Addressing Intimate Partner Violence of Central American Women

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This essay aims to address the health outcome as intimate partner violence for the target population of Central American women. An intimate partner is defined as “a husband, cohabiting partner, boyfriend or lover, or ex-husband, ex-partner, ex-boyfriend, or ex-lover” (World Health Organization, 2013, pg.vii). Intimate partner violence (IPV) is defined as

> “behavior by an intimate partner that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors. This definition includes violence by both current and former spouses and other intimate partners. Other terms used to refer to this include domestic violence, wife or spouse abuse, wife or spouse battering. Dating violence is usually used to refer to intimate relationships among young people, which may be of varying duration and intensity, and do not involve cohabiting (World Health Organization, 2013, pg. vii).”

IPV is further defined as physical, sexual, emotional, and/or controlling behaviors done by an intimate partner or ex-partner (World Health Organization and Pan American Health Organization, 2012). For the purposes of reviewing the literature on IPV, the IPV definition will be further expanded to review literature on domestic violence. Domestic violence is recognized to include partner violence but also encapsulates child abuse, elder abuse, or any household member abuse (World Health Organization and Pan American Health Organization, 2012).

Some factors of domestic violence are being young, having a lower education level, history of physical violence in the family, childhood sexual abuse, depression, low socioeconomic conditions, and complications of alcohol consumption in either or both partners

(De Castro Bhona et al., 2015). Domestic violence leads to physical and psychosocial obstacles (De Castro Bhona et al., 2015). Family violence must be analyzed and prescribed as a complex phenomenon, not one which is restricted to a single member of the family unit (De Castro Bhona et al., 2015). Salazar & San Sebastian's study indicates having experienced IPV increases the reporting of unintended pregnancies (Salazar & San Sebastian, 2014). IPV and controlling behavior are also connected to unintended pregnancies (Salazar & San Sebastian, 2014). IPV affects women's mental health, decreases self-esteem, and therefore makes negotiating contraception with her partner difficult (Salazar & San Sebastian, 2014). There is a positive correlation between intimate partner violence and weak mental health in women, including depression, anxiety, and post-traumatic stress disorder (PTSD) (Högberg, Lundell, Syanberg, & Tinglof, 2015). This shows mental health to be a consequence of IPV.

Bad maternal and neonatal health results correlate with unintended or unwanted pregnancies (Fu, Kuhlmann, Shato, & Sierra, 2019). There are negative consequences of IPV at delivery of the baby (Izaguirre & Zumalde, 2014). These include premature labor and low birth weight, placental abruption, trauma and caesarean delivery (Izaguirre & Zumalde, 2014). If the woman is pregnant, the life of the baby could be endangered. Studies from many countries often find increases in induced abortion and miscarriage, in addition to increased low birth weight deliveries, stillbirths, and neonatal deaths among those women whom do choose to report unintended or unwanted pregnancies (Fu, Kuhlmann, Shato, & Sierra, 2019). Unsafe abortions are common in Honduras, given that abortions are illegal under law (Fu, Kuhlmann, Shato, & Sierra, 2019). Fu, Kuhlmann, Shato, & Sierra's study found women whom have experienced IPV are often more susceptible to having used contraception (Fu, Kuhlmann, Shato, & Sierra, 2019). Women whom use contraception may prefer to use forms of contraception which do not inhibit

her partner's knowledge or approval of the attempt to not become pregnant (Fu, Kuhlmann, Shato, & Sierra, 2019). However, the study results had a 98.4% of husband's knowledge of contraceptive use, which contradict the previous statement regarding the association of IPV and contraception (Fu, Kuhlmann, Shato, & Sierra, 2019). Further studies on the preferred method of contraception use for women whom are exposed to IPV is needed (Fu, Kuhlmann, Shato, & Sierra, 2019). Research evidence as conducted in Bolivia and Nicaragua finds women reporting IPV are more likely to use modern contraception, in particular pills or methods that are more secretive (Fu, Kuhlmann, Shato, & Sierra, 2019). IPV is associated with women using a male-dependent method of contraception (Fu, Kuhlmann, Shato, & Sierra, 2019). Women whom do experience IPV may want to utilize contraceptives that do not need their partner's knowledge or support to avoid pregnancy or having a child in unstable circumstances (Fu, Kuhlmann, Shato, & Sierra, 2019). IPV correlates with unwanted pregnancies and more contraceptive usage among married Honduran women (Fu, Kuhlmann, Shato, & Sierra, 2019). Poverty, low levels of education, few women using modern contraception, and an increased amount of partners whom engage in controlling behaviors yield to increased incidents of unintended pregnancies (Högberg, Lundell, Syanberg, & Tinglof, 2015). There are Nicaraguan women whom experience IPV during pregnancy (Högberg, Öhman, Salazar, & Valladares, 2012). A study centered in Nicaragua found a 13% prevalence of physical abuse and a 7% prevalence of sexual abuse of women during pregnancy (Högberg, Öhman, Salazar, & Valladares, 2012). Screening for IPV among women whom go to health centers seeking sexual and reproductive health services may assist in finding women whom need help in addition to reducing stigma around IPV (Fu, Kuhlmann, Shato, & Sierra, 2019).

