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Attitudes And Barriers To Intimate Partner Violence Screening And Follow-Up During Prenatal Care As Reported By Survivors In The El Paso, Texas Region

Luz Maria Luna
University of Texas at El Paso, lmluna1991@yahoo.com

ATTITUDES AND BARRIERS TO INTIMATE PARTNER VIOLENCE SCREENING AND FOLLOW-UP DURING PRENATAL CARE AS REPORTED BY SURVIVORS IN THE EL PASO, TEXAS REGION

LUZ MARIA LUNA

Master's Program in Public Health

APPROVED:

Thenral Mangadu, MD, MPH, Ph.D., Chair

María Duarte-Gardea, Ph.D, RD, LD

Yok-Fong Paat, Ph.D., LCSW

Charles Ambler, Ph.D.
Dean of the Graduate School

Dedication

To all families.

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by

LUZ MARIA LUNA

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Abstract

About 37.1% of Hispanic women in the United States have experienced intimate partner violence (IPV) (Breiding, 2014). In Texas, family violence cases among women comprised 73% of the total complaints (Texas Department of Public Safety 2012), and fatalities of women by an intimate partner totaled 102 women in 2011 (Office of Court Administration, 2013). In El Paso, Texas, the Center Against Sexual and Family Violence (CASFV) received 823 people in its emergency shelter from 2012 to 2013 and 70% of those residents were women (Center Against Family Violence, 2015). The Healthy People 2020 has assigned developmental objective IVP-39, under the Injury and Violence Prevention topic, to reduce violence by current or former intimate partners (U.S. Department of Health and Human Services, 2013).

IPV occurring prior to pregnancy may continue through it in 59% of women and IPV with related homicide is a leading cause of death by injury among pregnant women (Dunn & Oths, 2014). Health care providers have a unique opportunity to identify IPV. Two out of every five femicide victims requested medical attention one year prior to the fatality (Sharps, Koziol-McLain, Campbell, McFarlane, Sachs, & Xu, 2001). The American Congress of Obstetricians and Gynecologists recommends providers to screen for IPV throughout pregnancy (ACOG, 2014). It is estimated that only about 22-39% of pregnant women are screened for IPV during prenatal care (Anderson, B., Marshak, H., & Hebbeler, D., 2002). Nevertheless, the communication about IPV between health care providers and survivors can be limited by factors including linguistic barriers (Schouten & Meeuwesen, 2006) and fear of retaliation (Rodriguez, M. A., Bauer, H. M., McLoughlin, E., & Grumbach, K., 1999). Moreover, it has been documented that Hispanics are less likely to report abuse (Anderson et al., 2002) and to receive timely prenatal care (Bengiamin, Capitman, & Ruwe, 2010), compared to other ethnicities.

This mixed methods exploratory study documents the frequency of IPV screenings and follow-ups during pregnancy among IPV survivors and examines the attitudes and the barriers related to the communication about IPV between the survivor and the prenatal care provider. A standardized semi-structured individual interview guide was used to collect quantitative and qualitative data from 13 participants. The participants were adult women who had utilized services from the CASFV in El Paso, Texas during the last three years, had delivered at least once during the last three years, and had one prenatal care visit during the last pregnancy.

Quantitative data were entered, cleaned, and analyzed for descriptive statistics related to study aims using Microsoft Excel. Qualitative data were transcribed, translated and coded to identify emergent themes and categories. There were only two cases of IPV screening reported by participants, although disclosure of IPV and referral did not occur. Emergent themes from data analysis include a positive perception of IPV screening, referral, and communication of the same with the provider, barriers for communication about IPV with the prenatal care provider, and provider-related barriers such as being male and not speaking Spanish. The results of this study have implications for reducing the risk of IPV among women of Mexican origin, especially along the U.S.-Mexico border by increasing the effectiveness of IPV communication with care providers during the prenatal period.

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Chapter 1: Introduction

Intimate partner violence (IPV) is any type of violence, physical, sexual, or psychological, perpetrated by a former or current intimate partner (National Center for Injury Prevention and Control Division of Violence Prevention, 2010). Intimate partner refers to a current or former husband, cohabitation partner, boyfriend, or a date (Tjaden & Thoennes, 2000). Intimate partners can be living together or not, and can be romantic or sexual partners (National Center for Injury Prevention and Control Division of Violence Prevention, 2010). IPV is the most common type of violence against women. In 2010, about 64% of the reports of violence against women committed after 18 years of age were perpetrated by an intimate partner. IPV affects females and males. However, it has more detrimental consequences on female survivors (Tjaden & Thoennes, 2000). Experiences of IPV may continue through pregnancy (Dunn & Oths, 2014), leading to negative outcomes for the woman and the unborn child (Ramirez-Rodriguez, 2006). Hispanic cultural norms surrounding IPV can contribute to the prolongation of abuse (Agoff et al., 2006). In the United States, it is recommended that all prenatal care providers screen for IPV at different stages during pregnancy, in order to improve the identification of abuse and appropriate referral (American Congress of Obstetricians and Gynecologists, 2014). In some institutions, the measured rates of IPV screening have been lower than 50% (Anderson et al., 2002). Among Mexican Americans and Hispanics, these rates may be lower due to structural barriers, beliefs of the survivor, cultural norms, and other barriers that may inhibit the disclosure of IPV by the pregnant patient (Agoff et al., 2006).

