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Bridging Prevention and Health: Exploring Community Perceptions of Intimate Partner Violence in Rural Honduras

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Abstract

This qualitative study rooted in community-based participatory research principles utilized semi-structured interviews with 2 focus groups ($n=9$) with female healthcare volunteers (FCVs) and 3 male key informants who were community leaders (MCLs). The study aimed to examine how a rural Honduran community defines and responds to intimate partner violence (IPV) in order to lay the foundation for future interventions. Based on grounded theory, the authors assessed for common themes across transcripts. Authors found that a number of participants denied the existence of IPV. Perspectives on the causes and definitions of IPV varied between FCVs and MCLs. All participants affirmed the need for intervention and many participants mentioned healthcare and legal systems as potential venues to ameliorate IPV. The results highlight potentially important differences between FCV and MCL perspectives that may inform future interventions. Findings suggest health-care workers can play a role in IPV prevention and intervention in rural Honduras.

Keywords

Domestic violence; Intimate partner violence; Latin America; Honduras; Rural; Community health

The morbidity and mortality of intimate partner violence (IPV) have been documented on an international level. A 2006 World Health Organization (WHO) multi-country study found that a woman's lifetime prevalence of physical or sexual partner violence ranged from 15 % to 71 % with most jurisdictions falling between 30 % and 60 % (Garcia Moreno et al. 2006). Further research specific to Latin American women in the United States found that lifetime IPV prevalence rates among this group remain high, despite acculturation. For example, in Indianapolis, estimates are as high as 51 % (Fife et al. 2008), with North Carolina reporting 19.5 % (Denham et al. 2007).

Adverse health consequences of IPV range from physical injury to mental illness. Female victims of IPV are more likely to experience physical injury, depression, substance abuse, attempted suicide, homicide, perinatal complications, and chronic pain (Champion 1998). IPV takes on a unique dimension in rural communities where systemic IPV sequelae include decreased access to resources, poverty, and geographic and social isolation (Chamberlain 2002; Johnson 2000). Women in rural areas also report slower responses from the criminal justice system. The challenging social context and enmeshed relationships in rural jurisdictions further contribute to the designation of rural women as a hard to reach and difficult to treat population (Bunch, and Eastman 2004).

Despite the breadth of research highlighting IPV as a global public health issue, there is a paucity of literature on IPV in rural Latin America and in the Central American nation of Honduras. A nation of approximately 8 million inhabitants, Honduras is described as having an unequal distribution of income and is ranked as the second poorest nation in the Western Hemisphere (The World Factbook. 2009). Given the frequent associations between poverty and IPV, it is imperative to begin understanding the prevalence and potential responses to IPV in Honduras. This paper fills an important gap in the literature by examining community residents' perceptions about both of these issues. The potential implications of this research extend beyond Honduras by highlighting the unique issues pertaining to IPV in Latino and rural communities across the globe.

Background

In 2004, the University of Rochester School of Medicine Department of Family Medicine (UR-DFM) partnered with Shoulder to Shoulder, a non-governmental organization (NGO) and a rural community named San José, San Marcos de la Sierra in the Southwestern state of Intibucá in Honduras. San José includes seven villages and approximately 2,000 residents. Most homes have no running water, no sanitation, and no electricity. The nearest medical facility requires a 1 to 3 h walk. Most households have a per person income of less than \$1 a day, and there is a high prevalence of child malnourishment (Hagen 2008). In response to these disparities, the collaboration aimed to develop and implement an ongoing community health project with an emphasis on community development and sustainability. Curative medicine is a means through which community partnership has been established with UR-DFM, but is not the sole focus. Public health education is concurrent with treatment of acute disease and improvements in water sanitation, the introduction of an improved vented cook stove, and educational supports such as teacher training and scholarships.

Since commencing the project, UR-DFM conducted an internal needs-assessment survey that demonstrated both alcoholism and IPV as the primary psychosocial issues affecting the community of San José. After consultation with UR-DFM, the primary investigator (PI) chose to pursue further investigation of IPV with members of the San José community as an expansion of the existing project into the realm of psychosocial interventions. In sum, this study was designed to explore local perceptions and experiences of IPV, as well as to identify ideas for a prevention program that could include diverse members of the community.

