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Socioecological Determinants of Community Resource Utilization among Low-Income Women in Mexico City Who Experienced Male-to-Female Intimate Partner Violence

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Abstract

Women who experience intimate partner violence (IPV) face multiple barriers to seeking help from community resources, but little research has examined the impact of ecological influences on community resource utilization among women living in low- and middle-income countries. The current study investigated individual-, relationship-, family-, and community-level influences on community resource utilization among Mexican women experiencing IPV. Using baseline data from 950 women in Mexico City enrolled in a clinic-based randomized controlled trial, multilevel

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DECLARATION OF INTEREST STATEMENT

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regressions were performed to assess associations between socioecological factors and women's community resource utilization. 41.3% women used at least one resource. At the individual-level, every additional resource that women were aware of, was associated with a 20% increase in the total number of resources used ($p<.001$). Every additional lethal risk factor was associated with a 5% increase in the total number of resources used ($p=.004$). At the family-level, women who reported having an in-law encourage IPV used 46% more resources ($p<.001$). At the community-level, stronger supportive norms around community resource utilization was associated with a 6% increase in the total number of resources ($p=.01$). These findings suggest the importance of addressing family and community factors in the broader ecological context of Mexican women's help-seeking behaviors.

Keywords

male-to-female IPV; community community resource utilization; social ecological model

INTRODUCTION

Male-to-female intimate partner violence (hereafter, IPV) is an important public health issue. In 2013, a WHO-led multi-country study estimated that 1 in 3 women experience physical and/or sexual IPV at some point in their lifetime (Devries et al., 2013). Globally, women and girls bear the burden of violence by male intimate partners and sexual violence by any perpetrator (Bott, Guedes, Goodwin, & Mendoza, 2012). There is variation in regional prevalence of IPV and the WHO-led multi-country study found some of the highest rates in Latin American and Caribbean countries (Devries et al., 2013). In particular, greater understanding of women and girls' experiences of IPV in Mexico is critically important. In Mexico, it is estimated that nearly 44% of women have reported IPV in their lifetime, and 25.6% of women experienced IPV in the past year alone. Further, an extreme form of violence, *femicide*, is prevalent in Mexico. In general, femicide is the intentional murder of women because they are women (World Health Organization, 2012); and in Mexico City, it is estimated that 7 women are killed daily by a male intimate partner or family member (Meyer, 2017). Since there is no systematic approach to documenting femicides in Mexico, it is unclear how many femicides in Mexico are due specifically to intimate partners (Meyer, 2017); however, the WHO estimates that more than 35% of all femicides globally are committed by a male intimate partner (World Health Organization, 2012). IPV is considered one of the primary contributors to morbidity and mortality among women in Mexico (Bott et al., 2012). Policies and programmatic efforts are needed to help women access formal (e.g., shelters, healthcare providers) and informal (e.g., family, friends) resources. Increasing access to formal and informal resources is key to reducing the risk and vulnerability of the negative health sequelae of violence. Although increasing women's access to resources is important, previous research indicate that women often are reluctant to seek resources (Frías, 2013; Frías & Agoff, 2015; McDonnell, Burke, Gielen, O'Campo, & Weidl, 2011). Given the sociocultural context of IPV in Mexico City, a comprehensive examination of drivers of women's utilization of formal and informal resources is needed to inform the development of survivor-centered interventions and address barriers to women's help-seeking behavior.

The expanded version of the social-ecological model provides an opportunity to examine how social and contextual factors across ecological levels (i.e., individual, partner, family and community) influence women's help-seeking behavior in Mexico. Specifically, guided by the Heise's ecological framework (Heise, 1998), it is possible that women's community resource utilization may be influenced by factors associated with the individual (women), relationship (or partner), family and community (i.e., social normative and contextual factors). The expanded social-ecological model separates the relationship ecological level into two levels: family members and partners. A growing body of literature in low- and middle-income countries (LMICs) has shown that family members, especially among women's partners, can be a source of vulnerability (Falb et al., 2013; Gupta, Falb, Kpebo, & Annan, 2012; Scolese, Roth, OConnor, Hategekimana, & Falb, 2019). A qualitative study in Mexico found that family members can impose a submission to violence (Agoff, Herrera, & Castro, 2007; Frías & Agoff, 2015), and thus may be a barrier to women's community resource utilization. Therefore, it is critically important to expand the social-ecological model to better understand how extended families can restrict women's access to resources.