Health care providers are in a privileged position to identify and follow-up on IPV cases. The aim of this exploratory qualitative study was to assess the likelihood of pregnant IPV victims being screened for IPV in the El Paso region and to explore the factors which may shape

the communication about IPV between the survivor and prenatal care providers. This study provides insight into the regional and cultural factors which may deter pregnant IPV victims from seeking help and/or communicating about IPV with their prenatal care providers. The results may provide information that can be used by local community-based organizations and health care providers to improve screening, disclosure, and follow-up among IPV survivors who are pregnant.

1.1 Healthy People 2020

The Healthy People 2020 created objectives related to the Injury and Violence Prevention topic to reduce IPV, such as objective IVP-39 aiming to reduce violence by current or former intimate partners (U.S. Department of Health and Human Services, 2013). This study addressed this developmental objective by providing useful knowledge for health care providers and non-profit organizations to increase IPV screening and appropriate referrals to support resources in the community. By screening and referring IPV cases at routine check-ups, it could be prevented that victims were screened until after an event of violence.

Chapter 2: Demographic Characteristics of the Population in El Paso, Texas

The state of Texas has a population of 26,059,203, with 38.2% of its habitants identifying themselves as Hispanic or Latino. In Texas and the United States, the Hispanic or Latino communities constitute the second highest ethnicity group, preceded by whites. El Paso is located along the United States border with Mexico, with a population of about 827,398. Unlike the state of Texas and the rest of the U.S., 81% of El Paso's population is composed of Hispanic or Latino habitants, of which 77.6% identify themselves as Mexican (ACS Demographic and Housing Estimates, 2012). The majority, 71.6%, was born in the United States, and only 26.5% were born in a foreign country; 94.2% of those not born in the U.S. were born in a Latin American country, primarily Mexico ("ACS Demographic and Housing Estimates", 2007-2011). People living in the U.S. who are foreign-born could be immigrants entering as legal permanent residents, refugees, temporary migrants such as students, or undocumented migrants (Nguyen & Altshuler, 2011). Among U.S. residents in El Paso, Texas 5 years and older, 25.9% reported that English is the only language spoken at home and 72.2% reported Spanish as the language spoken at home (ACS Demographic and Housing Estimates, 2007-2011).

Social issues, including the violence in Ciudad Juarez, Mexico and the proximity to the U.S.-Mexico border has made El Paso a receiving point for Mexican immigrants during the recent years, increasing the immigrant population in the city (Community Health Assessment Final Report, 2013). The number of individuals crossing or entering the United States through the ports of entry located in El Paso, Texas is high. In fact, El Paso, Texas houses one of the busiest ports of entry in the country (Quintana, Stigler, Muñoz Melendez, Quintero-Nuñez & Rodriguez Ventura, 2012). During 2013, there were 21,595 bus passengers, 17,545,433 personal vehicle passengers, and 6,015,421 pedestrians crossing over to the United States through El Paso (United States Department of Transportation, 2013).

El Paso County has a mean household income of 53,280 dollars, a mean family income of 57,500, and a mean non-family income of 36,945 dollars. It is estimated that 25% of the

population lived under the poverty level from 2007 to 2011. Among those aged 25 and over, 24.3% have completed high school or the equivalent, 13.2% a Bachelor's degree, and 6.6% a graduate or professional degree. The majority (76.4%) of the local population has attained a high school diploma or further studies, while only about 28% of the population has attained a Bachelor's degree or higher (ACS Demographic and Housing Estimates, 2007-2011). Among women, 73.7% have attained a high school diploma or more and 21.9% a bachelor's degree or more (ACS Demographic and Housing Estimates, 2007-2011). Among El Paso women 15 years or older, 46% reported being married, 29.5% never married, 11.6% divorced, 8.4% widowed, and 4.5% separated. Moreover, 51.7% of women are in the labor force, while only 47.3% are employed (ACS Demographic and Housing Estimates, 2007-2011).

Overall, the population of El Paso County has a higher percentage of individuals reported as uninsured compared to Texas. According to the 2008-2012 estimates, among Texan non-institutionalized civilians, 23.0% were uninsured, while 28% of El Paso non-institutionalized civilians did not have insurance. Among Texan non-institutionalized civilians 18 years or younger, 14.6% were uninsured, compared to 15.0% in El Paso (Selected Economic Characteristics, 2008-2012).