A study conducted by Castro et al. used probabilistic representative sampling of Mexican women with at least one child aged 5 years or younger whom were participants in the Encuesta Nacional de Salud y Nutrition (National Survey of Health and Nutrition) in 2012 (Martel, McWhirter, & Terrazas-Carrillo, 2016). The results showed that women whom did experience IPV had the highest risk of post-natal depression, which was enlarged by lack of social support, food security, and access to healthcare (Martel, McWhirter, & Terrazas-Carrillo, 2016). Please denote that this study was limited to women with children younger than 5 years of age (Martel, McWhirter, & Terrazas-Carrillo, 2016).

Low income middle income countries' evidence from the study by Arango, Ellsberg, Gennari, & Kiplesund found estimates suggesting approximately 1/3 of women have experienced physical or sexual IPV; however research on low-income nations heavily focuses decreasing harmful outdated practices, not IPV (Arango, Ellsberg, Gennari, & Kiplesund, 2014). This implies stigma associated with discussing and tackling IPV (Arango, Ellsberg, Gennari, & Kiplesund, 2014). 46 percent of women in Mexico have had an experienced incident of IPV (O'Brien & Walsh, 2019). 29 percent have experienced a form of violence within 12 months by a current or former partner (O'Brien & Walsh, 2019). In Nicaragua non-governmental organizations (NGOs) state that about 60 percent of women have been physically mistreated by at least one partner once, in addition to one third of Nicaraguan women whom reside with a man having experienced an instance of domestic violence (O'Brien & Walsh, 2019).

The case study of Jalisco State, Mexico, shows the conservative disapproval and organization towards a progressive feminist bill on intrafamilial violence. Mexico has 32 subnational units that each have autonomy (O'Brien & Walsh, 2019). Legal efforts for victims of domestic violence are taken care of at the subnational level (O'Brien & Walsh, 2019). Jalisco's

subnational level of government, with strong religious-state ties often against feminist policy changes, is favorable for reviewing local opposition to progressive policies concerning violence against women under the justification of patriarchal family discourse (O'Brien & Walsh, 2019). Activists in 2010 called out the local government of Jalisco for wrongly being obedient to Catholic hierarchy, often claiming that Governor Emilio Gonzalez Marquez abided by Catholic Church beliefs which were against legal rights of sexual violence victims under national and international laws (O'Brien & Walsh, 2019). Regardless of international criticism, the Jalisco government continued to follow Catholic Church doctrine over feminist activism for improved women's legal rights (O'Brien & Walsh, 2019). Such is the conservative history of Jalisco which had impeded the passage of the bill against intrafamilial violence since the 1990s (O'Brien & Walsh, 2019). The local women's movement aimed to criminalize and make domestic violence condemnable, to protect both married and unmarried or dating partners and their family members (O'Brien & Walsh, 2019). Religious leaders argued the Church's definition of family as endangered by feminist action (O'Brien & Walsh, 2019).

In November 1997, the NGO Women's Research Centre provided the executive branch of Jalisco with a draft law against intrafamilial violence (O'Brien & Walsh, 2019). No concrete results were achieved, as there was both major conservative opposition and blockage in the 1997-1998 Jalisco Congress, in addition to doctrine argument posed against the movement by Catholic Church officials, as publicized in the public media and by politicians (O'Brien & Walsh, 2019). The following is an activist's opinion which provides further contextual evidence for Jalisco's case study:

> "The concept of family is very carefully looked after by the Catholic Church in Mexico … Domestic partners are not acceptable … The Church typically refers to a strict

> definition of family as in the nuclear family, the father, mother, and children. But if the aunt living there is the perpetrator or the victim of violence in the household, then we cannot discuss this with that definition … In Mexico, the definition of family needs to include the full relations and people in households, so in the bill put forth in the Popular Initiative by citizens, we included both intrafamilial [extended family] violence and [nuclear] family violence (O'Brien & Walsh, 2019, pg. 13)."

