Original Article

Performance of Healthcare Providers Regarding Iranian Women Experiencing Physical Domestic Violence in Isfahan

Abstract

Background: Domestic violence (DV) can threaten women's health. Healthcare providers (HCPs) may be the first to come into contact with a victim of DV. Their appropriate performance regarding a DV victim can decrease its complications. The aim of the present study was to investigate HCPs' performance regarding women experiencing DV in emergency and maternity wards of hospitals in Isfahan, Iran. **Materials and Methods:** The present descriptive, cross-sectional study was conducted among 300 HCPs working in emergency and maternity wards in hospitals in Isfahan. The participants were selected using quota random sampling from February to May 2016. A researcher-made questionnaire containing the five items of HCPs performance regarding DV (assessment, intervention, documentation, reference, and follow-up) was used to collect data. The reliability and validity of the questionnaire were confirmed, and the collected data were analyzed using SPSS software. Cronbach's alpha was used to assess the reliability of the questionnaires. To present a general description of the data (variables, mean, and standard deviation), the table of frequencies was designed. **Results:** The performance of the participants regarding DV in the assessment (mean = 64.22), intervention (mean = 68.55), and reference stages (mean = 68.32) were average. However, in the documentation (mean = 72.55) and follow-up stages (mean = 23.10), their performance was good and weak respectively (criterion from 100). **Conclusions:** Based on the results, because of defects in providing services for women experiencing DV, a practical indigenous guideline should be provided to treat and support these women.

Keywords: *Domestic violence, healthcare providers, Iran, women*

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Introduction

Physical domestic violence (DV) is any intentional use of physical force by a family member which may lead to death, disability, and injury of the victim. DV is an important and widespread public health problem. The financial impact of DV on communities is estimated to be more than $8.50 billion annually with the majority of costs going to healthcare services.[1] DV can have physical, mental, sexual, and reproductive health consequences.[2] Women experiencing DV are in danger of prenatal and neonatal mortality more than other women during pregnancy.[3] The World Health Organization (WHO) has reported that 35% of women worldwide have experienced physical and sexual violence. Regrettably, because of lack of supportive actions for DV victims in several countries, many cases of violence go unreported.[2] Previous studies have reported a prevalence of 24.30% and 60% exposure to DV among women in the United States[4] and Bangladesh,[5] respectively. In India, 31% women experienced severe physical DV in 2012.[6] It is estimated that 36% of women over the age of 18 years in Tehran, Iran, have experienced physical DV. The prevalence of physical abuse in Isfahan, Iran, was reported to be 27.20% in 2005.[7] Moreover, the prevalence of physical DV among pregnant women in Tehran was approximately 10.70% in 2014.[8] Therefore, due to the high incidence of DV (66%) in Iran[9] and other countries,[10] it is necessary to identify the problem and provide adequate treatment and support to reduce and prevent its complications. Healthcare providers (HCPs), especially those working in emergency and maternity wards, have an important role in identifying and intervening in DV[11] because they may be the first to come into contact with a DV victim. Therefore, their appropriate measures can reduce the mental and

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physical consequences of DV in women. According to standard protocols, HCPs should identify and manage DV efficiently. Moreover, they should refer the victims to available services and centres if needed. Finally, to prevent and reduce DV, HCPs should investigate and explore the cases of DV.[11] With regard to DV and the performance of HCPs, a few studies have been carried out based on standard protocols. Considering the knowledge, attitude, and performance of HCPs with regard to DV, two studies have examined the quality of DV screening.[12,13] Similarly, in another study, the relationship between attitude and performance of HCPs and other health-risk factors was investigated.[8] The aforementioned studies examined only some areas of the protocol. Screening for DV is currently performed at the level of the primary healthcare (PHC) in Iran. However, it is still under the assessment of the health system.[8] Accordingly, considering DV protocols, the present study aimed at investigating the performance of HCPs regarding women experiencing DV.