Chapter 3: Intimate Partner Violence in the United States

The United States Department of Justice defines domestic violence as abusive behavior exerted by one partner over the other one as a form of power (The United States Department of Justice, 2013). It can be present in physical, sexual, emotional, and psychological forms. Financial and verbal abuse can also occur. Physical violence includes physical aggressions; emotional violence occurs when the perpetrator does or expresses something that makes the victim feel low; psychological violence can occur in the form of threats or fear to gain control over the victim; sexual violence occurs when the victim is forced to participate in a sexual activity (National Center for Injury Prevention and Control Division of Violence Prevention, 2010). Verbal abuse can occur when communication is used to harm the victim, while financial abuse commonly happens in the form of monetary restriction or misuse. Female victims are more likely to suffer many forms of IPV, while men are more likely to experience physical violence (Tjaden & Thoennes, 2000). The results of the 2010 National Intimate Partner and Sexual Violence Survey indicate that in the United States 1 in 4 women have experienced severe physical abuse by their intimate partner, while 1 in 7 men have experienced it (National Center for Injury Prevention and Control Division of Violence Prevention, 2010). The Centers for Disease Control and Prevention reports that more than 1 in 3 heterosexual women have been victims of physical violence, rape, or stalking from an intimate partner at some point in their lives. In addition, in cases of rape against women, most perpetrators are intimate partners, as opposed to acquaintances. In 2010, about 5% of women reported that their intimate partner tried to get them pregnant against their will. During the same year, about 2% of female victims of any type of IPV became pregnant as a result of IPV (National Center for Injury Prevention and Control Division of Violence Prevention, 2010). Nevertheless, among female victims of rape and

physical violence, the risk for injury is higher when it is perpetrated by an intimate partner (Tjaden & Thoennes, 2000).

3.1 Intimate Partner Violence in Texas

According to the Texas Department of Public Safety (2012), 38% of the family violence reports in 2012 were among marital relationships including husband, wife, common-law husband, and common-law wife, ex-husband, and ex-wife associations. Family violence reports include a wide spectrum of relationship associations between the perpetrators and the survivors. In Texas, family violence reports were highest among women, ages 20 to 24 years old (Texas Department of Public Safety, 2012). Fatalities of women caused by their intimate partner were totaled at 102 women in Texas in 2011 (Office of Court Administration, 2013). In El Paso, Texas the Center Against Sexual and Family Violence received 823 people in its emergency shelter from 2012 to 2013, and 70% of those residents were women (Center Against Family Violence, 2015).

3.2 Intimate Partner Violence against Women

Female victims of abuse are more likely to present with injuries compared to men. The National Violence Against Women Survey in 2000 reports that among survivors of rape, 31.5% of females report suffering injuries from the event, compared to 16.1% of males. Among survivors of physical abuse, 39% of females and 24.8% of males reported injuries. In addition, the risk of injury from physical assault and rape in female survivors increases when the intimate partner acts as the perpetrator (Tjaden & Thoennes, 2000). IPV in teens may be associated with previous experiences of abuse. Teenage survivors of sexual abuse are less likely to make

decisions for themselves to prevent sexually transmitted infections, unintended pregnancies, and abuse (Shadigian, 2004).

3.3 Intimate Partner Violence among Hispanic Women

The reports on the prevalence of violence against Hispanic women may not be comprehensive due to the uncertainty of whether the cases are being properly reported. The results of the National Violence Against Women Survey suggest that Hispanic women are just as likely to report physical assault as non-Hispanics, but less likely to report rape (Tjaden & Thoennes, 2000). Estimates show that about 37% of Hispanic women in the United States have been victims of IPV in the form of rape, physical assault, or stalking (Breiding et al., 2014). In Mexico, many women experience IPV while dating and 60-96% experience it during the first year of union with their partner. In addition, violent events are more common among young couples (Ramirez-Rodriguez, 2006). Mexican young women of ages less than 35 years old tend to tolerate IPV in a greater scale (Agoff et al., 2006).

3.4 Intimate Partner Violence during Pregnancy

Female survivors of abuse are less likely to involve their partner in the progress of their pregnancy. Compared to non-abused women, survivors of abuse are less likely to tell their partner about their pregnancy and have their support (Glander et al., 1998). IPV in pregnant women is associated with substance abuse, low birth weight, and death of the mother and baby (Anderson et al., 2002). Studies in Mexico suggest that IPV may also pose a greater risk for infant mortality, dead births, pregnancy complications, and genitourinary infections, besides post-traumatic lesions that are not necessary physical (Ramirez-Rodriguez, 2006). In the healthcare setting, sometimes the harm resulting from IPV might present itself in the form of

frequent headaches, sleep problems, depression, gastrointestinal problems, insecurity, forgetfulness, among others (Ramirez-Rodriguez, 2006).

Women who are abused before pregnancy can also be victims while pregnant due to their increased vulnerability during pregnancy. A study showed that 59% of survivors abused one year prior to getting pregnant were also abused during pregnancy (Dunn & Oths, 2014). Some studies estimate that about 52% of women abused prior to pregnancy are abused more harshly while pregnant. This is especially true for adolescent mothers, an age group that has an incidence of IPV of 1 event of violence per 5 pregnancies compared to adult mothers who have an incidence of 1 event of violence per 6 pregnancies (Anderson et al., 2002). IPV may peak at the post-partum period for adolescents, yielding a key period to perform screening in this young age group (Shadigian, 2004).

Sexual abuse, arguing, and psychological aggression can increase during pregnancy (Martin, Harris-Britt, Li, Moracco, Kupper, & Campbell, 2004). It has been reported that abusive situations increase in severity during pregnancy, that abuse may start at pregnancy, and that abuse stops or decreases while the woman is pregnant. Yet, IPV prior to pregnancy is the strongest indicator of abuse during pregnancy (Dunn & Oths, 2014) and IPV during pregnancy tends to continue post-partum (Andersen, Martin, Petersen, Clouthier, Convington, Buescher, & Beck-Warden, 2000). In Mexico, the incidence of IPV during pregnancy has been associated with the presence of IPV during the year previous to the pregnancy, a low socioeconomic status, and having a partner that witnessed domestic violence at home (Ramirez-Rodriguez, 2006).

