Family Practice 2012; **29**:189–195
doi:10.1093/fampra/cmr061
Advance Access published on 5 September 2011

Help-seeking behaviour of Serbian women who experienced intimate partner violence

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Received 24 February 2011; Revised 19 July 2011; Accepted 28 July 2011.

Objective. This study aimed to identify whom women in Serbia approach for help in case of intimate partner violence (IPV), their reasons for seeking help and their satisfaction with the received help.

Methods. A cross-sectional, population-based household survey of a random sample of women aged 15–49 years was conducted in Belgrade (WHO Multi-country Study on Women's Health and Domestic Violence against Women). A standard questionnaire was administered by trained interviewers through face-to-face interviews.

Results. The questionnaire was completed by 1456 women and 1196 of them ever had an intimate partner. Almost one in four ever-partnered women reported experiencing either physical and/or sexual violence, at least once in their life. Among these abused women, ~22% had ever sought help from formal institutions. Police and health services were most commonly approached (12% and 10% of abused women, respectively). Satisfaction with services was highest for health services and legal advice and lowest for police and social services. Women sought help especially when violence had a severe impact on them or when they saw that their children suffered. Women who did not seek help stated that they believed that the violence was bearable or had ended. Other reasons for not seeking help were fear of undesirable consequences of seeking help and lack of trust in institutions.

Conclusions. From the abused women's perspective, health care services are the institutions with the highest potential to help women in cases of IPV. Developing a comprehensive health sector response is of critical importance to ensure appropriate care and referral.

Keywords. Health care professionals, help-seeking behaviour, intimate partner violence, satisfaction, violence against women.

Introduction

Between 15% and 71% of women worldwide have ever experienced partner violence, according to the WHO Multi-country Study on Women's Health and Domestic Violence (a study conducted among >24 000 women in 10 countries, including Serbia).[1] This global problem is a serious public health challenge. The most common perpetrator of violence against a woman is her male intimate partner.[1] Almost every fourth partnered woman in Serbia (23.7%) experiences physical and/or sexual intimate partner violence (IPV) during her lifespan,[2] but little is known about whether she is seeking help, from whom and why.

Abused women suffer many adverse consequences of the violence, such as health consequences, diminished quality of life and limited working ability.[1,3] Health consequences are not only directly acquired physical injuries and bruises but also the development of a wide range of functional symptoms and diseases, affecting physical, reproductive and mental health.[1,4,5] Sometimes a woman's life or that of her children is in danger and she may need to seek the protection of police, social workers or other resources in the community, such as counselling centres, women's support organizations or religious leaders.[6–9] In addition, recent studies have shown that women's informal social support network, i.e. friends

and family members are the first, and the most important resource where women seek help.[10,11] Many times, however, women hide their violent experiences from everyone, which is known as the 'culture of silence' related to IPV.[6]

There are different triggers or driving forces for women to seek help. Apart from the severity of injuries or threats, important factors are availability of both formal and informal sources for help and women's perception of their effectiveness. Also, personal attitudes towards partner abuse influenced by gender norms in society play a considerable role.[6,12] The identification of patterns of women's help-seeking behaviour, including which support services are most trusted, is important in order to strengthen the response of these services. To date, in Serbia, no study has explored this issue in depth.

The primary aim of this study was to find out where women in Serbia turn to for help in cases of IPV, as well as their reasons for seeking help. Secondly, this study aimed to investigate women's satisfaction with the received help and also to identify women's reasons for not seeking any help.

Methods

A cross-sectional, randomized population-based survey of women aged 15–49 years took place in Belgrade, from March to June 2003, using the methodology of WHO Study on Women's Health and Domestic Violence and implemented by the Women's Health Promotion Centre (a women's non-governmental organization in Belgrade). Serbia was one of the 10 initial countries participating in this study.[1]

Ethical permission for the multi-country study was obtained from WHO's ethical review group (WHO Secretariat Committee for Research in Human Subjects), while a local advisory group oversaw and supported the study implementation.

Study sample

The study sample consisted of women aged 15–49 years living at home in Belgrade. The sampling frame consisted of voter registration lists in Belgrade, covering 11 urban municipalities and ~1 300 000 citizens organized in ~2000 clusters. A cluster is an electorate block pertaining to a polling station, consisting on average of 200 households. Of 2000 clusters, 206 were systematically selected from a geographically ordered list, with a probability proportional to size. Initially, within each cluster, 15 addresses were systematically selected for visits.