To date, however, very few studies have addressed social and contextual aspects of help-seeking behaviors and community resource utilization among women who experience IPV in Mexico. For example, Frías (2013) found that, in Mexico, individual and family-level factors shaped women's decisions to seek support from law enforcement agencies. First, women did not want their families to learn about their IPV experiences. Second, a strong distrust of public authorities was a barrier to seeking help from law enforcement agencies. Third, women with children less than 5 years of age were less likely to seek support for law enforcement than women without child. When children are involved, mothers have to consider additional factors when deciding to leave a relationship such as being economically dependent on the partner to provide basic necessities and keeping children safe (Randell, Bledsoe, Shroff, & Pierce, 2012). Four, separate and divorced women had a higher odds of seeking support from law enforcement than married or cohabitating women. Leaving an abusive relationship can be dangerous time for women, and divorced and separated women may have sought help from law enforcement in order to end the abuse. This previous research has provided insight into individual-level barriers of Mexican women's help-seeking behavior with law enforcement, but it is unclear what barriers and facilitators Mexican women experience when making decisions to seek support from other formal (e.g., shelters, healthcare providers) and informal (e.g., family, friends) resources across other ecological levels (e.g., partner, family and community).

Relationship and characteristics at the community-level (e.g., neighborhoods, clinics) can shape the lived realities of women experiencing IPV. For example, healthcare providers are important referral pathways toward accessing services that can address legal and psychosocial needs (García-Moreno et al., 2015); and with routine IPV screening, providers can identify women experiencing IPV and link women to other formal resources (e.g., domestic violence organizations, IPV helplines). However, existing research on healthcare provider screening and community resource utilization remains scarce in Mexico. Recently, a cluster randomized controlled trial concluded that comprehensive IPV training among nurses at local public clinics in Mexico City yielded improvements in use of community resources among women with IPV experiences, though significant treatment effects were not

observed (Gupta et al., 2017). In addition to the healthcare setting, communities such as neighborhoods may also affect women's community resource utilization. Qualitative research in Abidjan, Côte d'Ivoire also found that low social cohesion can impact help-seeking behavior among internally displaced persons (Cardoso et al., 2016). Furthermore, a previous study in rural Kenya found that community norms towards violence can deter resource use among women experiencing physical IPV (Odero et al., 2014). Previous research in other cultural and geographical contexts have demonstrated an important relationship between social cohesion and norms with help-seeking behavior, however these relationships are largely unexamined in Mexico. Broader social constructs (e.g., norms and attitudes) can influence women's perceptions of whether seeking services and resources is appropriate and thus investigation of this phenomenon is warranted in Mexico.

To address these gaps in the literature, this paper broadly investigates social influences on women's community resource utilization across multiple ecological levels including individual, partner, family and community (Figure 1). The current study is a secondary analysis of baseline data collected from the aforementioned cluster randomized controlled trial examining the implications of a nurse-delivered IPV intervention to women residing in Mexico City (Gupta et al., 2017).

MATERIALS AND METHODS

Methods described below have also been reported elsewhere (Gupta et al., 2017; Gupta et al., 2018; Willie et al., 2020).

Procedures

The current analysis used baseline data collected from a completed randomized controlled trial with 42 public community health clinics serving low-income women in Mexico City. The randomized controlled trial sought to examine the impact of a nurse-delivered intervention to women who experienced recent IPV. Mexico City is the capital and most populous urban center in which approximately 3.8 million uninsured persons reside. According to the 2015 inter-census, 8,918,652 people reside in Mexico City; 4,687,000 are women (Instituto Nacional de Estadística, 2015). The Mexico City Ministry of Health provides healthcare to uninsured persons through a federal health care program through the public health clinics. At the time of the study, this health care system comprised three types of health care clinics and Type III, which was utilized for the randomized controlled trial, offered more services and had a greater patient volume.