Pregnant women can become victims of femicide. In fact, pregnant women can have more risk factors leading to femicide than women who are not pregnant (Martin et al., 2004). The leading cause of death by injury in pregnant women is homicide resulting from IPV (Dunn

& Oths, 2014). A study found that 23% of women killed by their intimate partner were physically abused during pregnancy and 5% were killed while they were pregnant (Sharps et al., 2001).

Chapter 4: Cultural Norms for Intimate Partner Violence against Women among Hispanics

Intimate partner violence can be perceived and defined differently among cultures. The cultural norms and views of IPV can affect the continuation and outcome of the abusive relationship. IPV in the Mexican culture can arise as a form of control over the partner. In Mexico, domestic violence is a common social problem almost seen as 'normal' and may, in turn, be unrecognizable as abuse to victims of IPV (Agoff et al., 2006). Social impairment can also contribute to IPV through attacks to the integrity of women and promotion of their subordination with men (Ramirez-Rodriguez, 2006). The survivor's expectation to endure certain behaviors from their partner results from social norms embedded in culture; and example of such a norm is the acceptance of the husband's extramarital relationships due to time and distance by women living in Mexico partnered with seasonal U.S. immigrant workers (Hirsch & Wardlow, 2006). Survivors may also perceive that sexual activity with their partner is required from them regardless of their will.

Latina women, in general, are often exposed to machismo, a social attitude where the male partner may seek to be in control and dominate the female partner (Harvey, Beckman, Browner, & Sherman, 2002). The Mexican culture seems to have an inclination for power inequality; women are valued differently than men (Maternowska, Estrada, Campero, Herrera, Brindis, & Miller Vostrejs, 2010). Nonetheless, machismo can also carry some positive connotations in the Hispanic culture, such as protecting the family by being a good provider and fulfilling responsibilities (Galanti, 2003). Men can also be targets of violence prevention strategies, such as the CASFV battering intervention and prevention program (BIPP). In 2013-2014, 408 out of 465 participants in CASFV's BIPP were male (Center Against Family Violence, 2015).

Among Mexican American women the effects of IPV can be amplified because of societal and cultural norms around the issue. The social norms and values that influence gender roles are instilled in the family. Unfortunately, some of those norms may promote IPV by subduing women in different ways. For example, Mexican women may try to diminish their partner's culpability for an act of violence against them; they may attribute the violence to factors outside of the partner's control such as past traumas. In other cases, women may assume responsibility for the violence perpetrated to them, since, according to the partners, they are not fulfilling their gender roles and deserve punishment for it. Women may also consider IPV as a future that awaits all women and thus, develop a sustained tolerance for it (Agoff, Rajsbaum, & Herrera, 2006). Some gender roles in the Mexican culture may promote IPV, such as the expectations for a married woman to be passive, tolerant, to bear children, and to sacrifice herself for the well-being of her children (Poma, 1987). Situations of IPV are usually kept private and within the home environment, women usually do not talk about it with their social network (Lewis, West, Bautista, Greenberg & Done-Perez, 2005).

The social networks of the woman can have an effect on their perception of IPV and the continuation of abuse. Sometimes women receive advice from people that try to help them get out of the abusive situation. In other instances, women are convinced by social networks to stay and endure violence (Agoff et al., 2006). Mexican women often experience a cultural expectation to stay with in an abusive relationship. Among Latinos in the United States, families may avoid involvement in a woman's situation of IPV, may encourage them to leave the perpetrator, may expect the victim to tolerate the abuse, may blame her for the situation of IPV, or may accompany to get help (Klevens, Shelley, Clavel-Arcas, Barney, Tobar, Duran, Barajas-Mazaheri & Esparza, 2007).

The social network of women can be limited by migration, in turn promoting IPV. The Mexican side of the U.S.-Mexico border is a zone that meets many characteristics that promote IPV, such as high mobility of the population, women's loss of social support because of migration, strong financial dependency on the partner, and lack of institutional support in the form of resources for women to exit a situation of abuse (Ramirez-Rodriguez, 2006). For Hispanic immigrants in the United States, being unfamiliar about the rights of abuse victims, the country's legal system, and the available resources within the community pose additional barriers to getting help (Lewis et. al., 2005). Other factors contributing to IPV among Latinas in the United States might be immigration status, economic issues, and unemployment, especially among immigrants. The negative connotation to police involvement presented by media may also inhibit help-seeking among victims due to mistrust. In the case of immigrant women, being undocumented, language, and cultural differences with police and resources, may pose barriers to seek help (Lewis et. al., 2005). Survivors of IPV can also be targets of structural violence from public authorities. In the past, abused women in Mexico have been ignored by legal and medical authorities when trying to file a claim against an abusive partner. In other cases, women are scrutinized with accusations of wishing to abandon the relationship or destroying the family for seeking help; they are sometimes encouraged to stay in the relationship regardless of the presence of abuse (Agoff et al., 2006).