Method

Research Design

The setting of a rural Honduran community with an academic partnership is well suited to a Community Based Participatory Research (CBPR) approach to equalize the power structure and facilitate an action-oriented research process. CBPR methods are grounded in the concepts of social action and change and are considered an ethical approach to research

within the historical context of discrimination against disadvantaged communities (Israel et al. 2005). Since CBPR emphasizes an equal partnership between researchers and community members, gaining the trust of the community is considered a common challenge of the CBPR approach (Christopher et al. 2008). At every step of the CBPR process, the researchers respected community members as key informants and considered local customs and hierarchies. CBPR has been successfully adapted for IPV research in the past. For example, in a similar study examining perceptions of IPV amongst Samoan women, CBPR was used to address concerns regarding exploitation and questions of skepticism amongst community members (Magnussen et al. 2008). The CBPR approach also aligns with research on IPV prevention in non-Western societies, (Haj-Yahia and Sadan 2008) which suggests that prevention efforts can honor culture and foster community resilience, thus facilitating the building of cultural pride rather than perpetuating judgment or exploitation (Parks et al. 2007).

The researchers discussed the issue of IPV with partners in both Honduras and Rochester to inform the implementation of the study. Consultation took place informally with community leaders and Honduran-based translators to gather information about cultural norms, community hierarchies, and gender roles that were pertinent to the research.

The study involved both female and male participants to gain a broad perspective of the scope and nature of IPV within the community and to respect gender roles. Female community healthcare volunteers (FCVs) included a community health worker and local midwives (madreguías) comprising focus group participants. Male community leaders (MCLs) were included as key informants in accordance with community hierarchies and to obtain broad input.

In 2007, UR-DFM began working with the midwife group, which came to be known as the “madreguías,” translated to “Mother-guide” in Spanish. The Madreguías work as midwives and distributors of folic acid to women of childbearing age in the community. The group was considered an ideal choice for female participants due to existing literature that identifies reproductive health as an appropriate avenue for IPV research and prevention (Castro et al. 2008; McCarraher et al. 2003). In addition, the Madreguías have unique access to individual homes due to their travel on foot providing reproductive healthcare in the rural, mountainous, and difficult to traverse geography of the San José region.

The research team strived for a cooperative relationship between researchers and the community. To ensure sustainability and according to CBPR strategies, investigators advised participants that an analysis of their responses would be presented to them for further input, and that their participation would inform the design and implementation of violence prevention efforts.

Focus Group and Interview Process

The Institutional Review Board (IRB) at the University of Rochester approved the study and considered it exempt as observational research. Given research suggesting broad flexibility on ethical standards of informed consent in the developing world and the low risk of the study, formal consent was neither required by the University of Rochester IRB, nor obtained from participants (Hyder and Wali 2006). In lieu of formal consent, all participants were recruited using an information letter and an oral explanation of the study, which included an explanation that participation was completely voluntary. All written materials were translated from English to Spanish by a post-doctoral level physician and back translated to ensure accuracy.

While focus group participants were recruited from an existing list of FCVs, three additional MCL key informant interviewees were identified by UR-DFM leadership, in consultation with the community. Focus groups were designed for 7–10 women and conducted in three one-hour sessions over the period of two days with the same group each time. Three one-hour interviews were conducted with individual male community leaders from a wide selection of villages within the San José community. The groups and interviews were limited to discussion between focus group participants, facilitators and translators. Community members at large did not participate.

The PI acted as facilitator and interviewer for the focus groups and interviews. He trained for this role through mentorship and research sessions conducted by the Laboratory of Interpersonal Violence and Victimization at the University of Rochester School of Medicine. The PI met with the translators in advance of the interviews and focus groups to discuss the topic and plan the nature of translation. While the translators lacked formal training in translation techniques, both were fluent in both Spanish and English and had previous experience working with the San José community. One translator was a first year medical student in Northern Honduras at the time of the focus groups, and the other was an undergraduate student.

Data Collection

Participants verbally provided their age, village of residence and whether they were literate. At the beginning of the sessions, the PI read a standardized introductory statement and used a discussion guide that was adapted from (Clark et al. 2005; see Table 1). Prior to the sessions, the PI used the discussion guide to maintain focus, however, remained open to group responses and attempted to direct discussion while allowing for a spontaneous exchange of ideas.

The focus groups and interviews were recorded using a digital audio recorder and were transported from Honduras to Rochester in a secure receptacle. The audio recordings were simultaneously translated and transcribed by a doctoral level student, prior to data analysis. Before coding, all identifying information was removed from the transcripts and each participant was assigned a number.