Materials and Methods

The present descriptive, cross-sectional study was conducted among HCPs working in the emergency and maternity wards of 10 general hospitals of Isfahan from February to May 2016. All hospitals affiliated to the Isfahan University of Medical Sciences, Isfahan, which are referral centres for DV cases, were selected according to the census. To calculate the sample size, assuming normal distribution of scores, Cochran's formula ($Z = 1.96$, $d = 0.05$, $p = q = 0.50$) was used, and the scores were converted on a scale of 1–100. Among 796 HCPs, 300 were selected using random sampling. The participants of the study consisted of 42 physicians, 46 midwives, and 212 nurses. The inclusion criteria included one year or more of professional experience and at least one encounter with a woman experiencing DV. The data for the present study were collected through a self-administrated questionnaire developed by the researcher. It was based on DV international guidelines and consisted of two sections. The first section of the questionnaire included demographic information. The second section consisted of 35 items evaluating treatment and supportive measures.The questionnaire consisted of the subscales of assessment (performances regarding physical and mental assessment) (12 items), intervention (performances regarding physical and mental treatment) (7 items), documentation (recording all information on the victim and the services provided for her) (8 items), reference (performances regarding referral of victims to appropriate services) (4 items), and follow-up (following the victim by phone calls or revisits) (4 items). The items were scored based on a five-point Likert scale (1–5 scores).

The DV questionnaire was prepared based on international guidelines. The developed questionnaire was examined in terms of its psychometric characteristics (i.e., reliability and validity). The content validity of the questionnaire was delineated through expert judgment. To determine quantitative face validity, impact score was used and important items were kept. To determine quantitative content validity, content validity ratio (CVR) (≥0.99) and content validity index (CVI) (≥0.79) were used. Finalizing the final questionnaire with 35 questions was the next step. To assess the reliability of the questionnaire, a pilot test was performed on 20 participants selected from the same study population. The reliability of the questionnaire was confirmed with Cronbach's alpha of at least 0.75. The purpose for implementing such a phase was to discover any existing problems and eliminate them, as well as to assess the time allotted for administering the questionnaire, the quality of the instructions, and the quality of the individual items. Finally, the questionnaires were distributed among the participants to be completed in the presence of the researcher.

To analyze the data obtained through the administration of the questionnaire, data were entered into SPSS software (version 20, IBM Corporation, Armonk, NY, USA). To have a general description of the data, descriptive statistics (i.e., the means and standard deviations) were calculated for each subcategory of the questionnaire used in this study. Scores of less than 50, 50–75, and over 75 in different sections of HCPs' performance regarding DV were, respectively, considered as poor, average, and good (criterion from 100).

Ethical considerations

The ethics committee of Isfahan University of Medical Sciences approved this research (Ethic code: 394461). Ethical considerations in this study included obtaining written or oral consent from participants, assuring them of confidentiality, and allowing them to freely participate in this research.

Results

The response rate was 100%, and 300 questionnaires were analyzed. The age of the participants ranged from 24 to 50 years with the mean (SD) age of 34.34 years (5.98). The majority of the participants were women (75.33%) and married (74%) with a mean professional experience of 9.10 (6.12) years [Table 1]. The mean (SD) scores in the assessment, intervention, documentation, reference, and follow-up stages were 64.22 (17.24), 68.55 (15.42), 72.66 (17.38), 68.32 (20.05), and 23.10 (26.17), respectively. The mean score of measures was 58.19 (14.48) (criterion from 100). The frequency of performance stages is presented in Table 2. Only 12% of the participants evaluated the victim's decision after leaving the hospital whereas 86% assessed the physical and mental effects of DV on the victim. Moreover, 84% of the participants performed the right measures to repair the physical damages. It was demonstrated that 94% of the

Table 1: Demographic characteristics of participants (*n*=300)