The inclusion criteria was women aged 18–44 years, in a current heterosexual relationship, experienced physical and/or sexual IPV in the past year, and were either not expecting or within the first trimester. Exclusion criteria were cognitive impairment, sought treatment for a life threatening emergency, or intended to relocate within two years. Trained female research assistants recruited participants by approaching women in the waiting rooms, at which point they verified study eligibility and asked women to participate in an Abuse Assessment Screen (AAS) that had been previously validated in Spanish (Díaz-Olavarrieta, Campbell, De La Cadena, Paz, & Villa, 1999). Women who screened positive for recent IPV were invited to participate in the study; and interested women completed written and/or

verbal informed consent. All study procedures were conducted in private rooms within the clinics. 29,947 women across the 42 clinics were approached and screened for eligibility. Among those who were eligible, the participation rate was 83.6%, representing a final total of 950 participants. All study protocols were approved by Yale School of Public Health (Protocol # 1202009793), George Mason University (Protocol # 704016–4), Innovations for Poverty Action (Protocol # 555.23May001), and National Institute of Public Health (Mexico) (Project #1089) human subjects committees.

Measures—Socio-demographics included age (in years), number of children, their birthplace, marital status, employment status, highest education completed, and their current partner's age (in years).

IPV Knowledge was assessed using seven items that presented an example of IPV and asked women whether they thought that was an example of IPV. An example item was “If a man threatens to hit a woman but does not actually hit her, it is not an example of violence against women?” The response options were “No, this is not an example”, “Yes, this is an example”, “I don’t know”, and “I prefer not to say”. An affirmative response was coded as a 1 and disconfirming responses were coded as a 0. A count variable was created by summing the responses with higher values indicating more knowledge around IPV.

Lethality was measured using 13 items from the Danger Assessment Tool (Campbell, Webster, & Glass, 2009). This tool captures a woman's risk of homicide in her relationship. Women were asked to respond either Yes (1) or No (0) for each of the items. An example item is “Has the physical violence increased in frequency over the past year?” A count score was created based on the number of affirmative responses.

In-law Encourage IPV was assessed using one item that asked women “Has anyone in your partner's family ever encouraged your partner to hurt you?” The response options were Yes, No, I don't know, and I do not want to answer. An affirmative response was coded as In-laws encouraged IPV.

Likelihood to Disclose IPV to Family and Friends was assessed using one item that asked women “How likely are you to tell your family or friends that you have been physically or sexually abused?” The response options ranged along a 4-point Likert scale from 1 = Very Likely to 4 = Not Very Likely.

Previous IPV Screening by HCP was assessed using one item that asked women “Have you ever been told by a health care provider that you are or were a victim of IPV?” An affirmative response was coded as being screened for IPV.

Injunctive Norms about Community Resource Utilization was assessed using three items that asked women how other women in their community would view them if they used IPV-related resources. These items were created based on extensive literature review on research on male-to-female IPV conducted in global settings. The three items were: “I think women in my community would approve of me making a safety plan”; “I think women in my community would approve of me disclosing IPV to a healthcare providers”; and “I think women in my community would approve of me using community resources.” The response

options ranged along a 4-point Likert scale from 1 = Strongly disagree to 4 = Strongly Agree. Responses were summed to create a total score in which higher values indicated greater support for community resource utilization (Cronbach's alpha =0.80).

Injunctive Norms about IPV was assessed using 16 items that asked women whether other women in their community would view male-to-female IPV as acceptable. This is an investigator-developed scale based on extensive literature review on research on male-to-female IPV conducted in global settings. An example item is "Most of the women you know (neighbors, friends, co-workers) think it's okay for a man to hit his partner if she does not obey him." Response options were 1 = Yes and 0 = No. A count variable was created by summing all the responses. Higher values indicating greater acceptability of IPV in the community (Cronbach's alpha = 0.96).

Perceived Social Cohesion was assessed using the social cohesion subscale of the collective efficacy scale by (Sampson, Raudenbush, & Earls, 1997). Women were asked five items that measured trust and cohesion in their neighborhood. Examples of the statements were: "People around here are willing to help their neighbors," and "People in this neighborhood can be trusted." Women were asked to respond as 1 = Yes or 0 = No. A count variable was created by summing responses across all the items with higher values indicating greater social cohesion.

Community Resource Awareness and Utilization was assessed by the Community Resources Checklist (McFarlane et al., 2006) but expanded to include a total of 14 community resources in Mexico City (Gupta et al., 2017). Women were first asked if they ever heard of each of the 14 community resources separately. An example item was "Have you ever heard of battered woman's counseling?" If a woman responded in the affirmative, she was then asked if she used the service before. An example item was "Have you ever gone or used the service?" The response options for both types of questions were: No, Yes, I don't now, and I don't want to say. For resource awareness, a count variable was created by summing the number of affirmative responses to the awareness items. Similarly, for community resource utilization, a count variable was created by summing the number of affirmative responses to community resource utilization.