Data Analysis

Once transcribed, the PI reviewed the texts together with the audio recordings and notes taken during the focus groups and compared them to the translation to ensure that the transcripts correctly reflected the focus groups and interviews. During the coding process, grounded theory (Allan 2003) and ATLAS.ti were used to derive salient concepts (Creswell and Maietta 2001). The authors conducted a qualitative thematic analysis of the three hours of focus groups and the three key informant interviews. They used key words, phrases and themes to iteratively create a coding system for focus group dialogs and informant interviews. Once coding was complete, transcripts were re-coded until saturation was achieved with differences resolved by majority. Observations were made regarding the process of the focus groups and interviews. The authors focused the analysis on areas that the community identified as important and could form a basis for further prevention and knowledge regarding IPV. The codes were divided into categories, and subcategories (Table 2). Codes were then developed into overarching themes, using ATLAS.ti level 1, 2, and 3 coding and supercoding.

During the writing of this paper, preliminary findings were presented by BAG to several study participants to engage in a triangulation process (Gilchrist 1999). Overall, participants agreed with the findings.

Results

Balancing Denial and Minimization

When initially prompted regarding IPV, some FCV and MCL participants expressed outright denial. While most participants acknowledged the existence of IPV, a number of them minimized the existence of IPV in their own homes and families. FCVs acknowledged that IPV exists in general, but denied it within their particular families and communities of residence.

Let me tell you about my case. In my case, at home, with my husband, I have no problems. Thank God, we live happily. (FCV 3)

I would say that domestic violence exists. Although we have been exposed to the opinion that domestic violence is bad, there are other women who are not here that would likely say otherwise. Many of these other women are involved in domestic violence. (FCV 2)

Denial was more commonly noted amongst MCLs:

I would like to tell you in my community that doesn't happen. There are some small offenses but they are punished and it doesn't happen again. (MCL 3)

Key Barriers to Intervention

Some FCVs noted that fears of disclosing violence or seeking intervention inhibit victims from coming forward. They described fears of repercussions from the perpetrator, stigma from the community, and inaction or punishment from the legal sector.

Some women are afraid because if their husband is the perpetrator, they have to live with him. They have fear of their husband's hating them more, hitting them more or insulting them more. They are afraid of putting up with that. (FCV 2)

Many women do not look for the authorities because of fear. They remain quiet, suffering silently with the violence. (FCV 1)

Several participants commented on barriers to intervention including the concept that IPV is a private issue. All three of the MCLs commented on privacy, and noted that IPV takes place between individuals in the home, thus making it difficult for community members to become involved in prevention.

People think that it is best to not get involved in others' business. In the school, the teachers can get involved and sometimes they try to talk about it. The problem is when it's not in school, I am not sure of what we can do to stop this. (MCL 2)

Disparity Between FCV and MCL Perspectives

Despite some areas of agreement, differences between FCV and MCL perspectives on the types, causes and effects of violence emerged. In particular, FCV definitions included control and sexual violence. Examples of control included men preventing women from participating in meetings or other activities outside of the home.

I consider myself a leader of the community. For example, I may tell my husband that I am going to a meeting and he says, 'why are you going there? You have things to do at home.' By doing that men take away the first step for a woman. By controlling us they commit violence against us because we may want to listen to the message of community meetings. (FCV 4)

In contrast MCL definitions of IPV did not mention the use of control as a form of psychological abuse. MCLs more generally addressed physical and psychological abuse and their effects:

I would say that violence is both physical and psychological. When it's physical, it is a direct hit to the body. Psychological violence can be committed with thoughts. (MCL 1)

Multiple FCV participants cited sexual violence as a type of IPV. None of the MCLs noted sexual violence.

In some marriages, men come home drunk and they want to have sex with their woman, even though she may not want to. And I think that women's rights can't be treated that way because there needs to be mutual respect. If the man comes home drunk, she shouldn't have to sleep with him. She may even contract a sexually transmitted disease. (FCV 2)

FCV and MCL responses also diverged on causes of IPV. Both FCVs and MCLs cited alcohol as a potential cause, however FCVs, reflected upon the role of cultural norms and gender roles in the perpetuation of violence.

