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Combating IPV With Community Leaders in Honduras: An Evaluation of an IPV Training Program Among Teachers and Health Professionals

Chunrye Kim[1], Joel A. Capellan[2], Hung-En Sung[3], and Eduardo Rafael Orellana[4]

Abstract

Intimate partner violence (IPV) among women in Latin America, including Honduras, is serious. To help IPV victims, a community-based educational program has been implemented. This study aims to examine the impact of IPV training among teachers and health care professionals ($n = 160$) on increases in IPV knowledge, attitudes, and self-efficacy when dealing with IPV victims using a pretest and posttest design. We found that the treatment group who received IPV training showed significantly lower justification for IPV, higher gender equality attitudes, and higher IPV knowledge as well as higher confidence levels in identifying IPV victims and safety planning for victims. We concluded that the IPV training program using the community-based approaches has the potential to help IPV victims in Honduras. More efforts should be made to increase the educational opportunities the community members can receive.

Keywords

intimate partner violence, intervention programs, Latin America, community leaders

[1]Saint Joseph's University, Philadelphia, PA, USA
[2]Rowan University, Glassboro, NJ, USA
[3]John Jay College of Criminal Justice, New York, NY, USA
[4]University of Central America, Bulevar Los Proceres, El Salvador

Corresponding Author:
Chunrye Kim, Assistant Professor, Sociology and Criminal Justice Department, Saint Joseph's University, 5600 City Ave, Post Hall 133, Philadelphia, PA 19131, USA.
Email: ckim@sju.edu

Introduction

Intimate partner violence (IPV) is a serious social and health issue worldwide. According to the World Health Organization (WHO), about one in three women (35%) across the world have experienced physical and/or sexual violence from their partners in their lifetime (WHO, 2017). The rate of IPV varies depending on the country and other factors, such as socioeconomic status, but scholars suggest that violence against women from their partners in Latin American countries, in particular, might be more serious than that in other Western countries for two reasons. First, these countries have gender-based norms that reinforce hypermasculinity (i.e., machismo) among men, which is strongly correlated with IPV perpetration (McCarthy et al., 2018). Second, their violent political and social environment normalizes violence in general and increases women's dependence on men (Flake & Forste, 2006; Wilson, 2014). Although it is important to note that the incidence and severity of political and community violence across Latin American countries vary, it is well reported that violence in the community in many Latin American countries, including Honduras, is very serious (Peetz, 2011). Many other studies support the relationship between exposure to political violence and IPV in different countries (Clark et al., 2010; Gupta et al., 2012).

According to one study conducted by Flake and Forste (2006) using data from Demographic and Health Surveys (DHSs) in five different Latin American countries, the lifetime prevalence rate of IPV among women ranged from 15.7% in Haiti to 38.9% in Peru in 2000. Similarly, the Pan-American Health Organization's report, based on population-based data from 12 Latin American countries and the Caribbean (Bott et al., 2012), showed that the lifetime prevalence rate of physical or sexual violence ranged from 17% in the Dominican Republic in 2007 to 53.3% in Bolivia in 2003. The prevalence rate of physical or sexual violence in the past year ranged from 7.7% in Jamaica in 2008/2009 to 25.5% in Bolivia in 2008. Among women who experienced physical abuse, the prevalence rate of emotional abuse and controlling behaviors in the past year ranged from 61.1% in Colombia 2005 to 92.6% in El Salvador in 2008. Although due to the methodological differences it is hard to directly compare the IPV prevalence rate in Latin American countries with that in other non-Latin American countries, these statistics indicate that violence against women in Latin America is serious, and we need to address it urgently.