For reasons of safety and confidentiality, only one woman per household could be interviewed following the WHO ethical recommendations for research on violence against women.[13] In situations where more than one woman aged 15–49 years lived in a household, the woman selected for the interview was the one whose birthday would come first, from the date of the visit to the household. Prior to interviewing, women had to give verbal informed consent. At the end of interview, every woman received a list with contact details of institutions dealing with violence against women, regardless of whether she disclosed an experience of violence or not.

Data collection

Data were collected through face-to-face interviews. Interviewers were carefully selected on the following criteria: female, ability to engage with people from different backgrounds in an empathic and nonjudgemental manner, emotional maturity, skills to build report and ability to deal with sensitive issues. Interviewers were trained during a 3-week intensive training. The first part of the training covered the following topics: distinction between sex and gender; definitions of IPV, its frequency and characteristics; dynamics of abuse and support systems available to women who experience violence. The second part of training covered interview techniques, role-play simulating difficult situations, such as circumstances that might jeopardize confidentiality, practical application of safety measures as well as familiarization with the questionnaire and survey techniques.[14]

Questionnaire

The questionnaire 'Study on Women's Health and Life Experiences' (Version 10), as developed for the WHO Multi-country Study on Women's Health and Domestic Violence, was used in this study.[15] The original core questionnaire consists of 12 sections. In the Serbian survey, the sections on children (Section 4) and financial autonomy (Section 11) were left out.

In the questionnaire, exposure to physical and sexual IPV was measured using behaviour-specific questions, related to each type of violence. For physical violence, every respondent was asked about the following acts: whether she was ever slapped or had something thrown at her that could hurt her; pushed or shoved; hit with fist or something else that could hurt her; kicked, dragged or beaten up; choked or burnt on purpose and whether the partner threatened to use or actually used a gun, knife or other weapon against her.[16] In data analysis, being slapped or pushed (without the occurrence of any of the other acts) was considered as 'moderate' violence, while being hit with fist, being kicked, beaten up, choked, burnt or threatened with a weapon was considered as 'severe' violence. This distinction was based on the likelihood of physical injury.

Women who reported partner violence were also asked whom they had told about their partners' behaviour (unprompted) and to whom they turned for

help (prompted by providing a list of services). The latter focused on formal sources of support and help including police, health care services, social services, legal services (lawyer), courts, shelters, local authorities, women's organizations and priests. Subsequently, women were asked whether they were satisfied with the help received. Women were also asked to state reasons why they sought help and if not, why not. In the questionnaire, interviewers matched stated reasons with predefined categories of possible reasons, but they were not allowed to read them to women, in order to avoid suggesting certain responses (i.e. unprompted).

Data analysis

Descriptive analysis was done using cross-tabulations. Fisher's exact one-tailed chi-square tests were used to test for statistically significant differences in outcomes between women who reported moderate versus severe violence. For internal consistency (a reliability measure) of the violence measures, Cronbach's alpha coefficients were calculated. All analyses were performed using SPSS version 14.

Results

Response rate

Of 4631 visited households, 2769 households agreed to participate in the household interview (household response rate 59.8%). Of 1638 households with women aged 15–49 years, 1456 women completed the individual interview (individual response rate 88.9%). The rest of the women were unavailable for interview during three consequent visits (5.0%), rejected participation (5.9%) or did not complete the interview (0.1%). Of 1456 interviewed women, 1196 women ever had an intimate partner.

Internal consistency of violence measures

Psychometric analysis performed on the violence questions showed the following Cronbach's alpha coefficients: 0.79 for physical violence, 0.63 for sexual violence and 0.81 for both types of violence combined. This demonstrated that internal consistency of these measures was comparable to those found in other sites in the WHO study.[2] The increased coefficient for the combined variable indicated that sexual violence items contribute to increasing the internal consistency and corroborates the aforementioned patterns.

Lifetime prevalence of physical or sexual partner violence

Of the 1196 ever-partnered women, 23.6% (95% CI: 20.7–26.7) experienced either physical or sexual violence or both, at least once in their life. Physical violence was experienced by 22.7% (95% CI: 20.4–25.2) women, while sexual violence was experienced by 6.3% (95% CI: 4.9–7.7) women. Women who reported to have ever experienced sexual violence almost always also reported physical violence: 5.2% had experienced both sexual and physical violence and only 0.9% women had experienced only sexual violence.

Of those who experienced physical partner violence, one of every three women reported severe acts of violence (35.3%) and 64.7% reported solely moderate acts violence. Of the women who reported severe physical violence, 60.9% also reported sexual violence, whereas, of women who reported moderate physical violence, only 39.1% reported sexual violence in their lifetime.

