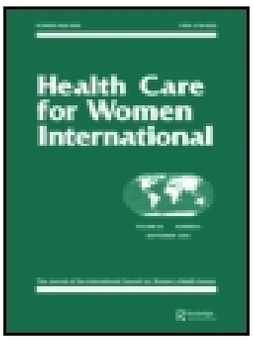

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# Midwives' experiences with screening for intimate partner violence in Santiago, Chile

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**ABSTRACT**

Although intimate partner violence (IPV) is well-established as a highly prevalent global issue, research examining the experience of health providers who screen women at risk for IPV is scarce. We aimed to explore the experience of midwives in primary health care centers in Santiago, Chile, regarding identification of at-risk women and barriers to screening. We highlight the intersection of complex issues of global relevance, such as culture, language, provider–patient relationships, and allocation of time and resources. In our results, we illustrate the importance of providing midwives extended time, interpreter services, and cross-cultural education to address IPV in their transcultural context.

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Effective screening of women for intimate partner violence (IPV) is an essential public health issue of global concern. We do not yet know enough about the experience of health providers who conduct screening for IPV. In Chile, midwives provide primary women's health care for most women in the public sector. We worked alongside midwifery faculty at the University of Chile, recruited and interviewed six midwives in several primary health care centers in a lower-income region of Santiago, Chile. We aimed to explore the process of screening, to better understand the factors that influence midwives conducting the screenings. In so doing, we gained insight into firsthand encounters with women of various cultural and social backgrounds. While this study took place in a developed Latin American country, we believe our findings are relevant to other contexts and cultural

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dynamics. Our findings may inform those beyond women's health care providers; researchers in other disciplines, such as social work, religious studies, and education, may also encounter women at risk for IPV. Therefore, the cross-cultural challenges, such as language and cultural norms presented in our study, are applicable in any multicultural context.

IPV is well-established as a highly prevalent global scourge, with 30% of women reporting violence in current or previous relationships (Garcia-Moreno et al., 2013; Smith et al., 2017; Tower, 2007). In the Americas, there is abundant published literature about IPV in the United States and Canada, but proportionately less so in Latin America and the Caribbean (Lacey et al., 2016). The World Health Organization (WHO) Multi-country Study on Women's Health and Domestic Violence Against Women, one of the studies listing the global prevalence of IPV, selected Peru and Brazil to be representative countries from the Region of the Americas (Garcia-Moreno et al., 2013, p. 7). Our study took place in Chile, a country of particular interest in South America because IPV is prevalent and is a country with many immigrant women who are known to face discrimination, an important violence-related factor (Colorado-Yohar et al., 2012; Dahlen et al., 2018; Godoy-Ruiz et al., 2015). Additionally, the nationally funded primary health care system in Chile deploys midwives to provide care for women. In Chile, midwives in the public sector provide over 90% of antenatal, family planning, postpartum, and interconception care (Segovia, 1998).

In southern Latin America, 23.68% of women reported physical or sexual violence by an intimate partner in 2010 (Garcia-Moreno et al., 2013). In Chile, 50% of married women reported abuse by their partner in 2004 (Larrain et al., 2009). In 2016, of the 127,682 domestic violence crimes, 77.66% were against women (Public Ministry of Chile, 2016). These statistics indicate that women in Chile are experiencing a significant burden from IPV.

United States data reveals only 54% of IPV cases were reported to the police in 2015, and the percentage of those who received assistance from a victim service agency dropped from 28.2% in 2014 to 18.3% (United States Department of Justice, 2016). This leaves just under half of IPV cases unreported and a large majority of cases without support or assistance. Women may choose not to report violence for many reasons, including fear of retaliation by the partner, belief that police will not help, that the matter was too personal, or it was not important enough to report (United States Department of Justice, 2013). Comparable data for Chile is not available, but it is reasonable to assume under-reporting is a similar phenomenon. Additionally, Chile has flows of immigrant women from Peru, Colombia, Bolivia, Venezuela, and Haiti, among other countries, that add to the complexity of identifying IPV among those groups. There are approximately 120,000 Haitians living in Chile, who have been immigrating since the earthquake of 2010 (Millesi, 2018).