It was not until August 2000 that Congress passed reform measures in the civil and penal codes allowing for the criminalization of intrafamilial violence against women and children, in addition to the criminalization of corporal damages to women in effect of such form of violence (O'Brien & Walsh, 2019).

Women in poverty whom experience IPV, especially in underdeveloped nations, are vulnerable due to lack of welfare services and social contextual evidence which allows for the open-mindedness of behavior inherent with experiencing IPV (Vázquez, Rivas, Suarez, & Panadero, 2017). Therefore, IPV among women in underdeveloped nations is understudied (Vázquez, Rivas, Suarez, & Panadero, 2017). Machismo is also another condition in Latin American which stimulates gender norms (Duffy, 2018). Machismo in Latin America refers to a male provider whom works and is responsible (Duffy, 2018). Machismo inherently exaggerates the nature of manliness, sexual prowess, and subordination of women, effectually resultant in male dominance and domestic violence of women that is fueled by the nature of machismo (Duffy, 2018). Hegemonic masculinity is endorsed by emphasized femininity, which perceives women as subordinates to men (Goicolea, Öhman, & Salazar, 2016). In Latin America, the term marianismo refers to emphasized femininity promoting unselfishness, inaction, and maternity as essential feminine traits (Goicolea, Öhman, & Salazar, 2016). Marianismo is made of changing

gender norms as defined by the intersection of women's economic exclusion inherent in Latin American patriarchal society (Goicolea, Öhman, & Salazar, 2016). IPV is not justified under dominant femininity discourse, for those women who decide to stay in abusive relationships are known to give into marianismo (Goicolea, Öhman, & Salazar, 2016). This dominant discourse does not address that ending abuse is beyond individual characteristics of being a woman, as it has economic, social, and cultural implications which ease or hamper women's agency (Goicolea, Öhman, & Salazar, 2016). Possessive jealousy, life history strategy, mate value, and intrasexual competitiveness are other determinants of IPV relevant to the notions of machismo and marianismo (Buunk & Massar, 2019; Duffy, 2018; Goicolea, Öhman, & Salazar, 2016).

Few women decide to report their experiences of violence (Duffy, 2018). This societal silence allows for violence forms to continue (Duffy, 2018). Having more health promoters and midwives in rural areas of Guatemala would improve capacity for violence-related services (Duffy, 2018). There is weak or no sex education in Guatemalan schools which is a barrier for women and girls to being educated on reproductive health topics (Duffy, 2018). Parents and teachers alike are uncomfortable on how to approach sex education (Duffy, 2018). Midwives and health promoters do have the knowledge of sexual and reproductive health to teach women and girls in Guatemala, however there is stigma in teaching about contraception due to Roman Catholic beliefs' influence in the region (Duffy, 2018). In Guatemala, abortion is legal in the context of the mother's life being at risk (Duffy, 2018). Even though this law is active, some health professionals refuse to provide abortions under any circumstances (Duffy, 2018). Because of the religious beliefs surrounding abortion, when abortions are carried out they are often done illegally and in an unsafe manner (Duffy, 2018).

According to Billings, Paredes-Gaitan, Reyes, & Zuniga:

> "National estimates from Guatemala (2008), Nicaragua (2006), and El Salvador (2008) suggest that around 12% of women aged 15–49 years have been forced to have sex by an intimate male partner and that women are frequently victims of sexual violence perpetrated by non-partners. Macro-level risk factors for sexual violence in Central America include high rates of crime and weak social controls, which contribute to an atmosphere of high tolerance for violent behavior. In addition, about half of the region's population live in poverty, which may exacerbate women's vulnerability by limiting their ability to leave violent relationships, making them more vulnerable to sexual coercion in exchange for material goods, and/or increasing their exposure to high-risk situations. Other risk factors include norms that legitimize violence against women and keep child sexual abuse hidden. Although criminal laws in the region penalize sexual assault and other forms of sexual aggression, the Interamerican Court on Human Rights in 2011 documented a "pattern of judicial ineffectiveness vis-à-vis acts of sexual violence [in Central America]…[that] promotes and perpetuates impunity in the vast majority of cases... (Billings, Paredes-Gaitan, Reyes, & Zuniga, 2012, pgs. 83-84)."