Chapter 5: Prenatal Care

5.1 Prenatal Care Utilization by Hispanic Women

A study estimates that around 31% of Hispanic women, mainly Mexican, in the United States begin accessing prenatal care late. In 2002, Hispanic women were less likely to receive prenatal care during the first trimester of pregnancy compared to whites (Bengiamin et al., 2010). Among abused women, pre-natal care is often deferred until the last trimester of pregnancy (Dunn & Oths, 2014). Prenatal care that is inadequate or received at a late onset is defined as not receiving the appropriate number of visits or not starting care during the first trimester of pregnancy (Bengiamin et al., 2010). Inadequate or late prenatal care affects the well-being of the mother and the baby, the pregnancy outcome, and the consequent use of pediatric care such as well child visits and immunizations (Bengiamin et al., 2010).

5.2 Factors Influencing Utilization of Prenatal Care

The use of prenatal care is influenced by a variety of factors, including the partner's perception of the pregnancy. Having a desired pregnancy by the father and the presence of his support are factors that contribute to adequate prenatal care (Sangi-Haghpeykar, Mehta, Posner, & Poindexter, 2005). Private insurance coverage also influences prenatal care use. Women covered by a private insurance prior to pregnancy are more likely to begin prenatal care in a timely manner. Other factors include having a prenatal care provider close by and convenient clinic hours (Bengiamin et al., 2010). Common barriers to the use of prenatal care include not knowing of the pregnancy, not having insurance or money, and transportation issues (U.S. Department of Health and Human Services Health Resources and Services Administration Maternal and Child Health Bureau, 2013). In addition, younger women may delay prenatal care more compared their older counterparts.

In cases of IPV, the perpetrator may force women to not enroll in prenatal care (Shadigian, 2004). In the case of abused teenagers, they tend to wait until the last trimester to receive prenatal care unlike non-abused teenagers. During 2009-2010, the age group of United States women who delayed prenatal care in a greater proportion was 19 years or younger (U.S. Department of Health and Human Services Health Resources and Services Administration Maternal and Child Health Bureau, 2013).

5.3 Factors Influencing Utilization of Prenatal Care among Hispanic Women

In the case of migrants, Mexican immigrants in the United States are less likely to use health care services compared to U.S. born Mexicans and non-Latino Whites (Vargas Bustamante, Fang, Garza, Carter-Pokras, Wallace, Rizzo & Ortega, 2010). Among immigrant Hispanic women, language, culture, insurance issues have been found to limit the use of health care. Yet, another study found that the likelihood of receiving adequate prenatal care was the same for immigrant Hispanic women as for U.S. born Hispanics. This study also found that acculturation did not have an influence in the adequacy of prenatal care, while having a license as a form of identification was found to have a negative influence in the use of prenatal care services. This may imply that immigrant populations without any form of legal documentation may have less access to prenatal care since they may be more marginalized. In addition, having a father of the baby that is U.S. born and non-Hispanic may promote health care utilization due to income, insurance security, and familiarity with the U.S. health care system (Korinek & Smith, 2011). The neighborhood of residence also seems to be a factor in prenatal care utilization. Living in an area with a large population of migrants might be able to offer care that is culturally familiar to Hispanic women, increasing access and promoting utilization of prenatal care (Korinek & Smith, 2011).

Latinas have been found to perceive satisfactory health care when emotional support is offered (Wong, Korenbrot, & Stewart, 2004), thus, increasing their chances of returning for healthcare services. With regards to language barriers, being able to communicate with their health care provider in their language without the need of a translator is a factor of patient satisfaction among women in prenatal care. Unfortunately, satisfaction tends to decrease when the provider does not speak the patient's language and the aid of interpreters is needed or such service is not available (Shaffer, 2002).

Utilization of services is influenced by personal preference, insurance, cost, and access to services. Along the U.S.-Mexico border, cross-border utilization of medical services is an option that people may take based on cost, prescription requirements, and cultural similarities (Byrd & Law, 2009). El Paso, Texas holds one of the busiest ports of entry in the country and the percentages of uninsured are higher in the county than in the State. An important factor to cross-border utilization of medical services may be being uninsured in the United States (Byrd & Law, 2009). Yet, people residing in the United States may resort to seeking care in both sides of the border. In 2007, it was estimated that 33% of El Paso County, Texas residents had used medical services in Mexico in a two-year span prior to the study (Byrd & Law, 2009). The most common type of services sought was pharmaceutical-related. The number of people seeking care across the border for major reasons was low (Byrd & Law, 2009).

5.4 Prenatal Care Availability in El Paso, Texas

In El Paso, there are four University Medical Center of El Paso (UMC), the largest hospital on the U.S.-Mexico Border, prenatal clinics. UMC is known to provide services to the uninsured and low-income people in the area. It was reported that in 2012, the hospital provided a total of $326 million worth of services that were unpaid by the patients. The prenatal clinics

spread through the area are estimated to provide medical care and education to 5,000 women (University Medical Center of El Paso). The El Paso First Health Plans, Inc. reports that there are two locations of prenatal services for patients under the Children's Health Insurance Program (CHIP), both listed under the University Medical Center of El Paso and providing services in Spanish and English. Under the same program, there are 75 Obstetricians-Gynecologists providers in El Paso, Texas out of which 59 advertise that services are available in Spanish (El Paso First Health Plans, Inc., 2014). In Texas, CHIP has perinatal coverage for women without health insurance who are not eligible for Medicaid, usually covering prenatal care visits (Texas Health and Human Services Commission, 2016).