Statistical Analyses

We performed basic descriptive statistics (prevalence, means) to describe characteristics of the total sample. Separate bivariate and multivariable, multilevel Poisson regressions were performed to assess individual-, relationship-, family-, and community-level factors as predictors of women's use of community resources. Multilevel modeling was used to address clustering in the data (i.e., individuals nested within health clinics). The generalized mixed model in GLIMMIX procedure with a Poisson distribution was used to fit the multilevel models. Regression estimates (B), robust standard errors (SE), and p-values <.05 were used to assess significance in all Poisson regression models. All analyses were conducted using SAS 9.4 (SAS Institute, 1990).

RESULTS

Prevalence of Community Resource Utilization

Approximately two in five women (41.25%, $n=389$) reported using any community resource in their lifetime (Figure 2). The most prevalent forms of community resources used by women were: emergency medical services (16.12%), domestic violence organizations (13.57%), emergency services helpline (11.03%), and psychological services (8.38%). Some of the less utilized community resources were: the National Institute of Women (INMUJERES) (5.30%), IPV Helpline (1.91%), Mexico City MOH Emergency Services for IPV or Mexico City's MOH Specialized Preventive and IPV Care Services (Servicios Especializados de Prevención y Atención a la Violencia de Género or SEPAVIGE for its initials in Spanish, 0.53%), and Mexico City's Government, Family Violence Prevention Units or UAPVIF (Unidad de Atención y Prevención de la Violencia Familiar, (3.71%).

Associations between Socioecological Factors and Community Resource Utilization

Bivariate and multivariable Poisson models were used to test associations between social-ecological factors with women's community resource utilization (Table 2). At the individual-level, women who were separated or divorced used 70% more resources than women in a common law marriage ($p=.003$). For every additional resource that women were aware of, we found a 20% increase in the total number of resources used ($p<.001$). At the partner-level, every additional lethal risk factor was associated with a 5% increase in the total number of resources used among women ($p=.004$). At the family-level, women who reported having an in-law encourage IPV used 46% more resources ($p<.001$). As the greater likelihood of disclosing IPV to family and friends was associated with a 8% increase in the total number of resources used ($p=.04$). At the community-level, stronger supportive norms around community resource utilization was associated with a 6% increase in the total number of resources used by women ($p=.01$).

DISCUSSION

This study found that there are individual- and relationship-level barriers to community resource utilization among low-income women living in Mexico City. Approximately two in five women reported using at least one community resource. Among the women that used community resources, the most prevalent resources used were mostly publicly funded services: emergency medical services, battered women's counseling, and the emergency medical hotline. Our findings indicate that greater knowledge and awareness of community resources, greater lethality risk factors, and self-identifying as separated or divorced are significant correlates of community resource utilization among low-income women in Mexico City with recent IPV experiences. Notably, these relationships persisted after controlling for other important socioecological factors across the individual, relationship, family, and community levels. Collectively, these findings illustrate the importance of continuing commitment to address IPV in Mexico. Further, these findings also indicate the importance of interventions to address women's broader social contexts (e.g. community, partner/family) to optimize women's likelihood of community resource utilization due to IPV.

Individual- and relationship-level influences emerged as significant predictors of community resource utilization among women who experienced recent IPV. Consistent with previous research (Hayes & Franklin, 2017), community resource utilization tended to be greater among women who endorsed several risk factors for lethal and severe forms of IPV. Women who experience severe abuse may have reached a turning point in which seeking community resources was the optimal strategy to protect themselves and their families (Wood, Glass, & Decker, 2019). Also, women who had more knowledge about community resources tended to use resources. This finding is consistent with a study conducted in the United States among Black women who experienced IPV that showed a lack of knowledge surrounding resources related to low utilization (Sabri et al., 2015). Finally compared to women in a common law marriage, women who were separated and divorced tended to use community resources. It is possible that community resource utilization such as legal services might have helped women separate and divorce their abusive partners. Previous US-based research suggest that separation is an important risk factor for lethal violence and injury (Campbell, 1986; Campbell et al., 2009). Women experiencing severe IPV seek help because they may be confronted with a life or death situation, or the health and safety of children in the family may be compromised (Campbell, 2004; Chang et al., 2010; Fugate, Landis, Riordan, Naureckas, & Engel, 2005). Women in these situations may be more inclined to seek IPV resources under such circumstances. The significant findings between individual- and relationship-level influences and resource use highlight the need to strengthen social support networks alongside health sector interventions to increase community resource utilization.