Formal resources for help

All women who ever experienced physical violence were asked to whom they had turned for help. The women who reported sexual violence only (0.9%) were not included in the analysis on help-seeking behaviours. More than three quarters (77.9%) of women who experienced violence did not seek the help of any formal institution, implying that only 22.1% did. Among women who had ever experienced severe physical violence, 43.7% had sought help, whereas for women who had experienced moderate physical violence, this was much less, only 10.2% (Table 1).

Abused women most frequently sought help from police (12.2%) and health care services (10.0%) (Table 1). Among the severely abused women, the percentages were 22.3% and 24.5%, whereas among the moderately abused women, they were 3.4% and 5.7%, respectively. Severely abused women more often sought help from almost all official institutions compared to those who experienced moderate violence.

Satisfaction with received help

Despite the fact that few women sought help, the data showed that roughly three of four women were satisfied with the help from health care services and legal advice centres (Table 2), irrespective of the severity of the violence. Less than half were satisfied with the help from social work centres. Women were least satisfied with the help of the police (27.3%). It should be mentioned that women who reported severe abuse were even more likely to be dissatisfied with the help from the police than women who reported moderate abuse, though in this case, numbers were too small to reach statistical significance ($P = 0.068$). Only a few women approached courts, women's support organizations or religious leaders. None of the abused women mentioned that they had gone to women's shelters.

Reasons for seeking help and reasons for not seeking help

Women who sought help from any of the formal institutions (22.1% of all abused women) were asked what

TABLE 1 *Help-seeking behaviour of physically abused women, related to the severity of experienced violence*

	Total, *n* (%)	Moderate violence, *n* (%)	Severe violence, *n* (%)	*P* value
Any type of services				
Yes	60 (22.1)	18 (10.2)	42 (43.7)	<0.001
No	212 (77.9)	158 (89.8)	54 (56.3)	
Health care professionals				
Yes	27 (10.0)	6 (3.4)	21 (22.3)	<0.001
No	243 (90.0)	170 (96.6)	73 (77.7)	
Police				
Yes	33 (12.2)	10 (5.7)	23 (24.5)	<0.001
No	237 (87.8)	166 (94.3)	71 (75.5)	
Social service				
Yes	24 (8.9)	7 (4.0)	17 (18.1)	<0.001
No	246 (91.1)	169 (96.0)	77 (81.9)	
Legal advice centre				
Yes	17 (6.3)	6 (3.4)	11 (12.0)	0.008
No	251 (93.7)	170 (96.6)	81 (88.0)	
Court				
Yes	15 (5.6)	5 (2.8)	10 (10.8)	0.009
No	254 (94.4)	171 (97.2)	83 (89.2)	
Women's support organization				
Yes	6 (2.2)	2 (1.1)	4 (4.3)	0.110
No	263 (97.8)	174 (98.9)	89 (95.7)	
Religious leader				
Yes	3 (1.1)	1 (0.6)	2 (2.1)	0.275
No	266 (98.9)	175 (99.4)	91 (97.9)	

TABLE 2 *Women's satisfaction with the received help from the services that they have approached for help*

	Total number, *n* (%)	Severity of violence		*P* value
		Moderate, *n*	Severe, *n*	
Health care services				
Satisfied	20 (74.1)	5	15 (71.4)	0.498
Not satisfied	7 (25.9)	1	6 (28.6)	
Police				
Satisfied	9 (27.3)	5	4 (17.4)	0.068
Not satisfied	24 (72.7)	5	19 (82.6)	
Social service				
Satisfied	9 (39.1)	2	7	0.418
Not satisfied	14 (60.9)	5	9	
Legal advice centre				
Satisfied	13	4	9	0.445
Not satisfied	4	2	2	
Court				
Satisfied	8	2	6	0.343
Not satisfied	6	3	3	
Women's organization				
Satisfied	4	2	2	0.400
Not satisfied	2	0	2	
Religious leader				
Satisfied	2	1	1	0.667
Not satisfied	1	0	1	

Percentage based on fewer than 20 respondents suppressed.

made them seek support. The reasons given by the women were summarized in four main categories: (a) reasons related to severity of violence, (b) reasons related to the impact on children, (c) encouragement by family members and (d) other reasons as presented in Box 1.