Chapter 6: Health Care Providers and Pregnant Survivors of Intimate Partner Violence

6.1 Health Care Seeking by Intimate Partner Violence Survivors

Several studies have shown that it is common for abused women to attend the Emergency Department prior to femicide by their intimate partner. A study found that two out of five femicide victims contacted the health care system in a one year period before the fatality. In another study, about 13% of Emergency Department patients who were survivors of IPV were assessed. Among patients at clinics, only 1.5% to 12% was questioned about abuse. Screening for intimate partner physical abuse is not widely conducted in the health care setting, and screening for sexual abuse is lower yet. Yet, abuse might increase during pregnancy (Sharps et al., 2001).

6.2 Common Characteristics of Intimate Partner Violence Survivors Seeking Health Care

Studies have clustered the characteristics of pregnant women survivors that seek health care. Some of these characteristics include being young, single, having an unintended pregnancy, reporting friends as their source of support, being afraid of the partner, reporting depression and experiences of sexual abuse as a child (Anderson et al., 2002). Other characteristics among abused pregnant women include not completing a high school diploma, smoking and drinking, along with skipping pre-natal care appointments (Dunn & Oths, 2014). These characteristics have been utilized by health care providers as flag markers of possible abuse that could be means to identify and assist survivors of abuse.

6.3 Screening for Intimate Partner Violence in the Health Care Setting

At the time of a mother's visit to a health provider, the health care personnel can be agents of identification of IPV. The American College of Nurse-Midwives and the American

Congress of Obstetricians and Gynecologists (ACOG) recommend that all patients should be screened for IPV by health care personnel. Pregnant women need to be screened at different times compared to non-pregnant women. They should be screened at the first pre-natal visit, at least one time every trimester, and during a post-partum checkup (American Congress of Obstetricians and Gynecologists, 2014).

A study estimated that only about 22-39% of U.S. women are screened during prenatal care (Anderson et al., 2002). Reporting IPV to health care personnel can be difficult, especially when trust has not been developed between the two parties. Moreover, Hispanic survivors are less likely to report it to authorities compared to all other ethnicities (Anderson et al., 2002). For these reasons, the ACOG has set several abuse screenings for pregnant women since patients may not report it during the first visit and to account for abuse that may start at different stages of the pregnancy (ACOG, 2014).

A study found that assessing for IPV in pregnant women during pre-natal care every trimester significantly increased the rate of abuse identification, while conducting the assessment one time during pre-natal care did not produce an increment in identification of abuse (Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Another study found that some pregnant women screened for abuse during a pre-natal care appointment did not report being survivors of IPV until personal interviews were conducted. This indicated that abuse might not have started until the assessment process or that the screening setting might have contributed to the reporting by the patient. It was concluded that screening for abuse is needed at various times and using different methods of assessment.

Although IPV assessments are recommended, compliance by the health care providers is low (Martin et al., 2004). However, survivors of abuse have been found to appreciate abuse

screening as part of their examination (Chang, Cluss, Ranieri, Hawker, Buranosky, Dado, Scholle, 2005). Yet, the U.S. Preventive Services Task Force has not recommended or rejected screening for IPV among female patients due to the lack of studies that objectively measure the effects of screening in situations of IPV.

In Mexico, since 2000, health care personnel have been committed to identify, report, and follow cases of domestic violence. Cases should be treated medically first. Then, health care personnel are to refer victims to optional resources and discuss with them possible legal actions. Personnel are entitled to make specific reports on the patient's records about any situations of abuse, lesions, referrals, and medical follow-ups (Peña & Egan, 2005).

6.4 Recommendations for Screening in the Health Care Setting

The methods of screening for IPV that have been suggested are standardized domestic abuse questionnaires and directed interviews. Some studies suggest that directed interviews are a more efficient method in identifying abuse (Canterino, 1999). However, another study found that standardized questionnaires identified a higher prevalence of domestic abuse compared to directed interviews during initial prenatal care appointments (Canterino, 1999). Moreover, it suggested that the use of both methods one after the other increases the identification of abuse. Performing multiple queries about IPV has also been identified as an efficient way to improve cases of IPV among pregnant women (Canterino, 1999).

Previous studies have provided recommendations for medical providers performing the screening. First, it is recommended that the provider be trained on the topic. Training has been identified as an important promoter of screening and referral. Second, to consider the safety and autonomy of the woman. Third, the provider must be in a position to educate about IPV and provide referrals and information about local community resources (Shadigian & Bauer, 2004).

Another recommendation is to inquire for IPV history as well as any history of abuse. More specific recommendations are divided into three milestones: (i) to start the screening with a framing statement followed by direct questions, (ii) to respect the privacy of the survivor, and (iii) to screen for IPV in a routinely manner (Shadigian & Bauer, 2004).