The culture here in Honduras, is men-centered. Here the men direct and get married so the woman can stay home taking care of the house, and they are the ones going out. We were once told in church that we as mothers make little boys violent. For example, when little boys fall and cry, then we as mothers say something common: 'why are you crying? You're not being a man.' In that way we are being violent towards that little boy. (FCV 1)

Conversely, MCLs mentioned jealousy, lack of understanding, rumor and gossip as a cause of IPV:

The problem is that some people do not understand what people say, and so they get upset when they hear it. This is a problem that is usually affected by jealousy. (MCL 2)

Interventions

FCVs and MCLs had similar views regarding interventions. They described the importance of police and judicial officials in addressing IPV. They also noted the importance of preventive education and the role of the health sector in providing such information. Participants described limitations of the legal response system, including access, consequences and effectiveness.

They helped me, because as I wanted to separate, all he wanted to do was to get me out of the house. The court told us that I was not supposed to leave the house; that it was him who was supposed to leave the house. (FCV 2)

Laws are not enforced here. Even if you kill somebody you are safe. The one who ends up going to jail is the one who has not killed anyone. That is why I say that here in Honduras we will never bring ourselves together. (FCV 3)

The police always fine you. When you arrive and say there's a problem, and you don't have proof (physical proof or bruises), they think you're lying. They fine him if you have proof but otherwise they don't do anything. In domestic violence that is the problem, you have a witness or admission of guilt, because if they can not prove that violence occurs, they can't do much. (MCL 2)

Participants cited education as a tool for violence prevention. In particular, FCVs suggested that prevention should begin at an early age and include both women and men.

We can gather groups of people starting with children. First we would educate adults, but then you have to start incorporating the children to include all members of the household. The children are the ones learning by example...If our children were here today they could have started learning some thoughts and ideas. (FCV 5)

The first education would be done at home, so that children can go and learn good things at school. But it is up to the parent who has to educate the children. If the parents cannot provide a proper education then the child can learn to recognize bad things. If the father goes around drinking, so will the children. (FCV 2)

Health as a Means to Prevention and Intervention

Participants noted that preventive education could be incorporated within existing public health activities. FCVs saw their roles as community health volunteers as starting points for intervention. Both FCVs and MCLs described healthcare as part of a continuum of prevention and intervention.

The problem is if they go to a health center then people can lie to the community health worker. If someone gets beaten and goes to a doctor, they still have to report this. They still have to go to a judge. You only go to the health center for a talk or for medicine. Then they can go to the judge or police and both people can intervene. (MCL 2)

Some participants suggested that education could be incorporated as a part of other public health activities such as government weighing programs, referred to as 'weigh-ins' where babies are weighed and parents are compensated for adequate growth by the federal government.

I think education can be done in meetings at schools, in weigh-ins and where young people are. We provide counseling for mothers during the weigh-ins, but we have not introduced the topic of domestic violence. We can start doing this from now on. (FCV 1)

Discussion

Key findings in this study included the tension between denial and acknowledgement, varying views between the FCVs and MCLs, and the role of healthcare providers in amelioration. Several participants accepted the existence of IPV in the community at large, with a simultaneous denial of its existence within the participant's home or family. Even when IPV was acknowledged, there was minimization of the problem. In addition, there were disparate FCV and MCL definitions and causes of IPV. FCVs emphasized control-based and sexual violence while MCLs defined IPV as having psychological and physical dimensions. FCVs saw cultural and gender norms as having a strong influence while MCLs felt that IPV was caused by jealousy, rumor and gossip. These differences are set amongst two unique groups of participants at varying levels in the community hierarchy. Despite their roles as community healthcare volunteers, the low literacy rate and relatively low community status of the FCVs as women are likely to influence their perspective. Responses from the FCVs on control-based violence and the influence of gender roles and cultural norms reflect a sense of immediacy as IPV has a pervasive influence on these participants' lives and those of the women they serve. In contrast, as community leaders, male participants have a predefined role with higher levels of literacy and status and did not describe direct contact with IPV.

Further, the disparity in FCV and MCL definitions and causes also emphasize the importance of education and the involvement of varied genders and social roles in the design and execution of prevention programs. These differences suggest that education and

prevention programs should be designed uniquely for target audiences. In this study, men were from the privileged class. Further research is needed to determine the role of gender and class in this context. Others have found that while females perceive male privilege and control as a significant contributor to IPV perpetration, males perceive traditional definitions of IPV (physical and psychological abuse) (Jewkes 2002). As a solution, comprehensive IPV prevention approaches have emphasized the establishment of new narratives of gender, power and relationships (Parks et al. 2007). Previous research suggests that cognitive-behavioral approaches may be effective in the establishment of new constructs relating to gender norms for male IPV prevention (Crooks et al. 2007).