Family-level influences emerged as significant predictors of community resource utilization. Regarding family-level influences, the current study found that women who had in-laws that encouraged IPV behaviors tended to utilize more resources. This finding contrasts existing studies that show in-law violence/encouragement of IPV to be a barrier for women in accessing resources particularly if culturally normalized (Childress, 2018; Frías & Agoff, 2015; Kapadia, Saleem, & Karim, 2009). Several studies that examine the influence of in-law violence is primarily conducted in South Asia (Raj, Livramento, Santana, Gupta, & Silverman, 2006; Raj et al., 2011; Silverman et al., 2016; Wagman et al., 2018), Africa (Falb et al., 2013; Gupta et al., 2012; McCauley, Falb, Streich-Tilles, Kpebo, & Gupta, 2014), and Middle Eastern contexts (Clark et al., 2019; Clark, Silverman, Shahrouri, Everson-Rose, & Groce, 2010; Morse, Paldi, Egbarya, & Clark, 2012), however, our study extends this research to the Latin American and the Caribbean region. Women experiencing IPV might seek support through resources not only because of the abuse being experienced from her partner, but also from the pro-violent attitudes from his family that results in the lack of a safe haven. Women might also be receiving support from their natal family, and extended family members in mobilizing resources as suggested by our finding that women who reported increased likelihood to disclose IPV to family and friends used a higher number of community resources. Women reporting a likelihood to disclose IPV may feel ready to address their experience with IPV.

Furthermore, community-level factors were also related to women's community resource utilization. For example, women who felt that their community was supportive towards the use of resources were more likely to use a higher number of resources. A growing body of research illustrates that social norms can affect women's help-seeking behaviors (Fleming &

Resick, 2017; Mannell, Jackson, & Umutoni, 2016; McDonnell et al., 2011; Overstreet & Quinn, 2013). Women who experience IPV often turn to informal sources of support like family, friends, and neighbors (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). However, if women perceive a lack of acceptance or willingness to help from this social support systems, women may feel that an offer for a safe haven is not available (McDonnell et al., 2011). Also, our bivariate model illustrated that women who were screened by healthcare providers were more likely to use more resources. In these clinical settings, routine IPV screening may help providers identify women experiencing IPV and offer referrals to other formal resources (e.g., domestic violence organizations) (Gupta et al., 2017; Falb et al., 2014). Nevertheless, our findings are promising and illustrate some potentially innovative community-level approaches to reduce poor wellbeing among women experiencing IPV. Community-level interventions that increase awareness and positive attitudes towards IPV-related services could increase women's help-seeking behaviors and reduce the risk of some adverse health outcomes.

The findings of this study must be interpreted within the context of limitations. Women in the current analysis were originally recruited to participate in a randomized controlled trial and thus had to be eligible based on the trial's specific eligibility criteria. Also, given the cross-sectional nature of the analyses, we are unable to infer causality which makes it difficult to place the timing of community resource utilization throughout the onset/duration of experiencing IPV. Data on sexual orientation and sexual identity was not collected as part of the larger study, thus we are unable to examine associations between sexual orientation and women's community resource utilization. Future research should examine associations between sexual orientation and community resource utilization in order to identify and address barriers to help-seeking that might be uniquely experienced by sexual minorities. The scales on injunctive norms have yet to be validated within this population. As a result, readers should use caution when interpreting the findings related to the scales on injunctive norms as these findings are exploratory. While exploratory findings could be subject to bias, it also lays the foundation for future studies; therefore, future studies should replicate our analyses with large representative samples. Similarly, the study did not assess the acceptability of short- and long-term support of community resources. Furthermore, we did not assess women's ability to obtain community resources such as living or working close to community resources, which could be a barrier or a facilitator of women's community resource utilization.

Despite the limitations, this article provides a novel perspective in assessing the relationship between socioecological influences and community resource utilization among women experiencing IPV in the context of an urban city in a middle-income country. The findings of our analyses underscore the importance of health sector interventions to support resource referral and subsequent utilization. Understanding how knowledge of community resources and the severity of lethal risk factors influence women's health-seeking behavior and resource uptake is a critical component to comprehensively support survivors of IPV. The current findings thus provide support for multisector interventions that include the health sector, as well as broader programming such as community outreach and social norms interventions. As the new Mexican government recently reaffirmed their commitment to

addressing IPV (Urrutia & Muñoz, 2019), such approaches will be critical in addressing this pervasive global health and human rights issue.