To prevent violence against women, including domestic violence (DV), many Latin American countries have enacted laws that criminalize offenders (Essayag, 2017; Macaulay, 2006). However, only a few countries (e.g., Guyana and Panama) have formulated national action plans to address DV or IPV specifically (Essayag, 2017). In many Latin American countries, including Honduras, due to the lack of government support of IPV prevention, victims are less likely to seek help from formal agencies such as the police (Bott et al., 2012) when they experience IPV. IPV victims' unwillingness to seek help from the police and other formal professionals is not a phenomenon unique to Latin America. Studies have found that IPV victims are less likely to seek help unless they fear for their lives (Loke et al., 2012) or their children's lives (Kim & Ferraresso, 2021; Rhodes et al., 2010) due to the severity of the abuse. However, this

might be particularly relevant in Latin America due to the mistrust of and low confidence in the police among the general public (Cao & Zhao, 2005).

To help IPV victims and to prevent further victimization, researchers have suggested using lay health advisors and/or natural helpers informed in community-based intervention approaches to deal with IPV, rather than relying on the criminal justice system (Kim, 2019; Leifeld et al., 2009). Natural helpers are "laypeople to whom others naturally turn for advice, emotional support, and tangible aid" (Israel, 1985, p. 68). Using their interconnected social networks in the community, natural helpers can intervene in IPV victims' lives by providing advice, emotional support, and help. Many studies have outlined the potential role of community leaders and members as natural helpers, including pastors (Choi, 2015), hair salon stylists (Kim, 2019), health care professionals (Ambuel et al., 2013; Wathen & MacMillan, 2003), and teachers (Koker et al., 2013) in helping IPV victims, as they tend to be people who interact with potential IPV victims in a routine way in their community, such as in hospitals, churches, and schools. Also, as community leaders are well known and highly respected in the communities they serve, community members—including IPV victims—tend to listen to what they say. However, most community leaders and members are not equipped with the knowledge and resources to help IPV victims appropriately (Choi, 2015; Kim, 2019).

Studies have found that appropriate training aimed at improving community leaders' and members' knowledge and competencies regarding IPV identification and intervention would benefit IPV victims, as they could provide advice, practical aid, and resources if they could identify victims. For instance, one study (Thayer et al., 2018) found that pastors who received IPV training gained knowledge in responding to IPV and changed their attitudes about IPV right after the training, as well as even 1 year after the training. Similarly, Short and colleagues (2006) examined the effectiveness of continuing medical education for physicians on how to manage IPV. Using a randomized design, they compared physicians who received 4 hr of online training with physicians who did not receive any training in IPV knowledge, attitudes, beliefs, and behaviors. They found that the training was associated with physicians gaining increased self-efficacy and IPV management skills over 6 and 12 months of follow-up.

Although to our knowledge no study has yet examined the impact of IPV training on teachers' knowledge and efficacy when dealing with IPV, there is evidence that teachers can play an important role in helping vulnerable populations, including child abuse victims, whose likelihood of IPV exposure is high. According to a systematic review conducted by Turner and colleagues (2017), training teachers increases their efficacy in identifying children who are exposed to IPV. Similarly, a 1-day mandatory training program among school teachers and staff increased their self-confidence in recognizing different types of child abuse, their knowledge, and their ability to respond appropriately to violence disclosure in Australia (Hawkins & McCallum, 2001).

Although researchers tend to agree that there is no intervention program or training that has a positive effect on desired outcomes, including behavioral changes, under all different situations (Grimshaw et al., 2003), there is evidence that multifaceted IPV intervention education has positive effects on participants' behavior changes

(McColgan et al., 2010; O'Campo et al., 2011; Zaher et al., 2014). For instance, McColgan (2010) and colleagues evaluated the effects of IPV intervention among physicians, residents, and social workers. They found that successful IPV victim identification and referrals among the participants significantly increased over 3 and 6 months of follow-up. Similarly, a systematic review of 17 programs that evaluated IPV screening found that comprehensive approach programs that have multiple components have a successful outcome in increasing IPV identification rates. This suggests that community intervention strategies that focus on knowledge and attitudes using community leaders and members, including health professionals and teachers, can lead to changes in desired behavioral outcomes, such as identifying and helping IPV victims, and can potentially break the cycle of violence in Latin American countries. Although there is promising evidence that we can help IPV victims through community-based approaches, to our knowledge there is no study that has evaluated the effect of an IPV education program targeting health professionals and school teachers in Honduras.