Participants identified health as a potential means to prevention. Their suggestions align with a traditional public health model and provide practical next steps for the community in addressing IPV. Participants suggested incorporating preventive education with existing public health activities. There was an identified role for both FCVs and MCLs with suggestions that they could meet with and educate the police. In addition, healthcare volunteers and community leaders could become sources of information for victims and perpetrators of IPV and facilitate their connection with the judicial system.

The identified role of healthcare as a bridge to IPV prevention is pertinent given the challenges to legal interventions in rural and developing communities compared to an urban setting. Existing literature demonstrates that in rural areas in developed and developing nations, the criminal justice system is seen as less helpful in addressing IPV (Shannon et al. 2006). In rural Latin America, inadequate laws, excess bureaucracy, little privacy, a lack of specialized personnel and sense of slowness for emergencies contribute to the problem (Sagot 2005). Further difficulties with the legal system in Latin America include the establishment of a two-track legal system, which criminalizes through penal code definitions while diverting offenses into legal arenas that tend towards the downgrading of social violence (Macaulay 2006). Members of the San José community acknowledged that distance could perpetuate the challenges noted above. Their concerns are connected to research that suggests existing legal constructs can perpetuate fear and re-victimization, which is a central challenge in encouraging IPV victims to speak out (Garcia-Moreno 2002).

Given FCV participant concerns regarding fear and re-victimization, women's empowerment and momentum for change are worth mentioning. Women in the community of San José are often home alone for months while men go out to work as migrant farmers. Hence they reportedly run a household independently and experience safety within the home. When the men return with money and alcohol, violence often follows. For that reason the women are motivated to make changes in their homes that will continue when the men return.

The empowerment and engagement of FCVs in IPV prevention are consistent with published attempts to promote the establishment of female solidarity groups and support networks in Latin American nations including Mexico (Castro et al. 2008; Pick et al. 2006) and Nicaragua (Ellsberg et al. 2000; Ellsberg et al. 2001; Wessel and Campbell 1997). In a comprehensive study spanning ten Latin American nations including Honduras, researchers found that optimal support for IPV victims came from women's organizations that connected women's health and legal rights (Sagot 2005). Further research in Mexico demonstrated that women feel more comfortable turning to other women for help such as their mother or a mother figure, rather than turning to formal support services (Fawcett et al. 1999). In the context of the previously established role of our study's FCVs as "madreguías," or "Mother-guides," these suggestions are reinforced by our findings.

IPV prevention must also be addressed in a culturally sensitive manner. While the study was conducted within the context of an existing partnership between UR-DFM, a United States/Honduran NGO and a rural Honduran community, there was potential for mistrust and perpetuation of inequality. The partnership is forged on the guiding CBPR principles of enhancing community motivation and engaging in collaborative problem solving with an acknowledgment that the community members are the experts. The project aims to improve health for the community while maintaining sustainability. The authors endeavored to incorporate these core principles and aims at all stages of the study. The CBPR model was chosen for its emphasis on developing solutions through collaborative research, planned action, along with process and outcome evaluation (Israel et al. 2005), while remaining accountable to the community of San José. While CBPR can help to address issues of inequity, there are additional limitations to this study including the PI's male gender, outsider status and limited time to build trusting relationships. These limitations had the potential to inhibit open discussion among female focus group participants in particular. Further, the lack of professional facilitator training may have limited the PI's effectiveness in following up salient points during discussion. It is also possible that this patriarchal culture had increased respect for males and physicians among study participants. An additional limitation is the lack of professional translation during the course of the interviews and focus groups. However, given these limitations, the findings nonetheless find support for community readiness to engage in interventions.

The results of this study contribute to the sparse literature on IPV in rural and Latin communities. The preponderance of prior studies examine IPV in urban jurisdictions rather than rural ones. Within this limited literature, however, there is one comprehensive examination of IPV cases in both urban and rural areas across several Latin American countries. That particular study aligns with the findings in our study as the authors describes the weaknesses of the legal sector in responding to IPV in rural jurisdictions, highlighting the role of health care systems as a bridge to IPV prevention. The authors found that existing women's organizations provided the best support for IPV victims, especially those addressing women's health and legal rights. In addition, existing research highlights that women's organizations tend to lack information, skills and policies to respond to IPV and therefore would benefit from education and empowerment programs (Sagot 2005).