Screening for IPV in health care is an opportunity to prevent or break a cycle of violence because screening ideally can help lead to the appropriate provision of resources for victims and those at risk (American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, 2012). IPV is a challenging problem to address, and its complex nature necessitates discussing the potential consequences with those at risk and providing support. Also, the financial burden of IPV is high: women who report IPV have reported more emergency department and outpatient visits, acute-care admissions, and use of mental health and substance use services compared to women who reported no IPV (Rivara et al., 2007). Because contact can be made in a wide variety of health care settings, health care workers need to be equipped to identify victims, provide appropriate resources, and discuss such a sensitive topic (American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, 2012; Rivara et al., 2007; Zakar et al., 2011).

Midwives in Chile are highly trained health care providers. Since being integrated into university education in the late 1800s, midwifery programs have developed into a what is currently a 5-year university baccalaureate program. Midwifery students are educated and trained in topics such as biology, chemistry, anatomy, nursing, neonatology, obstetrics, and gynecology (Binfa et al., 2011; Pettersson & Stone, 2005). Students also practice their skills and observe midwives through clinical rotations and internships. In Chile, midwives work in various areas of health care—in both private and public practice, in public health, and in policy.

Since Chilean midwives serve as the primary care providers for women in the public sector, they have significant exposure to women's health needs and concerns (Ministerio de Salud Chile and División de Estadísticas Sanitarias (DEIS), 2016; Lillo et al., 2016). Midwives provide more than 90% of antenatal and postnatal care, as well as the majority of family planning, menopausal care, and gynecology services (DEIS, 2016; Pettersson & Stone, 2005; Segovia, 1998). Midwives attend 70% of deliveries in Chile, while physicians attend the other 30% (Pettersson & Stone, 2005).

Thus midwives in Chile play a critical role in screening for physical, mental, and environmental factors that can adversely impact the health and well-being of women. Midwives are also in the unique position to improve the health of women as well as families and entire communities by providing resources, education, and referrals to other available community services. Additionally, Chile has the Ministry of Women and Gender Equity, a government agency that promotes equal opportunity and raises awareness of women's issues. In the public health care system, midwives refer women to psychologists and social workers in the system who subsequently refer them to the programs within the Ministry of Women and Gender Equity.

This is a large responsibility for midwives that requires them to account for the many factors affecting a woman's individual health care needs. These factors include, but are not limited to, socio-economic status, culture, race and ethnicity, language, and familial dynamics (Binfa et al., 2011; Weber, 2006). When midwives assess a woman's needs, they need to consider how these various factors intersect differently within individuals. Such intersectionality highlights the complex and dynamic nature of every woman's experience, and it requires great commitment on behalf of health care workers to be informed by this complexity (Bowleg, 2012; Weber, 2006).

To prevent negative consequences of IPV, midwives in Chile need to be equipped to screen, detect, discuss, and refer cases of IPV in the various populations they encounter. Early intervention is vital in cases of IPV to prevent further adverse consequences, and screening tools may better inform health care providers, such as midwives, in their provision of care. The University of Chile's midwifery program incorporated information regarding gender-based violence into the midwifery curriculum only in the last several years. The accounts and perspectives of midwives in this study highlight the need to develop curriculum and trainings to prepare health care providers for such challenging and sensitive patient encounters.

In 2017, faculty at the University of Chile in the Department of Health Promotion of Women and Newborns, which houses the midwifery education program, conducted a collaborative qualitative research study. The researchers' study purpose was to examine the experiences of midwives in IPV screening and their perceptions of what hinders women under their care from disclosing a history of violence. Specifically, the research questions were: (1) What are the experiences of midwives during IPV screening related to factors that may influence the screening process? (2) What are midwives' opinions on how such factors may impact patient reporting?

## Methods

### *Design*

The University of Chile's Department of Health Promotion for Women and Newborns is a WHO/Pan American Health Organization (PAHO) Collaborating Center for Midwifery in the Americas, making it a regional leader in the development of midwifery practice through research and clinical education. Midwifery faculty initiated an IPV prevalence study meant to inform a protocol to eventually task midwives with screening all pregnant mothers cared for in the public national health system. (There is also private health care in Chile.) The immediate location of the study was in four primary health care centers in the Santiago comuna of Recoleta, in coordination with appropriate services through the Ministry for Women

and Gender Equity. A comuna is the smallest administrative unit that contains cities, towns, and rural areas.

We implemented this study as a qualitative arm of the larger prevalence study, with the aim of informing the University faculty's implementation of a selected screening tool, the Woman Abuse Screening Tool (WAST). The WAST is widely used, although systematic reviews of this and other commonly used screening tools report that no single IPV screening tool has achieved well-established psychometric properties that are gender and culture sensitive (Arkins et al., 2016; Rabin et al., 2009). Students under faculty mentorship, as global field scholars from a partnering university in the United States, conducted the study as a joint endeavor with Chilean faculty and midwifery students. The recruitment and data collection periods of the study took place over 7 weeks, through funding from the U.S. University.