6.5 Actions to Follow Screening for Intimate Partner Violence in the Health Care Setting

The actions taken by the health care provider after the screening are as important as the identification of abuse in a patient. It is important to recognize that every time a survivor seeks medical care and discloses IPV, efforts can be taken to increase her awareness of injury, help her reduce the chances of injury, and address the abuse (Sharps et al., 2001).The Joint Commission on Accreditation of Healthcare Organizations requires health care facilities to intervene on an identified case of IPV. The female participants of a study inquiring about the needs of battered women indicated that they would want their clinicians to deliver information about IPV and sources of help. Specifically, women in this study identified counseling, legal and resource information, as well as hotline assistance as necessary services. However, some useful sources of help such as counseling require the survivor to report and health care personnel to screen for abuse (Chang et al., 2005).

Health care providers should have knowledge about the legal and moral requirements for reporting situations of abuse. From the medical perspective, the survivor must undergo a complete physical examination, a psychiatric assessment, and a review of any history of abuse (Shadigian & Bauer, 2004). The patient should be given immediate referrals to shelters, social work services, support groups, law enforcement, legal counsel, therapy, among others. A danger assessment scale can be utilized to guide the patient into measuring their risk of becoming

homicide victims. Along with such assessment, safety planning appropriate for the survivor's situation are essential (Shadigian & Bauer, 2004).

Some recommendations may lead to questioning the health care provider's ability to provide complete outreach to patients who are identified as IPV survivors. Some may consider social workers as optimal agents for education and advocacy in the health care setting. Yet, health care providers can provide useful and complete information about local resources where the survivor can receive guidance, advocacy, and aid (Shadigian & Bauer, 2004).

6.6 Factors Influencing Screening and Disclosure of Intimate Partner Violence

Screening tends to be more common among cases of injuries compared to regular medical visits. Obstetricians and gynecologists have been identified as the primary care physicians that screen the greatest percentage of new patients (Rodriguez, Bauer, McLoughlin & Grumbach, 1999).

The chances of getting screened for abuse increase about four times if the mother's pre-natal care was provided by public assistance (Andersen et al., 2000). The rate also increases for women receiving care at a public healthcare facility as opposed to a private clinic, showing that screening compliance is greater in public facilities (Andersen et al., 2000). Another study found that a greater percentage of patient screening occurred at public facilities (37%), compared to private facilities (9%) (Rodriguez et. al., 1999). This could be attributed to the health care providers' perception of increased risk for abuse among low-income patients (Andersen et al., 2000).

Having received training in domestic violence topics has been identified as another factor that increases screening by physicians during prenatal care. It was found that more physicians who had received training within the last three years performed routine screening (24%),

compared to those that had not received training (8%) (Rodriguez et.al., 1999). In addition, screening for IPV over long periods of time has shown increased rates of IPV identification in the health care setting. This could be attributed to a fostered relationship between the provider and the patient (Shadigian & Bauer, 2004).

6.7 Barriers for Screening and Disclosure of Intimate Partner Violence in the Health Care Setting

Some of the barriers to screening women for abuse as reported by health providers include lack of education about abuse and lack of time (Waalen, 2000), not feeling comfortable, not wanting to offend the patient, and feeling powerless to make a change in the patient's situation. Another barrier may be the sex of the care provider. A study found that male nurses were less likely to identify a case of IPV compared to female nurses. Medical providers in emergency services identify that having a patient with psychiatric complains and receiving the patient at night are factors that inhibit screening. Women in need of ambulance transport and very ill patients have been reported to receive screening by emergency services personnel in a lower proportion as well (Larkin et al., 1999). This could be due to the lack of time and the urgent need for medical attention rather than for interviewing the patient. Lack of information about local community resources has also been identified as a barrier for screening and referral, especially among physicians without recent training on domestic violence (Rodriguez et.al., 1999).

Some physician-reported barriers from the patients' side include lack of disclosure of abuse during visits, fear of retaliation by the abusive partner, and hesitation due to possible police involvement. Structural and cultural barriers, as reported by physicians, are the lack of follow-up on any referrals and cultural differences between the doctor and the patient (Rodriguez

et. al., 1999). Women's late recurrence to prenatal care in cases of IPV may also be a limiting factor to screening and referral, along with other factors inhibiting prenatal care utilization (Shadigian & Bauer, 2004).

6.8 Recommendations to Implement Intimate Partner Violence Screening and Referral in the Health Care Setting

In order to improve the problem of IPV among pregnant women it is imperative to identify the survivors and to provide information, referrals to community resources, and safety plans. In order to increase the identification of cases of abuse among pregnant women, education and practice of IPV interventions should be included in the curriculum of health care providers (Dunn & Oths, 2014). A study among primary care physicians found that some of the most common referral-related activities were talking about the doctor's concern for the patient's safety, recording abuse in the patient's record, and providing referrals to counseling opportunities and information about support services. Remarkably, physicians with recent training about domestic violence, within three years, were more likely to recur to certain referral activities such as providing information about shelters, inquiring about guns at home, and making police reports (Rodriguez et.al., 1999).