Implications/Conclusions

The study's findings can inform IPV prevention in a variety of settings. This rural Honduran community can incorporate these results to address IPV prevention in San José, which could be relevant to IPV prevention in rural areas and amongst other culturally diverse communities. These findings may also be relevant in immigrant communities in developed nations depending on degrees of acculturation. The success of our efforts in conducting these discussions illustrates the importance of a community-centered, culturally sensitive approach. Prevention programs with an emphasis on community education and the re-evaluation of gender and cultural norms may have merit. Female community members, particularly community healthcare volunteers, can be empowered further to bridge health and legal sectors in addressing IPV.

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References

- Allan G. A critique of using grounded theory as a research method. *Electronic Journal of Business Research Methods*. 2003; 2(1):1–10.
- Bunch SG, Eastman BJ. Worker and victim issues unique to rural domestic violence. [Abstract]. *Family Violence & Sexual Assault Bulletin*. 2004; 20(4):11–15. Retrieved from <http://www.ncjrs.gov/app/publications/abstract.aspx?ID=208912>.
- Castro R, Casique I, Brindis CD. Empowerment and physical violence throughout women's reproductive life in Mexico. *Violence Against Women*. 2008; 14(6):655–677. [PubMed: 18535307]
- Chamberlain, L. The Network News. 2002 Jan-Feb. Domestic violence: a primary care issue for rural women.
- Champion JD. Family violence and mental health. *Nursing Clinics of North America*. 1998; 33(1): 201–215. [PubMed: 9478915]
- Christopher S, Watts V, McCormick AK, Young S. Building and maintaining trust in a community-based participatory research partnership. *American Journal of Public Health*. 2008; 98(8):1398–1406. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&NEWS=N&PAGE=fulltext&D=medl&AN=18556605>. [PubMed: 18556605]
- Clark, C. Domestic violence in Jordan: Its definition, prevalence, reproductive health correlates and sources of assistance for victims. 2005. (Unpublished)
- Creswell, JW.; Maietta, RC. Systematic procedures of inquiry and computer data analysis software for qualitative research. In: Miller, DC.; Salkind, NJ., editors. *Handbook of research design and social measurement*. 6. Thousand Oaks: Sage; 2001. p. 143–84.
- Crooks CV, Goodall GR, Hughes R, Jaffe PG, Baker LL. Engaging men and boys in preventing violence against women: applying a cognitive-behavioral model. *Violence Against Women*. 2007; 13(3):217–239. [PubMed: 17322269]
- Denham AC, Frasier PY, Hooten EG, Belton L, Newton W, Gonzalez P, Campbell MK. Intimate partner violence among Latinas in Eastern North Carolina. *Violence Against Women*. 2007; 13(2): 123–140. [PubMed: 17251501]
- Ellsberg M, Pena R, Herrera A, Liljestrand J, Winkvist A. Candies in hell: women's experiences of violence in Nicaragua. *Social Science & Medicine*. 2000; 51(11):1595–1610. [PubMed: 11072881]
- Ellsberg MC, Winkvist A, Pena R, Stenlund H. Women's strategic responses to violence in Nicaragua. *Journal of Epidemiology & Community Health*. 2001; 55(8):547–555. [PubMed: 11449011]
- Fawcett G, Heise LL, Isita Espejel L, Pick S. Changing community responses to wife abuse: a research and demonstration project in Iztacalco, Mexico. *American Psychologist*. 1999; 54(1):41–49.
- Fife RS, Ebersole C, Bigatti S, Lane KA, Huber LRB. Assessment of the relationship of demographic and social factors with intimate partner violence (IPV) among Latinas in Indianapolis. *Journal of Women's Health*. 2008; 17(5):769–775.
- Garcia Moreno C, Jansen HAFM, Ellsberg M, Heise L, Watts CH. WHO Multi-Country Study on Women's Health and Domestic Violence against Women Study. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*. 2006; 368(9543):1260–1269.
- Garcia-Moreno C. International conference on the role of health professionals in addressing violence against women: an overview. *International Journal of Gynaecology & Obstetrics*. 2002; 78(Suppl 1):S1–4. [PubMed: 12429432]
- Gilchrist, VJ. Key informant interviews. In: Crabtree, BF.; Miller, WL., editors. *Doing qualitative research*. 2. Thousand Oaks: Sage; 1999. p. 71–88.
- Hagen, S. Helping in Honduras: global health program marries medical training with community development. *Currents: University of Rochester Medical Center*; 2008 Aug 4.
- Haj-Yahia MM, Sadan E. Issues in intervention with battered women in collectivist societies. *Journal of Marital & Family Therapy*. 2008; 34(1):1–13. [PubMed: 18199177]
- Hyder AA, Wali SA. Informed consent and collaborative research: perspectives from the developing world. *Developing World Bioethics*. 2006; 6(1):33–40. [PubMed: 16436172]