Designing the study as a qualitative descriptive study allowed us to record and present the data in simple terms and examine it without unnecessary rephrasing or extensive interpretation (Sandelowski, 1995). Qualitative analysis allowed us to identify common or key ideas from the data, compile them into key themes, and then synthesize them to inform future effective strategies related to IPV screening. The specific data collection method was through semi-structured, individual, in-depth interviews, with more than one interview per participant.

### *Setting*

The setting of this study was in Recoleta, a comuna north of Santiago, Chile. The midwifery faculty at the University of Chile identified and approved two primary care clinics serving Recoleta as the study settings, based on participation in the IPV prevalence study previously mentioned. There were four health centers in Recoleta, our area of study. We did not include all sites in the study due to limited time in country. One of the chosen clinics serves a larger population of immigrants, including patients from Bolivia, Columbia, Haiti, Peru, and Venezuela. This clinic also employed more midwives to serve this larger community with the more complex life issues that immigrant or disadvantaged women may experience. This was the rationale for selecting Recoleta as our study setting. We conducted the interviews in the private offices of the midwives.

### *Sample*

Through convenience sampling, we recruited midwives working in selected primary health care centers in the clinics to be participants by approaching and informing them about this study. It was appropriate to choose

midwives as they provide most of the care in these clinics, but also because they are the primary providers for women's health in Chile (Lillo et al., 2016). No incentives were offered for participating. The planned sample size was between eight to 12 midwives, but the actual sample size was limited to six midwives due to scheduling difficulties during the time frame funded for the study. The larger of the two clinics serving the larger immigrant population employs eight midwives, four of which were interviewed. The smaller clinic employs two midwives, and both of them participated. The only inclusion criteria were that midwives were working at one of the two primary health care centers and had at least 2 years of experience. Because of the already small sample size available, minimal efforts were made to limit the number of midwives involved. The ages of the midwives ranged from mid-20s to 40s years.

### Measures

The first author designed the semi-structured interview guide based on the research questions and piloted it with Chilean native Spanish speakers on the research team. The first author wrote the interview guide in Spanish and acted as primary interviewer for all interviews. The first author created three to four questions to initially guide the interview, but also formed probes to prompt the interviewee.

### Procedure

Prior to recruitment, we obtained approval for the study by the Institutional Review Boards (IRB) of both universities. After we informed the midwives of the details of the study and they agreed to participate, we asked them to sign a consent form obtained from Emory's IRB. Once consent was obtained, the interview took place thereafter; the length of interviews ranged between 20 and 45 min. The first author audio-recorded the interviews, downloaded them as mp3 files to a secure password-protected laptop, and manually transcribed the interviews with the assistance of the third author, which the second author later verified. The first author locked the consent forms in a secure location and de-identified all digital information. As coauthors, we maintained constant communication to ensure proper study conduct and the identification of potential adjustments to the interview guide, recruitment strategies, or study progression (Weiss, 1995).

### Analysis

We analyzed the data for content. As the first and third author transcribed the interviews throughout the study period, preliminary analysis ensued.

Through this process, we identified new information about participants' experiences, and developed new probes to be asked in subsequent interviews with other participants and in follow-up interviews. After transcription, the first and second authors translated and discussed the interview content with the last author. We sought out assistance from the primary field mentor, the last author, for clarification of Chilean slang or colloquial sayings. After translation, the first and second authors coded and reviewed the data. Selected codes reflected the a priori study question aims: provider experience during screening, perceptions of IPV screening tools, and factors influencing screening and reporting. We then categorized codes and sorted them by patterns of relationships and clustered them into the central themes that are presented below.

## Results

### *Midwives' knowledge of IPV*

When asked about discussing IPV with patients, midwives expressed that the Chilean health care system is focused more on the physical and psychological forms of violence. One midwife discussed screening for IPV by using the Edinburgh Postnatal Depression Scale to assess for stress in a patient, and if a patient screened high enough, she would be referred to a psychologist and/or social worker. Several midwives mentioned the challenges of determining "*if it [violence] is physical, or economical, or psychological, or emotional*." Economic violence could manifest by restricting a woman's ability to work outside the home and have an income of her own that may foster independence. However, with nonphysical forms of violence, such as economical violence, the midwives felt that there were not obvious pathways to address the concern or provide resources to the patient.