Variable	*N* (%)	Total *N* (%)
Gender		
Female	226 (75.30)	300 (100)
Male	74 (24.70)	
Education		
Associate degree	10 (3.30)	300 (100)
Bachelor's degree	213 (71.00)	
Master's degree	35 (11.70)	
Doctorate	42 (14.00)	
Course		
Medicine	42 (14.00)	300 (100)
Nursing	212 (70.70)	
Midwifery	46 (15.30)	
Hospital position		
Physician	42 (14.00)	300 (100)
Nurse	198 (66.00)	
Midwife	46 (15.30)	
Supervisor	14 (4.70)	
Marital status		
Married	222 (74.00)	300 (100)
Single	73 (24.30)	
Divorced	2 (0.70)	
Widowed	2 (0.70)	
Other	1 (0.30)	
Economic status		
High	92 (30.70)	300 (100)
Moderate	174 (58.00)	
Low	34 (11.30)	
Referred women experiencing physical DV		
<20	157 (52.30)	300 (100)
20-50	84 (28.00)	
50-80	38 (12.70)	
>80	21 (7.00)	

DV: Domestic violence

participants recorded all the measures taken for the victim. Marking trauma on the body map was the measure least taken. Furthermore, 80.6% of the victims were referred to a psychologist or psychiatrist, but almost 85% of the participants did not follow the victim's condition after leaving the hospital.

Discussion

The present study is the first in Iran to evaluate HCPs' performance regarding DV according to standard protocols. No research could be found reporting HCPs' performance according to the DV protocol details as in the present study. The average quality of HCPs' performance regarding DV was the main finding of the present study. The response rate was 100%. This response rate may indicate the interest of the participants in DV. The age range of the participants was 24–50, that is, the participants of the present study were younger in comparison to other similar studies.[8,14] The mean number of participants who came into contact with victims of DV was 25.29. However, a study carried out in Hamburg (Germany) showed that the rate of encountering women who had experienced DV ranged from 1 case every 2 years to 10 cases per year.[14] Another study conducted in Lebanon found that physicians encountered DV cases with a prevalence of 0.50–70% during their professional career.[15]

Due to the high prevalence of DV in Iran[9] and some other countries[10] and the mean encounter with DV victims in the present study, it seems necessary that more attention be paid to DV. The mean score of general performance of the participants in the present study was average. The highest and lowest scores were related to documentation and follow-up, respectively. Likewise, a study carried out in the UK showed that the most important measures taken regarding DV were related to documentation,[16] which was similar to the results of the present study. Due to the legal consequences, documentation may be a sensitive topic in medical practices. It can be concluded that the health system should pay more attention to other components of performance related to DV and improve HCPs motivation to take appropriate measures. Based on the results related to the assessment, only a small number of the participants always took the injured woman to a private room. The WHO prioritizes the privacy and confidentiality of patients.[17] In many cases, because of shame or to prevent more quarrels among family members, the victims avoid talking about DV in the presence of HCPs. Thus, it is necessary to preserve patients' privacy. As can be seen a small number of the participants took this subject into consideration. Therefore, the causes of this issue must be identified and the staff must receive suitable training related to professional and ethical issues.

More than half of the participants never evaluated victim's decisions after leaving the hospital. According to a study carried out in Virginia, America, one of the decisions which a DV victim may take is to leave the house and become homeless, which leads to adverse effects and social damages.[18] Their bad decisions may even result in suicide or homicide.[19] Based on the San Francisco practical protocol for clinicians, before patients leave the clinic, they should be asked the following questions to determine their decisions: (1) If you return home now, will you be in danger?; (2) What type of help would you like?; (3) What action are you ready to take?; (4) How might we help?; and (5) Have you had any thoughts of harming or killing yourself)?[20] Nevertheless, the results of the study showed that the least attention was paid to the victim's decisions after their leaving the hospital. This could be due to a lack of knowledge and skills of the staff for effective communication with DV victims, lack of sufficient time for more evaluations, cultural community conditions, and lack of practical instruction for HCPs which can be the most important cause. Overall, the performance of the

Table 2: Frequency of assessment, healthcare providers' intervention, documentation, healthcare providers' reference, and follow-up regarding domestic violence (*n*=300)