- Israel, B.; Eng, E.; Schulz, A.; Parker, E. Methods in community-based participatory research for health. Jossey-Bass; 2005.
- Jewkes R. Intimate partner violence: causes and prevention. *Lancet*. 2002; 359(9315):1423–1429. [PubMed: 11978358]
- Johnson, R. Rural health response domestic violence: policy and practice Issues. Federal Office of Rural Health Policy; 2000.
- Macaulay F. Judicialising and (de) criminalising domestic violence in Latin America. *Social Policy and Society*. 2006; 5(01):103.10.1017/S1474746405002782
- Magnussen L, Shoultz J, Hansen K, Sapolu M, Samifua M. Intimate partner violence: perceptions of Samoan women. *Journal of Community Health*. 2008; 33(6):389–394. [PubMed: 18581217]
- McCarraher DR, Bailey PE, Martin SL. Are reproductive health services a good place to screen for intimate partner violence? *Violence Against Women*. 2003; 9(8):989–1002.
- Parks, L.; Cohen, L.; Kravitz-Writz, N. Poised for prevention: advancing promising approaches to primary prevention of intimate partner violence. Oakland: Robert Wood Johnson Foundation; 2007.
- Pick S, Contreras C, Barker-Aguilar A. Violence against women in Mexico: conceptualization and program application. *Annals of the New York Academy of Sciences*. 2006; 1087:261–278. [PubMed: 17189510]
- Sagot M. The critical path of women affected by family violence in Latin America: case studies from 10 countries. *Violence Against Women*. 2005; 11(10):1292–1318. [PubMed: 16135691]
- Shannon L, Logan TK, Cole J, Medley K. Help-seeking and coping strategies for intimate partner violence in rural and urban women. *Violence and Victims*. 2006; 21(2):167–181. [PubMed: 16642737]
- Wessel L, Campbell JC. Providing sanctuary for battered women: Nicaragua's casas de la mujer. *Issues in Mental Health Nursing*. 1997; 18(5):455–476. [PubMed: 9362723]
- The World Factbook. 2009. Retrieved October 26, 2009, from <https://www.cia.gov/library/publications/the-world-factbook/>

Table 1

Focus group discussion guide

Focus Group Discussion Guide	
1	Do you think partner violence is a problem within your community?
2	When you think of partner violence, what is the first thing that comes to your mind?
2	What do the words “partner violence” mean to you?
3	Can you describe a situation that you would consider partner violence? Probe: Who is involved? Husband, wife, children, extended family, neighbors, etc. What actions are being taken by whom and against whom?
4	Why does partner violence occur? Probe for immediate causes as well as for wider social structural and sociocultural causes. If physical, mental, or reproductive health problems are mentioned, probe for examples of health states and how they are related to domestic violence occurrence.
5	Under what circumstances would someone be entitled to use partner violence? Probe: What is the basis for this entitlement?
6	What effect does partner violence have for individual family members? Probe: health, economic, social
7	What effect does partner violence have for the community? Probe: health, economic, social
8	If a person decides that they need help, to whom should they turn to?
9	How effective is this help?
10	How can partner violence be prevented within your community?
11	What do you think are reasons why partner violence does NOT occur in many families?
12	Given the discussion that we just had, is there any other information that you think is relevant?

Table 2

Summary of themes

	Key informant interview	Health volunteer focus group
Overall theme(s)	Denial and minimization	Acknowledgement vs. denial
	IPV as a private matter	Fear of disclosure
Types	Bilateral violence	Control
	Physical	Sexual
	Psychological	Family violence
Causes	Jealousy	Cultural norms
	Lack of understanding	Lack of education
	Alcohol	Alcohol
	Rumor	
	Gossip	
Effects	Family	Family
		Stigma
Interventions	Legal	Legal
	Preventive education	Preventive education
	Health	Health