Interventions during the first five days of assault by the clinical care workers should be: first-line support, which includes care and support, listening to the woman, finding ways to provide relief and ease worry, and providing contacts to services and social supports (World Health Organization, 2013). Take a complete medical history of the woman, and do a physical examination, from head-to-toe, including the genitalia (World Health Organization, 2013). The gathered information should include the time since the assault, the type of assault, risk of HIV and other STDS, and mental health (World Health Organization, 2013). Oral emergency contraception should also be provided to the woman (World Health Organization, 2013).

Levonorgestrel at the dose of 1.5mg should be given if available (World Health Organization, 2013). If levonorgestrel is not available, combining oestrogen-progestogen with anti-emetics should be given (World Health Organization, 2013). Provide post-exposure prophylaxis for HIV or other STDs, and written information on coping strategies to deal with stress (World Health Organization, 2013). Interventions after 3 months of trauma are as follows: the woman should be tested for mental health symptoms, such as stress, PTSD, depression, substance overuse, suicidal nature or self-harm (World Health Organization, 2013). If she displays any of these symptoms, treatment should be done with WHO clinical protocol for mental health issues as defined by mhGAP intervention guide (World Health Organization, 2013). If she has PTSD, treatment is best achieved through cognitive behavioral therapy (CBT) or eye movement desensitization and reprocessing (EMDR) (World Health Organization, 2013). Doctors nurses and midwives should mainly be trained to treat patients whom may have experienced IPV (World Health Organization, 2013).

Interventions which include both economic empowerment of women and training in gender equality as well as promoting safer sexual relationships have proven to have better outcomes for violence and HIV prevention (World Health Organization and UNAIDs, 2013). Both men and women should be engaged to reform gender norms (World Health Organization and UNAIDs, 2013). Working with males to promote gender equitable attitudes and behaviors is an intervention which allows for individual reform through group participation, communication campaigns, and peer-based support (World Health Organization and UNAIDs, 2013). These interventions allow males to reflect on their masculinity, use of conflict resolution in romantic relationships, and educate them on sexual and reproductive health as well as violence against women (World Health Organization and UNAIDs, 2013). Previous studies which include low

and middle income countries show this intervention to be effective in addressing HIV and violence against women, however with a weak built program design (World Health Organization and UNAIDs, 2013).

Community mobilization is another intervention idea (World Health Organization and UNAIDs, 2013). Community mobilization is work with both male and females, community, religious leaders, and institutions over time to join for critical conversations on harmful cultural and social norms to promote positive changes in their lives (World Health Organization and UNAIDs, 2013). Activities of a community mobilization include conferences, discussions, performances, training, activism marches, and petitions (World Health Organization and UNAIDs, 2013). An example of a previous successful community mobilization intervention would be 'Stepping Stones' (World Health Organization and UNAIDs, 2013). 'Stepping Stones' project promoted gender equality and HIV prevention (World Health Organization and UNAIDs, 2013). More than 100 low and middle-income nations had adopted the model (World Health Organization and UNAIDs, 2013). Reviewing Stepping Stones interventions from Angola, Ethiopia, Fiji, Gambia, India, South Africa, United Republic of Tanzania and Uganda reported reductions of violence against women, some increases in condom use and partner dialogues about HIV, and changes to gender equality behaviors (World Health Organization and UNAIDs, 2013).

An example of an intervention that can be emulated in Central America is men targeted in a combined group education and community mobilization project (Fulu, Kerr-Wilson, & Lang, 2014). This type of intervention is usually implemented in low middle-income countries, such as Chile, South Africa, Brazil, and India, often training small groups of males aged 15 to 18 years old for the purpose of mobilizing other community members (Fulu, Kerr-Wilson, & Lang,

2014). The intervention had previously been implemented in Chile, a Latin American country, and has been a success (Fulu, Kerr-Wilson, & Lang, 2014). Training sessions can last anywhere from a few days to six months (Fulu, Kerr-Wilson, & Lang, 2014). Group education methods encompass topics such as but not limited to masculinity, gender, violence against women, authority in relationships, sexuality, human rights, and men having domestic roles (Fulu, Kerr-Wilson, & Lang, 2014). The trained males are later tasked with organizing community events to increase consciousness about violence against women through football games, life choices social marketing campaigns, and community discussions (Fulu, Kerr-Wilson, & Lang, 2014).