To examine whether community intervention strategies have the potential to help IPV victims through well-designed training programs in Honduras, we conducted an experimental study that implemented an educational program among teachers and health care professionals. The IPV training programs mainly focused on (a) detecting women who are at risk or have been victims of IPV, (b) creating a safety plan to mitigate the risk for potential victims, and (c) linking potential IPV victims to the legal, psychological, and economic resources available to them in the city of Tela, Honduras, accordingly. This study's main goal was to evaluate the efficacy of a training program for the participants in their readiness to help IPV victims in terms of knowledge, attitudes, and behaviors using the data collected from the IPV training program in Honduras.

Method

Participants

School teachers and health professionals were recruited for this project. Using a sampling frame of all school teachers (provided by *Direccion Municipal de Educacion de Tela*) and health professionals (provided by *Unidad Municipal Institucional de Salud*), a simple random sample of 160 primary and secondary school teachers and health professionals (doctors and nurses) were selected from the city of Tela, Honduras. The sample was made up primarily of teachers (90%), followed by health professionals (10%). This random sample was generated using STATA's *sample* command. Then using STATA's random number generator, the selected participants were randomly assigned to a treatment ($n = 80$) and a control group ($n = 80$). The treatment groups received a 2-month IPV education program. The control group received a talk about professional development opportunities in the city of Tela.

Of the 160 selected participants, 71% ($n = 109$) consented to take the baseline survey. Table 1 presents the baseline demographics of participants. In addition, we report the p values from t and chi-square tests of differences between the treatment and

Table 1. Summary Statistics of Control and Treatment Groups at Baseline.

Variable	Control ($n = 52$)	Treatment ($n = 62$)	t test/χ^2
Gender			0.77
Female	87.6%	86.4%	
Age	46.4 (avg.)	46.8 (avg.)	0.78
Race			0.11
Mestizo	93.8%	91.6%	
Amerindian	4.1%	4.6%	
Black	2.1%	0%	
White	0%	3.7%	
Occupation			0.90
Health professional	10.1%	10.5%	
Teacher	89.9%	89.5%	
Years of experience	24.3 (avg.)	24.4 (avg.)	0.97
Marital status			0.21
Single	30.8%	37.3%	
Married	57.4%	55.5%	
Divorced	1.1%	2%	
Widowed	7.4%	1%	
Other	3.1%	4.2%	

*$p \leq .10$. **$p \leq .05$. ***$p \leq .01$.

control groups. Both groups consist primarily of women (86%) of the mestizo race (92%) and work as primary and secondary teachers (89%). Both groups are similar in average age ($\bar{x} = 46$), occupation, years of work experience ($\bar{x} = 24$), and marital status. Significance tests show that control and treatment groups were balanced across all observed characteristics at baseline.

The project suffered an attrition rate of 9% (10 participants) from a baseline of 114 participants. Figure 1 presents the number of participants in the control and treatment groups pretest–posttest. Six participants who did not complete the posttest survey came from the treatment group and four from the control group.

Description of the Community-Based Intervention Program

The IPV prevention program titled *Formando linderes para combater la violencia domestica contra la mujer (Forming community leaders to prevent IPV)* was a 2-month educational program that met for approximately 2 hr weekly. The program was organized and led by two teams. The first team was made up of two independent experts in the field of DV prevention. This team was tasked with developing and executing the prevention program. The second team was made up of members of the Mayor's office (*Alcaldia de Tela*), Women's Office (*Oficina Municipal de la Mujer*), Education Board of Tela (*Direccion Municipal de Educacion de Tela*), and Public Health department

