are no specific laws to protect health staff in this area and many employees are reluctant to enter the field due to legal issues and lack of security.[16-19] Some health care providers may have an experience of domestic violence. Screening clients in this area can evoke their memories and it is very painful for them. Therefore, these employees prefer to be indifferent to this issue and not ask questions on this topic.[21,23]

Barriers related to the client according to the prevailing culture of the society

Two studies analyzed client-related barriers regarding the prevailing culture in the society. These barriers included tolerating domestic violence, fear of spouse, fear of losing children and life,[21] and racial and cultural differences.[20]

Women often do not report domestic violence and try to cover it up and make it normal when they go to health centers. Due to different cultures and races and different equality of rights for men and women in many societies, men still have a lot of power and many women are forced to endure this violence for fear of losing their family life and children and lack of family support.[20,21]

Barriers related to the organization

Seven studies examined barriers related to the organization. Obstacles related to the organization included inappropriate physical space of the centers, unavailability of proper protocol, improper functioning of the referral system, and lack of support.

In many service centers, there is no suitable environment for screening.[16,20] Due to the crowds of clients in the centers and the presence of two or more clients in the treatment room, there is not enough security for these women to report domestic violence. Moreover, there is no proper protocol for the identification and referral of these women, and this is a barrier to screening.[17,18] If victims of violence know that organizations will adequately support them, they will reveal this secret. However, due to a lack of funding, enough support is not provided by organizations.[12,15,17,24]

Discussion

By analyzing the results of studies, domestic violence screening challenges were divided into three main categories including barriers related to health staff, barriers related to the client according to the prevailing culture in the society, and barriers related to the organization. The first category of barriers related to health care providers includes low knowledge and information of employees about domestic violence, lack of attention and empathy, lack of training, lack of self-confidence to ask questions about IPV, their personal experience in this topic, Lack of enough understanding. Lack of preparation to share or deal with the problem, lack of self-confidence, embarrassment, fear of being harmed by the sexual partner, or fear of losing children are cited as barriers of domestic violence recognition for the clients. Barriers related to the organization include lack of privacy, lack of proper health services, lack of time, high workload by organizations to disclose domestic violence screening cases, as well as lack of coordination in policy and protocol preparation. The results of our study showed that the lack of sufficient time to perform screening is an important barrier that in most studies is related to the staff and is mentioned in various studies such as the study of Colarossi *et al*.[25] and Colombini *et al*.[26] The results of a study in Egypt indicated that from the perspective of health care providers, time constraint, socially acceptance of domestic violence and unavailability of the necessary referrals to help victims were the most important barriers for screening and dealing with domestic violence.[27] In another study, lack of time, personal

discomfort, concerns about misdiagnosis, reluctance to intrude into familial privacy, and lack of 24-hour social service support were perceived barriers by health care providers in the care of victims with domestic violence in emergency department.[28] Additionally, the results of a study in Australia to evaluate practice of domestic violence screening for pregnant and post-partum women by community based health care providers revealed that a lack of recognition that this was part of their role; and a lack of domestic violence screening policies and/or reminder systems were the most important factors contributing to this lack of screening.[29]

Considering that most health centers and medical services offer a lot of care in different health fields, many health care providers forget screening for domestic violence due to their large workload, different needs of clients, and fixed working hours. This finding is in concordance with the study of Owen-Smith *et al*.[30] that in this study, it has been suggested to ask about domestic violence in the routine care to solve this problem. Moreover, participants in the study of Zink *et al*.[31] mentioned that domestic violence is an issue that requires special attention and cannot be resolved within the limited time of the visit.

Most of the major health and medical centers provide services in the field of women and children treatment, and health staff and health care providers have a lot of information in this field. However, many of them do not have sufficient knowledge about domestic violence screening due to a lack of proper training. As the study of Cann *et al*.[32] showed, the response of health care providers is often inappropriate and wrong in the case of confronting abused women. Most of the health staff accepted that domestic violence is a critical and vital issue, though they did not have enough knowledge and information on this topic. However, in the study of Deboer *et al*.,[16] health staff felt comfort to do screening due to their appropriate education in this topic, which is in concordance with the study of Chamberlain *et al*.[22] In the study of Khani *et al*.,[33] lack of health staff prepared to provide services and the inadequacy of health care centers were barriers for speaking about sexual issues that are consistent with the findings of the present study.

The results of our study showed that many women refer to medical centers for periodic health care, but do not talk about violence by their husbands, which is consistent with previous related study.[34] Women's fears about their partners and the loss of their children, as well as the intervention of the police and the judiciary, were some of the barriers that prevented women from reporting domestic violence. Moreover, in the study of Moazzemi *et al*.,[35] in addition to the mentioned barriers, economic dependence on the spouse, observance of cultural issues, and fear of the spouse's reactions were introduced as barriers of complaint to judicial and disciplinary authorities. One of the reasons for unresponsiveness to the questions about domestic violence is the lack of laws to prevent domestic violence as well as lack of necessary support from relevant organizations. The question always arises that whether the criminal justice system has the appropriate structure to protect women who are victims of domestic violence and prevent it.[31] The study performed by Hajizade-Valokolaee *et al*.[6] analyzed factors that result in the violence against infertile women and categorized these factors into three personal, interpersonal, and social groups. The prevailing culture of the society was placed at the social group, and this is based on the present study. There are some limitations in this study which should be noted. Different questionnaires were used across included studies to evaluate the challenges of screening for domestic violence against women from the perspective of health professionals, therefore, the data were not similar across studies which might affect the reliability of our results. Also, in this study search strategy only considered studies in Persian and English language. This may have resulted in publication bias with potential relevant studies published in other language being missed.

Conclusion

In conclusion, considering the high number of barriers for the identification of violence victim women, and due to lack of violence reports by victims, as well as lack of education and preparation of the service providers, it is suggested that domestic violence management topics should be included in the medical, midwifery, and other related health care providers' curriculum. The referral system should also be altered; so that those educated for managing physical, psychological, and sexual violence should be employed and victims of violence should be referred to these trained staff after screening. However, all staff should be educated for domestic violence screening. Results of the present study could be used in the program designation and performing intervention effect on the removing barriers of domestic violence screening. Health service providers can use the results of this study to prepare educational packages in concordance with the social culture to improve the understanding and cooperation of women in domestic violence screening programs.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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