Home visitation programs and multilayered counseling programs prove to be effective interventions for women in perinatal context whom had experienced IPV (Parys, Temmerman, Verhamme, & Verstraelen, 2014). A few randomized controlled trials evaluating interventions for IPV around the time of pregnancy were found in Parys, Temmerman, Verhamme, & Verstraelen's study (Parys, Temmerman, Verhamme, & Verstraelen, 2014). Although the 9 studies did not provide strong confidence for effective interventions, home visitation programs and some multifaceted counseling interventions prove to be positive (Parys, Temmerman, Verhamme, & Verstraelen, 2014). Five studies testified a statistically significant reduction in physical, sexual and/or psychological partner violence, with the odds ratios being from 0.47 to 0.92. (Parys, Temmerman, Verhamme, & Verstraelen). Empowerment counseling through midwives is another valid intervention (Begley, Curran, & Panda, 2017). Midwives should ask questions about physical, emotional, or financial abuse (Begley, Curran, & Panda, 2017)

Improving and amending laws on rape and sexual assault within marriage, training police and judges on partner violence, and bettering the application of current laws would be another intervention (World Health Organization and Pan American Health Organization, 2012). The

legal sector assists with bringing justice to those whom have experienced intimate partner violence through fining those whom commit crimes against women, campaigning awareness of sexual violence against women as a crime, improving women's rights within marriage, divorce, property and child custody, improving women's access to the legal system, improving interventions for victim protection, tackling obstacles in criminal prosecutions, and decreasing the neglect of women and children within the law enforcement sector (Bott, Ellsberg, & Morrison, 2005). Education Ministries should partake in policy interventions which formulate a national action plan to combat gender-based violence in academic institutions, develop a code of conduct for prohibiting violence, making policies on dealing with teacher misconduct, and teaching violence against women and harassment in health and sexual education programs for students (Bott, Ellsberg, & Morrison, 2005).

My first case study intervention as relevant to IPV experiences of women in Central America is Gupta et al.'s study titled "*A nurse-delivered, clinic-based intervention to address intimate partner violence among low-income women in Mexico City: findings from a cluster randomized controlled trial* (Gupta et. al., 2017)." 29,947 women were screened for eligibility for the study at 42 clinics (Gupta et al., 2017). 950 women were ultimately chosen to participate, 480 of which were situated in control clinics, and 470 of which were put in treatment clinics (Gupta et al., 2017). The intervention was conducted from April to October 2013, at Mexico City, Mexico (Gupta et al., 2017). The main determinants that were designed to change in the intervention were social support and social networks, specifically through the examples of improvements of safety planning and mental health, and living and working conditions of the social environment, specifically through the examples of improving community capacity (Gupta et al., 2017; Institute of Medicine, National Academy of Sciences, 2003). Living and working

conditions includes the built environment and the social environment (Institute of Medicine, National Academy of Sciences, 2003). Examples of determinants of the social environment are community ability, civic involvement, and level of education (Institute of Medicine, National Academy of Sciences, 2003). Social support and social networks, also known as the interpersonal level, focus in on tangible support, emotional support, and informational support (Institute of Medicine, National Academy of Sciences, 2003).

Key activities of the intervention, as delivered by nurses, included an IPV exam through a health screening; care for the participant; safety and violence counseling including reproductive health needs; referrals; and an additional counseling session 3 months after the initial screening and counseling session (Gupta et al., 2017). Of the eligible women whom were chosen to interact with the nurses, a 3-day training covering IPV, safety planning, reproductive coercion, and referrals were carried out (Gupta et al., 2017). The study was co-founded by the study research team and International Planned Parenthood Federation of the Western Hemisphere Region (Gupta et al., 2017). 197 out of the 379 eligible nurses were also trained for the purposes of the study (Gupta et al., 2017). Researchers made 3 additional clinic visits to view and understand the supervised role-playing exercises (Gupta et al., 2017).