### *Barriers to routine screening*

Midwives expressed lack of sufficient time to discuss IPV with patients and screen them during appointments. They often felt that they had to compromise their attention to the patient; in the case of the Haitian patients, this was due to needing a translator, which slowed down examinations and lengthened discussions between patient and provider. Other times, the need to document the events of the encounter and update patient progress notes and examination findings took away attention from the patient. Midwives expressed that the time for prenatal appointments was extended under a recent political change, but they still felt strained to address all necessary aspects of patient care. A midwife may lack time to discuss IPV due to

completing documentation or discussing pertinent information with the patient, or she may lack time with one patient if she went over the allocated time with a previous patient. A few of the midwives appeared to be in tune with the needs of their patients, in terms of awareness of their medical risk and behaviors. Only one midwife explicitly stated that if a patient needs more attention related to her risk for violence, she will then compromise and shorten time with her other patients. Unfortunately, this is not feasible with every patient that appears to be at risk.

> Other times, when we see a person who is very sensitive in the consultation, w**e** dedicate ourselves to her, and after, we have all the people there waiting, which can be bothersome, but you have to have them [wait]. Because I can't send her away like that.

Language was a very salient issue for the midwives concerning their Haitian patients who did not speak Spanish; either the midwives had seriously limited communication due to inadequate translated resources or unavailable translators, or they felt conflicted by the ethical concern in using a partner as a translator. As the Haitian population has grown, so has the number of non-Spanish speaking patients in the health clinics in the capitol city of Santiago. In the clinics in the study settings, there was one Creole-speaking translator available to interpret for the Haitian patients, but her time was limited because she worked across four clinics in the region. When she was unavailable, the midwives described having very limited resources with which to communicate. They only mentioned one document, a fetal movement survey, translated to Creole that they could provide the patient. Additionally, midwives found that coordinating schedules with the translator proved challenging when patients needed a referral to the psychologist or other members of the health care team. One midwife expressed an interesting dilemma regarding the Haitian translator: since the one woman translated for much of the Haitian population in these clinics, she knew a lot of personal information about the members of this community. Midwives understood this could likely hinder a Haitian patient from disclosing something so intimate and delicate as IPV.

The difficulty in trying to screen for violence is compounded because often the partner was the one who would come to translate for the patient. This created an ethical issue for the midwives, because screening for violence through a partner could increase a woman's risk for future violence, and she would be unlikely to report it when a potential perpetrator is present (Waalen et al., 2000). In this scenario, the midwives stated they would not screen her. So, when the patient did not speak the same language, or no one was available to translate, or it was unethical in the situation of a present partner, it remained unknown if these women suffered from violence.

> There are other partners that come with the patient to the intake. So there they are, the two together, so how am I [if I were the patient] going to say "Yes, I am the victim of him."

Another barrier was the dual complexity of language and culture. This was mostly concerning the Haitian patients, as midwives expressed less concern with patients who spoke Spanish as communication was not so inhibited. Partly because the midwives did not have a good understanding of Haitian culture and respective interpersonal dynamics, the midwives struggled to determine if the partner translating for the woman was an indication of a risk factor for IPV. This seemed to make the midwives uncomfortable, as most of them expressed frustration with wanting to communicate directly with the woman but being unable to.

> In general, first the men come [to Chile], they work, they manage the language a bit better, and then the woman comes [from Haiti]. So, the fact that he speaks for her [could be] because he has been in Chile longer, handling the language a little better, or because of this patriarchal theme.

In the case of Haitian patients, several midwives mentioned that the partner would sometimes answer the midwife's questions regarding the patient's symptoms or care in Spanish, without appearing to discuss it with the patient in Creole. This caught the attention of the midwives, who wished for there to be an observable translation effort between the partners to hopefully ensure the patient was aware of the questions and could answer honestly. However, even then, it was difficult to tell if it was the patient or the partner answering the question.

> He isn't even translating. He isn't even like [midwife turns as if speaking to someone next to her] "Oh yes, she is asking how you feel." For her [the patient], she doesn't know a single word. And he tells you "No, she's fine, she is doing fine." So, one has to say, "Yea ok, but can you ask her please?"

> … [there were times] where he spoke Spanish and she didn't speak Spanish, so then when I asked her [something], she didn't understand, and he answered me. So, there are [situations] that I don't know if ultimately he is responding to me or if she is responding to me.