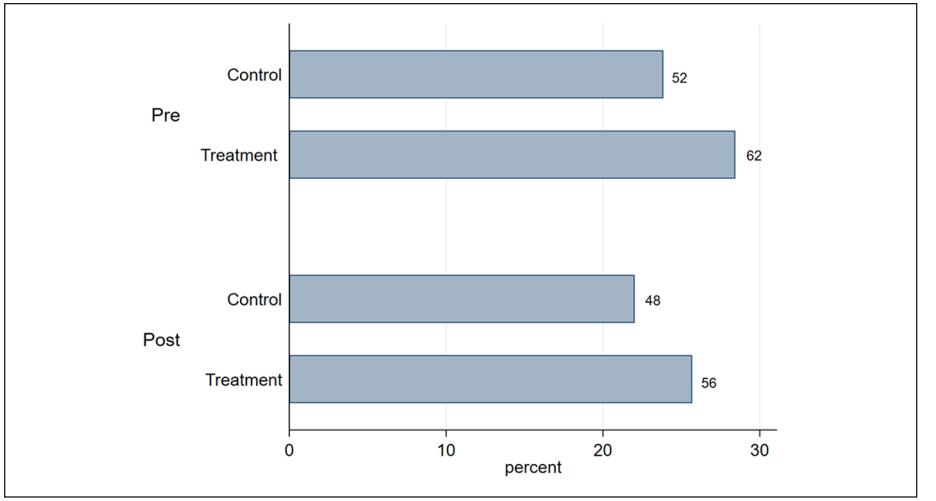

Figure 1. The number of participants in the control and treatment groups.

(*Unidad Municipal Institucional de Salud*). The second team was in charge of recruiting participants and logistics of execution. They booked the meeting rooms where the group sessions took place, organized the meals, took attendance, and arranged for transportation, among other administrative tasks.

The content of this educational or training program followed the WHO clinical and policy guidelines responding to IPV and sexual violence against women (WHO, 2013). The guidelines were developed to provide a blueprint for the design of the training curriculum for health care providers who interact with potential IPV victims in their work setting. Based on the guidelines, the curriculum of this program focused on basic knowledge about IPV (i.e., definitions, key statistics, relevant legislation, risk factors) along with knowledge of existing services (i.e., referral options) and attitudes toward IPV victims (e.g., IPV myths). Different aspects of responding to IPV, such as safety assessment and planning, and communication skills that are tied to the participants' characteristics as teachers and health care providers, have also been added to the training curriculum, as they might play a different role in IPV response due to their position. The education program consists of interactive workshops containing lectures, discussions, and skill practice sessions.

Data Collection Procedures

Information on participants was collected through a pre-program and postprogram survey. This survey measured participants' attitudes toward the role of women in society, their perception of what constitutes DV, as well as their confidence in their ability to identify, plan, and link potential IPV victims to the legal, psychological, and economic resources available for them in Tela, Honduras. Importantly, the survey

contains the results from a test that measures understanding of the material given during the 2-month program.

Measures

Dependent variables. This study evaluated the effectiveness of the education program across a series of attitudinal, self-perception, and knowledge indicators. Below, we list and operationalize the indicators examined in this study. We measured respondents' attitudes toward gender equality in several different dimensions using a short version of the "Attitudes Toward Women Scale (AWS)" developed by Spence and colleagues (1973). *Equality in risky behaviors* is a measure of participants' belief that women have the same rights as men to engage in risky behavior, such as getting drunk. This variable is a composite score extracted through principal component analysis (PCA) of survey items Q100, Q103, Q104, Q109, and Q112 (See Appendix). Higher values in this index indicate higher levels of gender equality in risky behavior. *Equality in the job market* measures participants' belief in gender equality in the job market. It captures respondents' openness toward women being able to have a career and take on traditionally male-dominated fields. This variable is a composite score extracted through PCA of survey items Q118, Q119, Q121, and Q122. Higher values in this index indicate higher levels of gender equality in the job market. *Work-home Life Equality* measures respondents' belief in gender equality in the home-work life of couples. This construct measures openness toward homemakers pursuing careers outside the home. This variable is a composite score extracted through PCA of survey items Q101, Q106, Q110, Q117, and Q120. Lower values in this index indicate higher levels of gender equality.