The study results do not suggest using enhanced nurse delivered intervention over standard of care to decrease IPV (Gupta et al., 2017). Pre-post improvement in outcomes in control and treatment do lend support to the idea that nurses as well as the health sector play a supportive role in assisting women with IPV experiences (Gupta et al., 2017). Nurse-delivered interventions are shown to better mental health and safety planning behaviors for the short term, but not for the long term (Gupta et al., 2017). The needs of women whom had experienced IPV within low middle income countries need to be further examined through interventions that

include healthcare provider responses alongside other sectors such as but not limited to economics, policy, and housing (Gupta et al., 2017). The living and working conditions of the social environment determinant, specifically nurse-led interventions, is limited in its effectiveness (Gupta et al., 2017; Institute of Medicine, National Academy of Sciences, 2003). Examples of determinants of the living and working conditions of the social environment are community ability, civic involvement, and level of education (Institute of Medicine, National Academy of Sciences, 2003). The intervention was effective to the extent that decreases were found in IPV, and improvements of safety planning, community capacity, and mental quality of life were resultant of the study (Gupta et al., 2017). Social support and social networks determinants were addressed, since this particular determinant addresses informational support (Institute of Medicine, National Academy of Sciences, 2003). Social support and social networks determinants were improved; as well as living and working conditions of the social environment (Gupta et al., 2017; Institute of Medicine, National Academy of Sciences, 2003).

My second case study intervention as relevant to IPV experiences of women in Central America comes from Ayala Quintanilla et al.'s study on IPV experiences during pregnancy (Ayala Quintanilla et al., 2010). The intervention was conducted at the Instituto Nacional Materno Perinatal (INMP) in Lima, Peru, a hospital run by the Peruvian government (Ayala Quintanilla et al., 2010). This case study is utilized as a culturally-appropriate model that could be emulated in a Central American context. 220 abused women were admitted to the study (Ayala Quintanilla et al., 2010). When the intervention was conducted, and how long the intervention occurred were not specified in the study (Ayala Quintanilla et al., 2010). It was only specified that the recruitment of pregnant women as participants for the study was from January 9th to July 26th, 2007, approximately 6 months (Ayala Quintanilla et al., 2010). The determinants

addressed in this study are living and working conditions and social support and social networks (Ayala Quintanilla et al., 2010; Institute of Medicine, National Academy of Sciences, 2003). Living and working conditions includes the built environment and the social environment (Institute of Medicine, National Academy of Sciences, 2003). Examples of determinants defined through the built environment are work and living conditions, delinquency and safety, and police involvement (Institute of Medicine, National Academy of Sciences, 2003). Social support and social networks, also known as the interpersonal level, focus in on tangible support, emotional support, and informational support (Institute of Medicine, National Academy of Sciences, 2003).

Activities of the interventions were specific to standard care intervention and empowerment intervention (Ayala Quintanilla et al., 2010). In standard care intervention, women whom received standard care were given recommendations to agencies whom provide IPV services to mistreated women, particularly as relevant to legal and social services (Ayala Quintanilla et al., 2010). Standard care intervention is an example of a social support and social networks determinant (Ayala Quintanilla et al., 2010; Institute of Medicine, National Academy of Sciences, 2003). This group at the pre-intervention interview did not receive referrals to psychotherapy, advocacy, education, or other services (Ayala Quintanilla et al., 2010). In empowerment intervention, women were given counseling, education, and instruction on safety by a social worker at the 6th-week postpartum visit (Ayala Quintanilla et al., 2010). Individual counseling sessions were roughly 30 minutes (Ayala Quintanilla et al., 2010). Women whom participated in the empowerment intervention were also given referrals, and interviewers were sensitive to the pregnant women's experiences (Ayala Quintanilla et al., 2010) The informational and emotional support provided are other examples of social support and social networks determinants (Ayala Quintanilla et al., 2010; Institute of Medicine, National Academy of