As mentioned earlier, a large proportion (77.9%) of women who experienced violence did not seek help from any official service. These women were asked to state reasons why they did not seek help, and the categories of their answers are presented in Box 2. The most frequently mentioned reasons were related to (a) women's ability to deal with the violence themselves. This was either because the violence was perceived not to be serious or the relationship had ended. (b) Fear of undesirable consequences of seeking help was the next most frequently mentioned

BOX 1 *Reasons for seeking help of health care professionals (in brackets are the number of times a certain reason was mentioned)*

Reasons for seeking help
a) Severity of violence
She could not endure more (20)
She had physical injuries or she feared being killed (13)
She was threatened by partner or she underwent an attempt to be killed (3)
b) Children suffered
Her children suffered (6)
Her children had witnessed violence or had been beaten too (3)
c) Encouraged by family member
She was encouraged by family members or friends (5)
d) Other
Because he (the perpetrator) needed treatment (1)
Other reasons (3)

BOX 2 *Reasons for not seeking help (in brackets are the number of times a certain reason was mentioned)*

Reasons for NOT seeking help
a) Violence was 'bearable' or ceased
Violence was bearable/seen as normal/not serious (154)
She ended the relationship immediately (7)
She solved the problem herself (5)
She did not need help (3)
She was <18 years old, her father solved it (1)
b) Fear of undesirable consequences of seeking help
Fear of bringing shame to the family (13)
She was confused/embarrassed/fear of being blamed (9)
Fear that relationship would end (9)
Fear of threats and more violence (7)
Fear of losing the children (4)
c) Lack of trust in institutions
She did not believe that help and support would be received (3)
d) Lack of ability/circumstances to ask for help
She was young and in a foreign country (1)
She was young and far away from the family (1)
e) Self-blame or justification of violence
She thought she was guilty (1)
He was a drug addict (1)
f) Hope that he will change
She believed that he would change (2)

reason. Less often mentioned reasons were (c) lack of trust in institutions, (d) reasons related to barriers to ask for help, (e) self-blame or justification of violence and (f) hope that the partner will change.

Informal sources of help

Women were asked whom they had told about their partner's abusive behaviours. Twenty-nine per cent of the women reported that they had never told anyone about the abuse before they were interviewed in this study. Among women who experienced severe physical violence, the proportion of women who had not disclosed violence was less (26.2%), while among women who experienced moderate violence, it was much higher (66.2%). This indicates that when violence is severe, women are more likely to tell someone. Informal sources such as friends (52.2% of physically abused women) or family members were most often mentioned as the people to whom the women disclosed the violence. The family members were mother (mentioned by 27.2% of abused women), sister or brother (25.7%) and father (12.1%) (Table 3). All informal sources were more frequently mentioned by women who experienced severe violence compared to women who reported moderate violence.

Discussion

The aim of this study was to identify patterns of and reasons for help seeking by women who had experienced IPV in Belgrade, Serbia. We explored whether or not the women who did seek help from official institutions were satisfied with the help received. The results indicate that 78% of abused women did not seek help from institutions at all. The results also show that women who experienced more severe violence were more likely to ask for help. Every 10th abused woman visited health care professionals for help, and among these, three of four are satisfied with the help they received. Although slightly more women mentioned the police as a source of help, only one of four women was satisfied with the support they received.

TABLE 3 *Help-seeking behaviour of informal sources related to the severity of experienced violence*

Informal sources of help	Total number, n = 272 (%)	Moderate, n = 176 (%)	Severe, n = 96 (%)
Friends	144 (52.2)	91 (51.7)	53 (55.2)
Mother	74 (27.2)	40 (22.7)	34 (35.4)
Sister or brother	70 (25.7)	39 (22.1)	31 (33.3)
Father	33 (12.1)	17 (9.6)	16 (16.6)
Partner's family	17 (6.2)	7 (4.0)	10 (10.4)
Neighbours	12 (4.4)	6 (3.4)	6 (6.2)
Aunt or uncle	5 (1.8)	4 (2.3)	1 (1.0)
Children	5 (1.8)	2 (1.1)	3 (3.1)
No one mentioned	80 (29.4)	53 (66.2)	21 (26.2)

In other countries in the WHO Multi-country Study on Women's Health and Domestic Violence, the percentage of women who had never sought help from agencies or authorities varied between 55% and 95%.[9] In the WHO study, help seeking from health care professionals was highest (>20%) among abused women living in urban areas of Namibia and Tanzania. However, in these countries, the incidence of violence (i.e. proportion of women who experienced violence during the last 12 months) is higher (19.5% and 21.5%, respectively) than in Belgrade (3.7%). Increased incidence of violence might cause prolonged stress, development of functional diseases and injuries and therefore increase women's needs for health care services and seeking help.