Item	A/O *N* (%)	N/R *N* (%)	Total *N* (%)
Assessment			
To assess and examine the victim, I take her to a private room	214 (71.30)	86 (28.70)	300 (100)
When I visit a victim of DV, I take a complete history of DV from her	279 (93.00)	21 (7.00)	300 (100)
When I visit a victim of DV, I perform a complete physical examination	255 (85.00)	45 (15.00)	300 (100)
I evaluate the physical and mental effect of DV on the victim	259 (86.30)	41 (13.70)	300 (100)
I ask the victim whether she is at risk of physical and psychological damage	278 (92.70)	22 (7.30)	300 (100)
I ask the victim whether she has children or whether other close relatives are exposed to physical and psychological violence	200 (66.70)	100 (33.30)	300 (100)
I ask the victim whether she has been thinking about suicide or homicide	193 (64.30)	107 (35.70)	300 (100)
I ask the victim what help she needs, if she would like to change something, and what she is prepared to do	207 (69.00)	93 (31.00)	300 (100)
I ask the victim what her reaction is at the time of DV	216 (72.00)	84 (28.00)	300 (100)
I ask the victim questions regarding the existence of previous physical and mental health injuries in the victim, her children, or other close relatives	184 (61.30)	116 (38.70)	300 (100)
I ask the victim questions on the impact of previous injuries on her physical and mental health, or that of her children or other close relatives	176 (58.70)	124 (41.30)	300 (100)
I evaluate the victim's decisions after leaving the hospital	116 (38.70)	184 (61.30)	300 (100)
Intervention			
In dealing with the victim of DV, I use sympatheticwords	195 (65.00)	105 (35.00)	300 (100)
I perform the necessary actions to cure the physical damages	252 (84.00)	48 (16.00)	300 (100)
I assure the victim that all information will remain confidential	272 (90.70)	28 (9.30)	300 (100)
If the victim consents to solving the problems, I will get help from her close relatives	208 (69.30)	92 (30.70)	300 (100)
I will notify the police if it is necessary	208 (69.30)	92 (30.70)	300 (100)
I will get help from hospital disciplinary personnel to secure the victim and her children	232 (77.30)	68 (22.70)	300 (100)
I will get help from other members of the healthcare team if needed	266 (88.70)	34 (11.30)	300 (100)
Documentation			
I mark the victim's physical trauma on a "Body Map."	157 (52.30)	143 (47.70)	300 (100)
I record the type, size, and color of the trauma	233 (77.70)	67 (22.30)	300 (100)
I use abbreviations to preserve confidentiality	219 (73.00)	81 (27.00)	300 (100)
I record demographic information, and the exact date and time of the visit	266 (88.70)	34 (11.30)	300 (100)
I record the victim's diseases and other problems	273 (91.00)	27 (9.00)	300 (100)
I record all actions performed for the victim	282 (94.00)	18 (6.00)	300 (100)
I record how I visited the patient and her clothing situation	243 (81.00)	57 (19.00)	300 (100)
I record the vehicle that carried the victim and its information precisely	217 (72.30)	83 (27.70)	300 (100)
Reference			
I refer the victim to social emergency or social workers	226 (75.30)	74 (24.70)	300 (100)
I refer the victim to a psychologist or psychiatrist	266 (88.70)	34 (11.30)	300 (100)
I refer the victim to the legal authorities	231 (77.00)	69 (23.00)	300 (100)
I provide the victim with a list of centres that provide social services or pamphlets on DV	126 (42.00)	174 (58.00)	300 (100)
Follow-up			
I follow the victim's behavior at home and work	44 (14.70)	256 (85.30)	300 (100)
I follow the behavior of her children at home and school	43 (14.30)	257 (85.70)	300 (100)
I ensure the victim's and her children's safety	49 (16.30)	251 (83.70)	300 (100)
I ensure her access to sources of support	62 (20.70)	238 (79.30)	300 (100)