Sciences, 2003). Interviewers also taught the pregnant women about the cycle of violence and safety behaviors as noted in the Safety Behavior Checklist (Ayala Quintanilla et al., 2010). As an example, interviewers would give advice to pregnant women whom had experienced or still experience IPV where to keep money or important documents safe, as well as form a coded language to utilize with family or close friends to signal help and/or plan escape from her partner (Ayala Quintanilla et al., 2010). The participants were also provided by a 13-item safety plan brochure to remind them of safety protocol discussed at the intervention session, in addition to informational prenatal brochures (Ayala Quintanilla et al., 2010). Interviewers also provided the women with a list of community resources, including emergency housing, legal and law enforcement, psychotherapy centers, and approaches to seeking assistance from these resources (Ayala Quintanilla et al., 2010). Informational resources provided by interviewers is an example of social support and social networks determinant (Ayala Quintanilla et al., 2010; Institute of Medicine, National Academy of Sciences, 2003). Interviewers were also responsible for assisting women with calls to social service agencies or women's groups, both of which have working advocates for abused women (Ayala Quintanilla et al., 2010). At the finality of the empowerment intervention session, supportive care, endorsement of feelings, listening to each other, and further elaboration on what to expect when seeking help from legal resources, housing, law enforcement, or counseling services was completed (Ayala Quintanilla et al., 2010). Improving living conditions is addressed through the determinant living and working conditions of the built environment, while emotional support is addressed through the determinant social support and social networks (Ayala Quintanilla et al., 2010; Institute of Medicine, National Academy of Sciences, 2003). Women were at liberty to speak about reasons to or to not leave the abusive partner, report abuse to the law, or request a protection order (Ayala Quintanilla et al., 2010).

Taking necessary safety measures to avoid the abusive partner is addressed through the determinant living and working conditions of the built environment, while emotional support is addressed through the determinant social support and social networks (Ayala Quintanilla et al., 2010; Institute of Medicine, National Academy of Sciences, 2003).

The intervention was effective to the extent that there was an increased number of women whom had adopted safety behaviors in both groups of women studied (Ayala Quintanilla et al., 2010). Women whom were part of the empowerment training group had developed more skillsets for safety behaviors than women in the standard care group, which is an improved living and working conditions of the built environment determinant (Ayala Quintanilla et al., 2010; Institute of Medicine, National Academy of Sciences, 2003). There were no statistically significant findings in this intervention (Ayala Quintanilla et al., 2010). Questioning pregnant women about abuse and providing recommendations to services is a means to preventing more IPV (Ayala Quintanilla et al., 2010) Providing recommendations to services is a social support and social networks determinant (Ayala Quintanilla et al., 2010; Institute of Medicine, National Academy of Sciences, 2003). The study authors conclude that combining formal and informal resource networks and care can assist in reducing IPV in Lima, Peru (Ayala Quintanilla et al., 2010).

My third intervention case study as relevant to IPV experiences of women in Central America is a study of systematic reviews of interventions (Anderson, Baird, Saito, & Sapkota, 2019). Locations and time frames of the interventions were not specified, however it is noted that all these interventions were made to decrease or regulate domestic violence among pregnant women in low- and middle income countries (Anderson, Baird, Saito, & Sapkota, 2019). Key activities in this systematic review were defined as the main interventions (Anderson, Baird,

Saito, & Sapkota, 2019). These included the screening and empowerment of pregnant women, facilitative strategies, capacity building of health and non-health workers, comprehensive integrative program, and developing cognitive behavioral skills (Anderson, Baird, Saito, & Sapkota, 2019). All of the interventions' essence was psychotherapy and mentoring for the women (Anderson, Baird, Saito, & Sapkota, 2019). Most studies focused on individual therapy, except for two studies which included group therapy sessions (Anderson, Baird, Saito, & Sapkota, 2019).

With psychological support, these interventions' goal was to make mindful and empowered women, which is meant to positively influence individual level attitudes, knowledge, beliefs and biology determinants to improve decision-making (Anderson, Baird, Saito, & Sapkota, 2019; Institute of Medicine, National Academy of Sciences, 2003). Through facilitative strategies, check-ins with the women allowed assistance with obtaining needed support services, allowing for social support and social networks determinant to improve informational and tangible support access (Anderson, Baird, Saito, & Sapkota, 2019; Institute of Medicine, National Academy of Sciences, 2003). Interactive discussions with mental health professionals were also made available to the women, which is another example of a social support and social networks determinant, as discussions with mental health professions provide informational support (Anderson, Baird, Saito, & Sapkota, 2019; Institute of Medicine, National Academy of Sciences, 2003). Through capacity building of health and non-health workers, social workers were trained on various topics such as screening domestic violence, speaking about physical and emotional needs of survivors, discussing with the women support services for the abused, and loyalty to ethical principles (Anderson, Baird, Saito, & Sapkota, 2019). The capacity of social workers speaks to the community ability to handle an IPV intervention, a determinant of the