The midwives frequently expressed a need among the health care team for intercultural training, one that would be both in-depth and relevant, so they might better understand their patients and their circumstances before judging behaviors or trying to impose their own cultural expectations. The midwives did not want to assume violence or overreact to behavior because of a misunderstanding of interpersonal relationships, but they also did not want to turn a blind eye to potentially abusive behavior. Several midwives expressed that this concern arose after various statements by patients who

desired to confirm health care related decisions with partners before moving forward in the plan of care.

> "Oh no, I have to ask him, and he [will tell] me, at least give me the authorization so that I can then tell you what [method of contraception] I'll use." So, I say to her, "But you can choose what you want. I am showing you the whole range of contraceptive [methods]. You can choose what suits you."

One midwife reflected on the tendency of allowing their own cultural and societal expectations be the lens through which they assess a patient's behavior and circumstances. By understanding a patient's cultural beliefs and customs, a midwife may be prepared to better communicate with and assist her patients.

> … you want … to turn her to a way of thinking, [a way] of doing. What you have to do, and what you don't have to do, without [the midwives] knowing what her way of life is and what her cultures or customs are.

The midwives were trying to determine if there was a cultural variance in the behavior or if there was some level of machismo occurring that was causing stress in the relationship. While cross-cultural understanding was a concern across nationalities and ethnicities, the midwives expressed more concerns with cultural issues with the Haitian patients. While not wanting to change a patient's cultural identity, they did want to educate their patients on how some aspects of culture could be putting them at risk for IPV, among other things. The midwives desired better training to manage this cultural difference and ambivalent sexism so they would feel more equipped to serve their patients.

### *The provider's approach matters as much as the screening tool*

The midwives believed in a balance in applying a screening tool while doing so in a sensitive and culturally competent way, according to individual circumstances. This concept was apparent throughout the interviews, as most of the midwives highlighted the importance of cultural sensitivity as well as provider communication skills and developing trust with patients.

While one of the midwives preferred to strictly use an IPV screening questionnaire for the sake of time, more midwives preferred to implement screening through conversation or more informal strategies. One midwife stated that asking directly if the patient suffered from violence was too blunt and insensitive, suggesting that the behavior and approach of the midwife to the topic of violence matters and could influence patient reporting. The midwives felt that by having a close relationship with the patient, or at least being able to empathize with them, the patient might feel they can trust them more. The desire to gain a patient's trust and confidence

seemed to be a factor that influenced the approach of several midwives toward discussing IPV.

> I try to respond to all the doubts they have, including questions from family members who have problems. And there, closeness [is created with] her a little. I feel that one of the most important things [is] to build trust.

### *Resources that could improve IPV screening*

Toward the end of the interview, we asked the midwives what kind of resources or tools they wished they had to aid in the endeavor to improve the identification of women suffering from IPV. Generally, the midwives desired more resources for their patients in the language the patients understand: information about what to expect during pregnancy, how a patient should take care of herself during pregnancy, partner behaviors that could increase their risk for adverse outcomes related to IPV, and where they can go to receive support if they experience IPV. The Haitian population would require all these resources in Creole, and the midwives understood that the provision of the resources in Creole would require significant financial resources and time. Several of the midwives discussed the benefit of Spanish and Creole classes, but that they had not been successful in clinics, either because patients and providers were not attending the classes or classes were not actually being held. Some midwives expressed that what might be most important would be knowledge of where the victims could seek help and providers could seek resources, as one stated

> I believe that what is lacking [is the knowledge] of the places where we can turn to.

Even though the midwives could refer women to the clinic psychologist, they did not have immediate awareness or knowledge about the referral process to the government ministry for women. The psychologists and social workers managed the direct referral to the Ministry of Women and Gender Equity, but the midwives were not intimately involved in the process. Midwives felt the health care team overall would benefit from more awareness about available resources and what the steps look like for patients, so they could directly answer patient questions about the process. For the midwives, this would be a long-term solution. Immediately, they stated that the need was for more translators for the Haitian patients, because at the end of the day, the patient and provider need to be able to communicate.

## Discussion

The interest in midwives as the health worker cadre to screen for IPV is an emerging area of study in many global contexts (Eustace et al., 2016; Jayatilleke et al., 2015; Samandari et al., 2016; Shamu et al., 2013). In Chile,

where midwives have been the primary health care providers for women in the public sector for many decades (DEIS, 2016), we found screening for IPV to be much more complex and nuanced than simply applying an "instrument."

Throughout the interviews, the midwives conveyed a sense of frustration with the difficulties in providing resources and being the support women need—affirming the post-modern critique by Tower (2007) of the dominance of structural constraints and prioritization of physical over mental health in health systems.