**A/O: Always/Often; N/R: Never/Rarely

participants in the present study in the area of assessment was average. However, in a study conducted in the UK, performance was weak; only 40% of the participants asked the victims if they were abused.[16] The results of the study showed that this was due to lack of confidence and poor knowledge of participants in identifying and managing women experiencing DV. Thus, through increasing their knowledge, HCPs can improve their assessment of DV victims. In addition, requesting assistance from other medical teams and ensuring patients' confidentiality was the most reported intervention. Expressing sympathy with the victim was ignored by the participants. In addition, the

ability to continue supporting the victim is an important component of care. Sympathizing with DV victims causes the victim to confide in HCPs and cooperate in treatment.[21] One reason for not offering sympathy to DV victims may be the lack of effective communication skills that could mostly be solved by training sessions. To inform the police is one of the interventions that may be controversial; however, a national instruction would solve this issue. The findings revealed that 69% of the participants informed the police when they came into contact with a victim of DV. Similar outcomes were found in a study carried out in Malaysia.[12] It is worth mentioning that any intervention should be guided by the principle of "do no harm" and prioritization of the safety of women and their children as the utmost concern.[17] An effective consultation with the victim and her family can lead to the right intervention.

In the documentation, the measure least taken was the marking of trauma on the "Body Map." It is important to document injuries because the injured may later wish to use it in law enforcement.[22] The participants reported that documenting the demographic characteristics of the injured, date and time of the visit, and the actions taken are the most important measures they had taken for the victim regarding documentation. It seems that the consideration of documentation by HCPs results from the control and supervision of the Ministry of Health. The outcomes of a similar study showed that documentation was conducted completely, and HCPs had taken photos of injuries when permitted by the victim.[14] In Iran, it is not common to photograph injuries except in special cases which have led to fatal injuries. Although our participants' documentation was good, another study in Iran reported poor documentation.[8] The difference between the findings of the present study and the above mentioned study may be due to the lack of a practical national DV protocol in Iran or differences between the studied populations. However, it appears that a national protocol is necessary to create harmony in the health system.

The results revealed that over 70% of the participants had referred victims to social workers, psychiatrists, psychologists, and at times legal authorities. Contrary to the findings of the current study, reference was weak in two similar studies.[8,16] When assessment is combined with appropriate referral to services and training, the incidence of DV may reduce and women's health can improve. Thus, HCPs can help victims by providing them with pamphlets and a list of centres. Nonetheless, only few participants reported giving information to the victims of DV. This may be due to unavailability of pamphlets or lack of HCPs' knowledge about service resources. Preparing a DV pamphlet and training HCPs can ease this shortage, and thus, increase victims' knowledge.

Furthermore, the results of the present study are in line with the results of a study carried out in Tehran. It was shown that participants had a weak performance regarding follow-up through phone calls or revisits.[8] It may be suggested that more attention be paid to follow-up in Iran. According to the protocol of the WHO, the victim should be followed up by phone or follow-up appointments at least once after the last act of violence. The next follow-up can prevent DV and create confidence in the victim.[23] The participants of another study stated that they were not trained regarding DV and that a large group of them were unaware of service resources.[16] Therefore, adequate training would improve performance. The lack of a national protocol in Iran, time constraints, and differences in attitude and culture result in conflicting performance regarding DV victims. Accordingly, employing a specialized group (physicians, nurses, and midwives) and codifying a national protocol to treat DV can improve the performance of HCPs and the health of women and society. Because of observational bias and other problems, we could not assess HCP performance directly.

Conclusion

Based on the findings of the study, it can be stated that the performance of HCPs regarding DV is not satisfactory. Because emergency and maternity wards as the first line of treatment and support can manage and control DV, their strategies and supports can reduce both the incidence of DV as well as its medical, social, and public health effects. Therefore, to improve women's health and reduce DV in the society, a national standardized protocol should be codified and HCPs should receive training on this protocol.

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Conflicts of interest

Nothing to declare.