We also measured respondents' perception of the circumstances under which it would be acceptable to engage in DV. *Justification* measures the degree of rationalization respondents are willing to accept for violence. This measure is based on Waltermaurer (2012) that reviews 23 quantitative studies measuring IPV justification among the general population. This variable is a composite score extracted through PCA of the survey items Q200–Q208. Higher values in this index indicate lower levels of justification.

The survey also measured respondents' awareness of what types of behaviors constitute IPV, adapted from the Checklist of Controlling Behaviors (CCB), which has been validated (Lehmann et al., 2012). *Physical violence* measures respondents' awareness of behaviors that constitute physical abuse. This variable is a composite score extracted through PCA of survey items Q300–Q309. *Sexual violence* measures respondents' awareness of behaviors that constitute sexual abuse. This variable is a composite score extracted through PCA of survey items Q310–Q319. *Emotional violence* measures respondents' awareness of behaviors that constitute emotional abuse. This variable is a composite score extracted through PCA of survey items Q320–Q328. *Economic violence* measures respondents' awareness of behaviors that constitute economic violence. This variable is a composite score extracted through PCA of survey items Q329–Q337. Lower values in this index indicate higher levels of awareness.

Table 2. Summary Statistics of Dependent Variables.

Variables	*M*	*SD*	Minimum	Maximum	Percent missing
Equality in risky behavior	0	1.63	−4.95	1.64	11
Equality in the job market	0	1.53	−4.79	1.53	11
Work-home life equality	0	1.36	−2.31	3.15	11
Rationalization for violence	0	2.59	−11.26	1.06	5
Physical violence	0	3.07	−1.10	11.11	1
Sexual violence	0	3.07	−1.28	9.65	4
Emotional violence	0	2.86	−1.23	10.41	3
Economic violence	0	2.73	−1.47	8.57	8
Identification	0	2.39	−2.74	6.57	9
Planning	0	1.32	−5.94	3.37	9
Agency over DV	0	1.19	−3.72	1.82	9
Knowledge	61.84	21	0	94.11	0

DV = domestic violence.

We also examined the program's effect on respondents' self-rating of their ability to *identify* and *plan* for the safety of potential IPV victims. *Identification* measures respondents' self-rated ability to identify potential victims of DV. This variable is a composite score extracted through PCA of survey Items Q400–Q402. *Planning* measures respondents' self-rated ability to help plan for the safety of potential victims of DV. This includes how to approach a potential victim and how to connect them with the resources available in Tela. This variable is a composite score extracted through PCA of survey Items Q403–Q408. Lower values indicate higher levels of confidence in their ability.

While these subjective indicators of success are important, they do not tell us if, in fact, participants learned the material given during the course of the 2-month program. For that reason, we also include *a measure of knowledge* about the phenomenon of DV generally, and in Honduras specifically. These items measure participants' ability to recognize risk factors, persons at risk or victims of DV, appropriate ways of approaching such persons and planning for their safety, as well as the legal, economic, and psychological resources available to victims in Tela, Honduras. Similar to exam scores, we report the percent of correct answers on these items. Table 2 presents the summary statistics for these outcome variables as well as the percent of respondents for which the information necessary to estimate these constructs was missing.

Analytic Strategy

Given the pretest/posttest research design, we use a randomized trial difference-in-difference approach to evaluate the impact of program participation on the outcomes of interest. The difference-in-difference estimate of the causal effect of program participation on outcomes of interest is estimated through linear models for each outcome of interest, Y_i.

$$Y_i = \beta_0 + \beta_1 G_i + \beta_2 T_i + \beta_3 \left(G_1 \times T_i\right) + \sum_{=7}^{s} \beta_k X_i + \varepsilon_i,$$

where $\beta_1 G_i$ is an indicator for group assignment where those assigned to the control group were "0" and those to the treatment group were "1." $\beta_2 T_i$ is an indicator of treatment, where "0" represents preprogram values and "1" indicates postprogram scores. The estimate for the causal effect of program participation is given by the following interaction term between group assignment and pre/postprogram indicators $(G_1 \times T_i)$. In addition, we include a vector of control variables $(\sum_{=7}^{s} \beta_k X_i)$ to adjust for imbalances brought about by missing data. These independent covariates include *gender, race, age, occupation, marital status, religion*, and *the importance of religion.*