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IPV Community Resource Utilization

Figure 1. Adapted socio-ecological framework.

This model shows the relationship between various socio-ecological factors that influence a woman's community resource utilization while simultaneously illustrating the opportunity for multi-level IPV interventions.

Figure 2.

The distribution of the types of community resources used among women who used at least one community resource (n=389, 41.25%)

Table 1

Distribution of Demographic Variables among Low Income Women in Mexico City with Recent Experiences of IPV (N=943)

	Total
	N (%) or Mean (SD)
Individual-Level	
Age	29.87 (7.16)
Number of Children	2.20 (1.20)
Birthplace	
Mexico City	677 (71.79)
State of Mexico or another state/country	266 (28.21)
Marital Status	
Single	56 (5.94)
Married	226 (23.97)
Common Law Marriage	633 (67.13)
Separated and Divorced	28 (2.97)
Employed	
Own a Business or Employee	269 (28.53)
Student, Homemaker, or Not Working	674 (71.47)
Education	
No Education/can read and write	25 (2.65)
Primary	207 (21.95)
Secondary	395 (41.89)
High School and Higher	316 (33.51)
IPV Knowledge	6.79 (.74)
Community Resource Awareness	4.04 (2.99)
Partner-Level	
Age Difference with Partner	3.34 (6.29)
Lethality	3.97 (2.53)
Family-Level	
In-law Encourage Partner's IPV Perpetration	213 (22.98)
Likelihood to Disclose IPV	2.52 (1.19)
Community-Level	
Previous IPV Screening by HCP	95 (10.07)
Norms about Community Resource Utilization	10.27 (1.84)
Norms about IPV	3.15 (5.05)
Social Cohesion	2.69 (.91)

Table 2

Predicting Resource Utilization among Low Income Women Residing in Mexico with Recent Experiences of IPV

	Total # of Resources Used					
	Bivariate			Multivariable		
	B (SE)	e ^B	p-value	B (SE)	e ^B	p-value
Individual-Level						
Age	.03 (.01)	1.03	<.01	.006 (.007)	1.00	.34
Number of Children	.09 (.04)	1.09	.03	.077 (.044)	1.08	.07
Birthplace						
Mexico City	-.25 (.10)	.78	.02	-.006 (.117)	.994	.95
State of Mexico or another state/country	REF			REF		
Marital Status						
Single	.23 (.20)	1.26	.26	.128 (.214)	1.14	.54
Married	.21 (.12)	1.23	.08	.115 (.108)	1.12	.28
Common Law Marriage	REF			REF		
Separated and Divorced	.54 (.19)	1.72	<.01	.533 (.147)	1.70	.003
Employed						
Own a Business or Employee	.06 (.09)	1.06	.50	-.068 (.099)	.93	.48
Student, Homemaker, or Not Working	REF			REF		
Education						
No Education	REF			REF		
Primary	.39 (.48)	1.48	.42	.105 (.445)	1.11	.81
Secondary	.65 (.45)	1.92	.15	.318 (.435)	1.37	.46
High School and Higher	.76 (.44)	2.14	.08	.504 (.428)	1.66	.23
IPV Knowledge	.24 (.10)	1.27	.01	.069 (.078)	1.07	.37
Resource Awareness	.198 (.012)	1.22	<.001	.185 (.012)	1.20	<.001
Relationship-Level						
Age Difference with Partner	.007 (.01)	1.00	.48	-.002 (.009)	.99	.83
Lethality	.09 (.02)	1.09	<.01	.048 (.017)	1.05	.004
Family-Level						
In-law Encourage Partner's IPV Perpetration	.43 (.11)	1.54	<.01	.378 (.093)	1.46	<.001
Likelihood to Disclose IPV to family/friends	.12 (.04)	1.13	<.01	.078 (.039)	1.08	.04
Community-Level						
Previous IPV Screening by HCP	.70 (.15)	2.01	<.01	.185 (.145)	1.20	.20
Injunctive Norms about Community Resource Utilization	.07 (.03)	1.07	.02	.062 (.026)	1.06	.01
Norms about IPV	.01 (.01)	1.01	.25	.008 (.008)	1.00	.32
Perceived Social Cohesion	.12 (.05)	1.13	.03	.015 (.044)	1.02	.73