References

1. Utah Department of Health, Utah Domestic Violence Coalition, Clinical Guidelines for Assessment and Referral for Victims of Domestic Violence: A Reference for Utah Health Care Providers. 3rd ed. 2013. p. 1-33.
2. World Health Organization, Global and regional estimates of violence against women: Prevalence and health effect of intimate partner violence and non-partner sexual violence, WHO Library Cataloguing-in-Publication Data; 2013. p. 2-33.
3. Sarkar N. The cause and consequence of domestic violence on pregnant women in India. J Obstet Gynaecol 2013;33:250-3.
4. National Center for Injury Prevention and Control Centers for Disease Control and Prevention, The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report, Atlanta,

Georgia, 2011. p. 1-113.

5. Khatun MT, Rahman KF. Domestic violence against women in Bangladesh: Analysis from a socio-legal perspective. BEJS 2012;9:19-30.
6. Dalal K, Lindqvist K. A national study of the prevalence and correlates of domestic violence among women in India. Asia Pac J Public Health 2012;24:265-77.
7. Mousavi SM, Eshagian A. Wife abuse in Esfahan, Islamic republic of Iran, 2002. EMHJ 2005;11:860-9.
8. Rasoulian M, Shirazi M, Nojomi M. Primary health care physicians approach toward domestic violence in Tehran, Iran. Med J Islam Repub Iran 2014;28:148.
9. Hajnasiri H, Ghanei Gheshlagh R, Sayehmiri K, Moafi F, MF. Domestic violence among Iranian women: A systematic review and Meta analysis. Iran Red Crescent Med J 2016;18:e34971.
10. García-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts C. WHO multi-country study on women's health and domestic violence against women. In: Organization WH, editor. Initial results onprevalence, health outcomesand women's responses Claudia. Geneva, Switzerland: World Health Organization; 2005. p. 1-118.
11. Franchek K, Duncan L, Searle N. Clinical guidelines for assessment and referral for victims of domestic violence: A reference for Utah Health Care Providers: A reference for Utah Health Care, Salt Lake City, UT; 2008. p. 1-44.
12. Othman S, Adenan NA. Domestic violence management in Malaysia: A survey on the primary health care providers. Asia Pac Fam Med J 2008;7:2.
13. Fawole OI, Yusuf B, Dairo M, AF. Intimate partner violence and primary health care workers: Screening and management. Niger Postgrad Med J 2010;17:138-46.
14. Kohler S, Höhne A, Ehrhardt M, Artus J, Seifert D, Anders S. General practitioners and managing domestic violence: Results of a qualitative study in Germany. J Forensic Leg Med 2013;20:732-5.
15. Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: A qualitative study of primary care practitioners. Br J Gen Pract 2014;64:e313-20.
16. Ramsay J, Rutterford C, Gregory A, Dunne D, Eldridge S, Sharp D, *et al*. Domestic violence: Knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. Br J Gen Pract 2012;62:e647-55.
17. World Health Organization. Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines. In: WHO, editor. Geneva, Switzerland: World Health Organization; 2013. p. 1-68.
18. Wilson PR, Laughon K. House to house, shelter to shelter: Experiences of black women seeking housing after leaving abusive relationships. J Forensic Nurs 2015;11:77-83.
19. Ohio Domestic Violence Network, the National Health Care Standards Campaign Committee Ohio Chapter, 2003, The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care, Revised by the Project Connect Protocol Committee, 2012.
20. San Francisco Medical Society San Francisco Domestic Violence Health Care Protocol, developed by the Family Violence Council Intimate Partner Violence, A Practical Approach for Clinicians, 2012.
21. Liebschutz JM, Rothman EF. Intimate-partner violence-what physicians can do. N Engl J Med 2012;367:2701-3.
22. Etheridge A, Gill L, McDonald J. Domestic violence toolkit for Health Care Providers in BC. British Colombia (BC); 2014. p. 1-30.
23. World Health Organization, Violence prevention the evidence, Series of briefings on violence prevention, WHO Library Cataloguing-in-Publication Data; 2010.