Results

Table 3 presents the unstandardized difference-in-difference estimates of the causal effect of program participation on the outcomes of interest. These estimates have been adjusted for demographic and background characteristics of participants. First, we examine the effect of program participation on individuals' attitudes on gender equality. The results show that the prevention program was successful in changing the attitudes of participants. Participants who participated scored 0.80 and 0.63 points higher (toward greater gender equality) in the *equality in risky behavior* and *equality in job market* scales, respectively, compared with those in the control group, which indicates an increase in gender equality after the IPV training. Similarly, those treated experienced a significant drop of 0.7 points (toward greater gender equality) in the *Work-home life equality* scale relative to their control counterparts, which indicates an increase in gender equality after the IPV training. Importantly, participants in the treatment group experienced a substantive increase of 1.49 points in the *justification for violence* scale relative to those in the control group. This indicates that participants in IPV training have a lower level of rationalization for violence compared with their counterparts in the control group.

The prevention program also sought to sensitize participants to or raise their awareness of behaviors that constitute IPV. In this regard, the program did not seem to be successful. Participation in the program did not have a significant effect on participants' awareness of what constitutes *physical, sexual, emotional*, and *economic* forms of violence. However, it is important to note that all differences were in the expected direction (toward greater awareness).

We also examined the impact of program participation on participants' self-rated ability to identify victims or women at risk of being victims of IPV and plan for the safety of potential victims of DV. This includes how to approach a potential victim and how to connect them with the resources available in Tela. The results indicate a statistically significant increase of 1.43 and 0.56 points on the treatment group's self-rated ability to identify and plan for the safety of IPV victims, respectively, relative to those assigned to the control group.

Table 3. Adjusted Difference-in-Difference Estimates of Program Participation on Success Indicators.

Variables	Difference-in-difference estimate[a]	*N*
Equality in risky behavior	0.80**	196
Equality in the job market	0.63*	196
Work-home life equality	−0.70**	196
Rationalization for violence	1.49***	209
Physical violence	−0.75	215
Sexual violence	−0.20	211
Emotional violence	−1.12	213
Economic violence	−1.12	201
Identification	−1.43***	199
Planning	−0.56*	199
Knowledge	15.06***	218

[a]All results are adjusted for demographic and background characteristics.
*$p \leq .10$. **$p \leq .05$. ***$p \leq .01$.

This increase in the self-rated ability to identify and plan for the safety of women at risk also manifested itself in our objective learning measure. As noted, participants answered questions to measure their ability to recognize risk factors, persons at risk or victims of IPV, correct ways of approaching such persons and plan for their safety, as well as the legal, economic, and psychological resources available to victims in Tela, Honduras. The results show that participants who participated in the prevention program scored 15 points higher, on average, relative to those participants assigned to the control group. The magnitude of this effect is substantial. It translates into a standard deviation increase in the average score of participants in the treatment group.

Discussion

This experimental study examined the impact of an IPV educational program among community leaders (i.e., teachers and health professionals) on increasing their knowledge, attitudes, and efficacy in dealing with (potential) IPV victims in the city of Tela, Honduras. Although IPV is a serious problem in Latin American countries, victims are less likely to seek help from formal agencies such as law enforcement. Thus, it is urgently necessary to find an alternative way to address the issue.