Other factors made a screening tool less useful to them, such as when a patient did not speak the language or did not trust the midwife. Midwives' dilemma of respecting cultural differences and values about normative behavior was another conundrum, as midwives recognized some immigrant women may have ambivalence over sexism (Alvarez et al., 2018) and constraints on personal agency related to gender norms and gender inequality (Hynes et al., 2016; Logie & Daniel, 2016). Midwives understood approaching a conversation about violence requires compassion, understanding, and trust, as well as a supportive environment and prepared provider (Chang et al., 2005, Kelly, 2009).

The midwives were conflicted by the dissonance of a partner translating for the woman while screening for IPV. Pragmatically, they found there were times when a screening tool became just another item on a checklist of tasks, rather than being appreciated as a carefully designed tool to find women in need of help. A Cochrane systematic review reports that while screening in health care settings increases the identification of IPV, there is not yet evidence of beneficial effects in terms of referrals and differential health outcomes to justify universal screening in health care settings (O'Doherty et al., 2015). Also, the WHO does not recommend universal screening to identify women who have suffered violence. Instead, they recommend that health care providers raise the subject with all women who present with injuries or conditions for which the provider suspects violence (World Health Organization (WHO), 2014).

The Chilean experience underscores a persistent, personal responsibility that midwives felt to provide excellent care and address these sensitive topics. As a result, there was a sense of deep frustration with the challenges in identifying women and ensuring they had access to the appropriate resources. To improve their care, the midwives desired intercultural training to become more familiar with the cultures of their immigrant patients. They recognized that this would require even more financial resources, education, and time.

There is no intention to refute the well-established case for the importance of IPV screening, considering the potential severity of health and well-being consequences for victims (Han & Stewart, 2014; Kishor & Johnson,

2006; Smith et al., 2017). In this study, we highlight some of the variables that would influence the success of universal screening for IPV. The detail provided in this study is one illustration for the rationale of why the WHO would not recommend universal screening (WHO, 2014).

The experience of the Chilean midwives raises the question of allocation of limited resources in addressing IPV. Would it be a more effective use of resources to develop midwives' understanding of the community level factors of gender norms, gender inequality, and collective efficacy within the communities of immigrants the Chileans midwives serve, than to universally implement a screening instrument? VanderEnde et al. (2012) call for this in future research in global IPV. Practitioners need to be assured that IPV is not an issue that can be addressed and solved by health care workers alone; it requires a broad interdisciplinary movement supporting health policies directed toward justice and safety.

## Limitations

There were several limitations in this study. First, as a pilot study, the small number of clinics involved do not indicate that the midwives in other primary health care centers would respond with similar concerns. Second, the first author is not a native Spanish-speaker, and this limited the pace of the transcription and translation process. Third, the short amount of time in-country to recruit participants and conduct the interviews limited the number of clinics and midwives who could be involved in the study. Possibly a larger sample size as well would have provided the researchers with opportunity to collect more data to more fully achieve data saturation.

## Conclusion and future study

We believe this research illuminates the complexity of screening processes, and the value that Chilean midwives place on sensitivity to individual contexts and interpersonal dynamics. While screening tools hold value within health care, factors that influence their usefulness (e.g., patient language and culture, time to discuss and refer patients, provider approach and behavior) deserve more attention in practice and in research. The experience of the Chilean midwives providing care to the Haitian immigrants brought to light the significance of culture and language in cross-cultural health care, and the need to broaden training in today's global communities. Rather than focusing on screening tools, perhaps future research and resources should be directed at training providers in best approaches to IPV screening, a deeper understanding of the referral system and available community resources, and cross-cultural training to improve patient-provider relationships. Clinical recommendations for this context would

include expanding and reinforcing opportunities for providers to discuss IPV with patients, translating and obtaining more resources for non-Spanish speaking patients, and increasing provider communication training related to IPV.

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## Author contributions

Savannah Gray and Jennifer Foster developed the original research proposal and co-wrote most of the manuscript. Matthew Revilla provided translation and interpreting assistance, as well as aiding in project development with the Chilean Ministry of Health regarding the Haitian population. Chelsea Medina provided translation and interpreting assistance. Ashley Rizzieri aided in developing initial qualitative interview questions for the study. Loreto Pantoja Manzanarez and Lorena Binfa provided in-country support in connecting co-authors with primary health care centers and midwives. All the co-authors read and edited the manuscript, giving their ideas and clarification, including adding references.

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