living and working conditions of the social environment (Anderson, Baird, Saito, & Sapkota, 2019; Institute of Medicine, National Academy of Sciences, 2003). Talking with survivors and providing support services is an example of social support and social networks determinant, specific to emotional and informational support (Anderson, Baird, Saito, & Sapkota, 2019; Institute of Medicine, National Academy of Sciences, 2003). Through the comprehensive integrated program, it was ensured that domestic violence programs would have information on domestic violence, effective means of communication for the relationship training, and security recommendations (Anderson, Baird, Saito, & Sapkota, 2019). The women were given a listing of domestic violence support services in addition to being comforted, another example of informational and emotional support for the social support and social networks determinant (Anderson, Baird, Saito, & Sapkota, 2019; Institute of Medicine, National Academy of Sciences, 2003). One study from South Africa denoted domestic violence intervention as integrated with an HIV PMTCT program (Anderson, Baird, Saito, & Sapkota, 2019). Other studies had the interventions at the same time as women's ANC visits (Anderson, Baird, Saito, & Sapkota, 2019). The last intervention denoted by the systematic review, cognitive behavioral therapy (CBT), allows for the women to improve decision-making, problem-solving, speech, and sexual relationship discussions with her partner (Anderson, Baird, Saito, & Sapkota, 2019). CBT is an example of both social support and social networks and individual level attitudes, knowledge, beliefs and biology determinants, given that the informational support given to the IPV survivor effectually improves personal beliefs and choices regarding reproductive health (Anderson, Baird, Saito, & Sapkota, 2019; Institute of Medicine, National Academy of Sciences, 2003).

My fourth intervention case study is titled "*Evaluating a health care provider delivered intervention to reduce intimate partner violence and mitigate associated health risks: study*

protocol for a randomized control trial in Mexico City (Campos et al., 2014)”. IPV has negative health consequences on women’s health, including bad mental health, unwanted pregnancies, forced sex, and susceptibility to HIV and STDs (Campos et al., 2014). The number of women whom participated in the study was not specified (Campos et al., 2014). The intervention was conducted from 2012 through 2015, for a total length of 4 years (Campos et al., 2014). The intervention was conducted in Mexico City, Mexico. Activities of this study included testing nurse training, fidelity tests with mock clients to evaluate nurses’ practice, and end interviews with women whom joined the study (Campos et al., 2014). Key determinants the study aimed to address include IPV screening, care, safety and personal security counseling, referrals, and follow-up counseling sessions after three months (Campos et al., 2014). Safety and personal security is an example of living and working conditions, the built environment determinant, while screening, counseling, and referrals are examples of social support and networks determinants, providing emotional and informational support to the women (Campos et al., 2014; Institute of Medicine, National Academy of Sciences, 2003). Examples of determinants defined through the built environment are work and living conditions, delinquency and safety, and police involvement (Institute of Medicine, National Academy of Sciences, 2003). Social support and social networks, also known as the interpersonal level, focus in on tangible support, emotional support, and informational support (Institute of Medicine, National Academy of Sciences, 2003). Because this study is a trial, the results of attempted change of determinants was not recorded (Campos et al., 2014).

The following gaps in the literature which need further study were found as follows: Arango, Ellsberg, Gennari, & Kiplesund studied more than 70 percent of impact evaluations referring to violence against women and girls, which were conducted in 7 high income nations

making up 6 percent of the world's population (Arango, Ellsberg, Gennari, & Kiplesund, 2014). The skewed distribution of evidence shows urgency for more investment in critical assessments of a variety of interventions across dissimilar sectors to avert violence against women and girls in low and middle-income countries (Arango, Ellsberg, Gennari, & Kiplesund, 2014). Barrington, Boyce, Tellez, & Zeledon's study based in Nicaragua found changes in marriage and gender norms must be taken into account in health interventions addressing intra-partner violence of women (Barrington, Boyce, Tellez, & Zeledon, 2016). Gender inequity being introduced into conversations would engage proper behavior changes as well (Barrington, Boyce, Tellez, & Zeledon, 2016). Interventions that are tailored to challenge traditional norms and values towards IPV including masculinities must also be implemented to improve family and social support accessibility (Högberg, Öhman, Salazar, & Valladares, 2012).

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