A relatively high percentage of abused women who sought help at health care services in Belgrade indicated that they were satisfied with the services. This can be interpreted that health care services are credible and trusted sources of help. They present a potentially valuable entry point to identify abused women and to respond to violence by providing appropriate support. This is corroborated by the findings from a qualitative study conducted in the same environment and population that showed that health professionals in Belgrade largely expressed an empathetic and supportive attitude towards abused women.[17]Additionally, findings from other studies conducted in Belgrade and also other settings worldwide, on women's views and experiences with health care providers, confirmed that most women appreciated the role of health care providers.[18–20] Our study again highlights that in Belgrade health care professionals are perceived as persons of trust, that patients are generally willing to share their private matters with them and that patients will ask for help or advice, in case of IPV.

Though less commonly used, a comparably high level of satisfaction was seen with legal advice centres. However, women's needs and expectations from physicians and legal advice centres might differ substantially. While women seek help of health care professionals mainly related to their health problems, help from the legal advice centres is usually sought when women want to leave the violent relationship. In addition, women differ in their capacities, willingness and timing to leave an abusive partner and relationship, which is explained by the stages of change theory.[21,22]

Health care professionals will see women at all stages of the process of dealing with partner abuse. They have to realize that women's disclosure of IPV does not necessarily mean that they are ready or willing to end the relationship. Nevertheless, it is an opportunity to inform them about available sources for further help, but without judging or insisting on certain actions, which may cause more harm than good.

The results on the reasons for seeking help suggest that the severity of violence and the impact of the violence on children are the most important triggers for women to seek help after experiencing IPV. This is consistent with the findings coming from population-based studies conducted in New Zealand and Bangladesh.[23,24] It has practical implications that every professional who deals with abused women has to keep in mind: always ask about the children and assess their safety. Children's well-being and safety are very important to women and the need to protect them might be the strongest drive for change and/or leaving the abusive partner.[22]

Among women who never sought support from formal institutions, the main reason for not seeking help were that they did not consider the violence serious enough and/or that they thought that they are able to deal with the situation themselves. Other studies show that some women manage to end the relationship after the first slap, especially if it happens at the beginning of the relationship,[25] being aware that violence has a tendency to gradually increase over time, exercising partner's control and power over women.[26]

A limitation of our study is related to the assessment of the women's satisfaction with the help they received. We did not investigate what they had actually expected of these services and why they were satisfied or not with the received help.

The strength of our study is that the results are coming from a well-organized, cross-sectional survey conducted in the general population using a validated and well-tested methodology. It allows generalizability of findings on the prevalence and patterns of IPV in Belgrade and thus allows us to see how many cases do not come to the attention of health services and other institutions. The results show that behind each known identified 'case' of violence by health care professionals, there are ~10 women who are suffering violence 'in silence'. These findings call for action towards a structured and better articulated response from health care professionals. We also recommend an active role of health care institutions in identifying abused women.

For the time being in Serbia, health care professionals play a role merely in medical treatment of the consequences of violence. Along with providing treatment, health care professionals should also be trained to recognize potential signs and symptoms that are consistent with experiences of IPV, even though women may not disclose what happened to them. They should learn how to respond appropriately: how to inquire about abuse, document this abuse and provide referrals to the relevant agencies.[27] Otherwise, they might miss the opportunity to save a woman's life, as many times IPV might have a fatal outcome.[1] Other consequences, such as depression, suicidal thoughts or posttraumatic stress disorder related to IPV may also be dealt with inappropriately if not properly recognized as related to IPV.[1] These problems require health care professionals' full attention and a multidimensional approach in treatment, based on the awareness that women's personal experiences were major triggers in the development of these illnesses.

There is an on-going international debate as to what an appropriate health care professionals' response to IPV should consist of.[27,28] Acceptability of screening all women for IPV was studied and results indicated that most female patients considered screening acceptable (range 35–99%), whereas acceptability of partner violence screening among health care professionals ranged from 15% to 95%. Although such an intervention might be potentially cost-effective, there is not sufficient evidence to support this.[29] However, there is a wide consensus that keeping the possibility of violence in mind and asking about it without hesitation when it is highly suspected, should be the minimal criterion and an opportunity to make a difference in providing care for all women.[28,29]

Acknowledgements

This study was part of the WHO-Multi country study on Women's Health and Domestic Violence conducted in 10 countries worldwide and in Belgrade, Serbia, implemented by the Women's Health Promotion Centre and funded by Trocaire, Ireland. We would like to thank all the women who agreed to be interviewed, as well as the field staff (interviewers and supervisors) for the fieldwork. Authors are grateful to Elizabeth King, PhD, Yale University, USA, who kindly completed English language editing.

Declaration

Funding: The Ministry of Science and Technological Development of Serbia. Project No (175025).
Ethical approval: WHO Secretariat Committee for Research in Human Subjects.
Conflict of interest: none.

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