The findings of this study show that community leaders and members can take on a potentially positive role in helping IPV victims through a well-designed education program. We found that the IPV education program among teachers and health professionals significantly increased their knowledge of IPV (not only their actual knowledge but also their confidence level in their IPV-related knowledge) and self-efficacy in dealing

with potential IPV victims, such as identifying IPV victims and providing appropriate resources for them. This finding is very important, as IPV victims are more likely to disclose their victimization to natural helpers in the community, but unfortunately, many of them are not well equipped to deal with IPV victims due to their lack of knowledge (Choi, 2015; Kim, 2019). Thus, if we provide appropriate education and training to the community leaders and members, they can help IPV victims and reduce the IPV victimization rate in Honduras.

Different from what we expected, the IPV training program did not have a significant effect on increasing awareness of behaviors that constitute IPV, although both groups increased their awareness. This unexpected finding can be explained by the fact that the participants (in both groups) already had some basic understanding of behaviors that can be considered IPV; thus, the training might not make a significant difference there. We found that most participants (more than 90% across the different types of IPV) in both groups tended to think that the behaviors described were "very likely" or "likely" to be considered IPV even before the intervention. As the program's participants were either teachers or health care professionals, it makes sense that compared with people with a lower educational level, they have a better understanding of IPV, and thus, the training did not have much impact on their understanding. To increase the effectiveness of education programs on helping IPV victims by increasing awareness of IPV in Honduras, targeting community members without higher educational backgrounds might be more beneficial.

One of the important findings of this study is that the IPV education program decreased IPV justification and increased the gender equality attitudes among the participants. This finding is especially important in the context of Latin American countries. In Latin America, the traditional values of *machismo* (for men to be dominant and strong) and *marianismo* (for women to be submissive) are prevalent; therefore, women are more likely to be in a vulnerable position (McCarthy et al., 2018). It has been found that *machismo* values and beliefs among men are one of the strongest risk factors for IPV among Latin American populations (Mancera et al., 2017). When individuals support traditional gender role values and beliefs, they are more likely to blame IPV victims (Eigenberg & Policastro, 2016) and remain silent when violence occurs (Kim, 2017). Thus, more educational training and program opportunities to increase gender equality attitudes and decrease IPV justification should be available to community members, and focusing on community leaders such as teachers and health care professionals can be an important first step.

This study is not without limitations. First, the study participants were recruited from the city of Tela, Honduras, and thus, our findings cannot be generalized to other Latin American countries. Second, this study did not measure how successfully IPV training program activities were implemented as intended, which can affect the results of this study. Finally, due to the lack of follow-up surveys after the participants completed the education program, we are not sure whether the program has had a long-term effect, as the effect of training tends to decrease over time (Ramsay et al., 2002). Future studies need to examine the long-term effect of IPV training through follow-up measures.

Despite these limitations, this experimental study has shed light on community leaders' potential role in helping IPV victims through appropriate training programs in Honduras and Latin America. This is the first study in the city of Tela, Honduras, targeting health professionals and school teachers that shows that a well-designed IPV education program can change attitudes which, in turn, may lead to changes in behaviors. Based on the findings of this study, we recommend engaging in continued efforts to educate community members and increase their capacity and efficacy in helping IPV victims, as significant ongoing efforts are required to maintain changes in attitudes and knowledge in Honduras, as well as Latin America at large.

Although this study shows that IPV training and education has a positive effect among community leaders when they are dealing with IPV victims, it is important to note that formulating national action plans to address DV or IPV in Latin America should be accompanied by community intervention approaches such as those examined in this study. At the same time, systemic changes within the health services and educational services sectors should accompany these to make any significant and lasting impact. Without structural changes, IPV cannot be addressed appropriately and we cannot break the cycle of violence among Latin American women.

Appendix

Equality in risky behaviors
Q100 Swearing and obscenity are more repulsive in the speech of a woman than of a man.
Q103 Telling dirty jokes should be mostly a masculine prerogative.
Q104 Intoxication among women is worse than intoxication among men.
Q109 Women should worry less about their rights and more about becoming good wives and mothers.
Q112 A woman should not expect to go to exactly the same places or to have quite the same freedom of action as a man.
Equality in the job market
Q118 Women should be concerned with their duties of childbearing and house tending rather than with desires for professional and business careers.
Q119 The intellectual leadership of a community should be largely in the hands of men.
Q121 On average, women should be regarded as less capable of contributing to economic production than are men.
Q122 There are many jobs in which men should be given preference over women in being hired or promoted.
Work-home life equality
Q101 Women should take increasing responsibility for leadership in solving the intellectual and social problems of the day.
Q106 Under modern economic conditions with women being active outside the home, men should share in household tasks such as washing dishes and doing the laundry.

(continued)

Appendix. (continued)

Work-home life equality
Q107 There should be a strict merit system in job appointments and promotions without regard to sex.
Q117 The husband should not be favored by law over the wife in the disposal of family property or income.
Q120 Economic and social freedom are worth far more to women than acceptance of the ideal of femininity which has been set up by men.
Justification
Q200 If she refused to cook and keep the house clean
Q201 If she neglects children
Q202 If she had sex with another man
Q203 If she refused to have sex with you
Q204 If she made fun of you at a party
Q205 If she told friends that you were sexually pathetic
Q206 If she disobeys
Q207 If she argues with him
Q208 If she goes out without telling him
Physical violence
Q300 Threw something at her
Q301 Pushed or grabbed her
Q302 Pulled her hair
Q303 Choked her
Q304 Pinned her to the wall, floor, bed
Q305 Hit, kicked, or punched her
Q306 Hit or tried to hit her with something
Q307 Threatened her with a knife, gun, or other weapons
Q308 Spit at her
Q309 Tried to block her from leaving
Sexual violence
Q310 Physically forced her to have sexual intercourse
Q311 Pressured her to have sex when she said no
Q312 Pressured or forced her into other unwanted sexual acts
Q313 Treated her like a sex object
Q314 Inflicted pain on her during sex
Q315 Pressured her to have sex after a fight
Q316 Was insensitive to her sexual needs
Q317 Made jokes about parts of her body
Q318 Blamed her because others found her attractive

(continued)

Appendix. (continued)

Q319 Refused to use condoms
Emotional violence
Q320 Insulted her in front of others
Q321 Put down her sexual attractiveness
Q322 Made out she was stupid
Q323 Criticized her care of children or home
Q324 Swore at her
Q325 Told her she was crazy
Q326 Told her she was irrational
Q327 Blamed her for his problems
Q328 Made untrue accusations
Economic violence
Q329 Did not allow her equal access to the family money
Q330 Told her or acted as if it was "his money, his house, his car, and so on."
Q331 Threatened to withhold money from her
Q332 Made her ask for money for the basis necessitates
Q333 Used her fear of not having access to money to control her behavior
Q334 Made her account for the money she spent
Q335 Tried to keep her dependent on him for money
Q336 Used her or family's saving without agreement
Q337 Not providing any financial resources to her and my family
Identification
Q400 I am able to identify signs of violence if I encounter a potential domestic violence victims
Q401 I know how to ask about violence if I encounter a potential domestic violence victims
Q402 I know when to ask about domestic violence if I encounter a potential domestic violence victims

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Declaration of Conflicting Interests

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ORCID iD

Chunrye Kim https://orcid.org/0000-0003-2403-5075

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Author Biographies

Chunrye Kim is an Assistant Professor in the Sociology and Criminal Justice Department at Saint Joseph's University, Philadelphia, PA. Her primary research interests are victimology, domestic violence, and crimes against vulnerable populations.

Joel A. Capellan is an Assistant Professor in the Law and Justice Studies Department at Rowan University, Glassboro, NJ. Capellan specializes in mass casualty events and lone-actor violence.

Hung-En Sung is a Professor and serves as the Director of International Partnerships at the Office for the Advancement of Research at John Jay College of Criminal Justice. His research revolves around corrections and rehabilitation, police behavior, political corruption, and the impact of democratization on crime and justice.

Eduardo R. Orellana is a Research Assistant for the Academy for Security Analysis in El Salvador. His research interests include crime and government response to crime in the Northern Triangle.