A study conducted on an Emergency Department, implemented an aggressive and universal screening protocol that aimed towards identifying cases of abuse in women seeking medical services. Education about IPV, IPV identification, and referral was provided to health care personnel. Prior to the intervention, only about 1% of cases was documented as involving IPV and referred to the appropriate services. After the intervention, the number of cases of women with reports of abuse and referrals increased to 18% (Larkin et al., 1999).

Chapter 7: Goals and Objectives

7.1 Goal

- To explore the factors shaping the communication about IPV between female survivors and health care providers in the prenatal setting in the El Paso, Texas region

7.2 Objectives

- To document the frequency of IPV screening and follow-up among female survivors during prenatal care

- To examine the barriers for the communication about IPV between the survivor and prenatal care providers

Chapter 8: Methods and Materials

8.1 Research Domains Examined

- IPV during pregnancy
- Cultural and regional norms related to IPV
- Prenatal care utilization by survivors of the El Paso area
- Patient-health care provider communication
- IPV screening and follow-up during pregnancy by prenatal care providers
- Barriers to the communication about IPV between the patient and health care provider

8.2 Theoretical Framework

This study was guided by the Social Cognitive Theory (SCT), the primary concept of which is the interaction between the environment, social experiences, and individual characteristics in shaping behavior. The SCT constructs of individual characteristics that affect behavior are self-efficacy, behavioral capacity, expectations, self-control, and emotional coping. Environmental constructs such as vicarious learning, the situation, reciprocal determinism, and reinforcement also influence behavior (Edberg, 2007). Most of these components are shaped by cultural norms, personal experiences, and current social situations and influence whether the IPV survivor communicates abuse.

8.3 Study Design

The study was conducted using mixed methods, qualitative and quantitative. The qualitative component was guided by Creswell's phenomenological tradition, in which a

perspective of interest is explored among people who have experienced a common phenomenon (Creswell, 1998). Since this type of methodology focuses on gathering data that is explored rather than compared, the data for this study was gathered through 1-hour individual interviews using a semi-structured interview guide. The individual interviews explored the study's research domains among women who had experienced IPV and were currently living in the El Paso, Texas region.

8.4 Data Collection

All the data was collected through individual interviews conducted by the investigator using the semi-structured interview guide. For the quantitative component, a standardized survey portion of the guide was used to collect demographic information, reproductive history, and information about prenatal care utilization. The qualitative component included open ended questions that were used to gather information about the prevalence of IPV during pregnancy, screening and follow-up during prenatal care, and about the barriers inhibiting the communication of IPV in the prenatal care setting (Appendix A).

Informed consent was a process throughout the study. Written consent was obtained from the participants at the meeting for the one-time interview. The consent forms were available in English and Spanish as requested by the participant (Appendix B). The privacy and confidentiality of study participants was protected by not collecting any personal identifiers tying the data to the participants. The interviews were conducted in a closed and safe space convenient for the participant. Participants were requested not to mention their names during the interviews and were assured that they had the right and control over what information they shared during the study. Participants were informed about their right to stop participating in the interview any time.

8.5 Participant Inclusion and Exclusion Criteria

For a phenomenological study, the recommended sampling method is "Criterion" sampling to make sure that the participants have experienced the phenomenon of interest (Creswell, 1998). For this study, the participants were women 18 years or older who had utilized services from the Center Against Sexual and Family Violence (CASFV) in El Paso, Texas during the last three years, had delivered at least once during the last three years, and attended at least one prenatal care visit for the pregnancy delivered. If there was more than one delivery during the three year span, the most recent pregnancy was be considered to decrease the risk of the recall limitations such as not remembering details about prenatal care or remembering incorrectly. The participant selection pool was limited to women who had delivered and did not include pregnant women to prevent any discomfort to the woman and fetus owing to their vulnerable state.

8.6 Sample Size

The most common number of interviews cited to reach data saturation in qualitative studies ranges from 20-30 participants. However, the ideal number of individual interviews to be conducted may depend on factors such as the research question and the nature of the issue of interest (Thomson, 2011). A sample size of at least ten individuals was deemed necessary for data saturation related to this study based on the availability of a participant pool with the characteristics of interest and the null emergence of new themes (Creswell, 1998). The sample size for this study was of 13 participants who were recruited from the CASFV with the help of the center's staff. A participant incentive of a $20 gift card was provided to each participant to compensate for time and transportation. Two additional participants recruited by the center staff

were rejected due to being less than 18 years old and being pregnant at the moment of the interview. However, these two rejections still received the participant incentive.

8.7 Data Analysis

Quantitative data was coded, entered, cleaned and analyzed using Microsoft Excel. Descriptive analyses were conducted for frequencies and percentages related to demographics and prenatal care. The interviews (qualitative) were recorded, transcribed and translated to English, if applicable. A coding system was developed to categorize the responses into main categories and sub-categories related to the research domains probed and the study's aims. Following this, emergent themes related to research domains were identified and hypothesis related to the risk factors for IPV and barriers to communication of the same with prenatal care providers during pregnancy were generated.

8.8 IRB Approval

Data collection was commenced after the University of Texas at El Paso Institutional Review Board determined the study was exempt from IRB review according to the federal regulations on November 20, 2015, protocol 812354-1.

Chapter 9: Results

9.1 Demographics

The average age of the participants was 29.9 years, ranging from 19 to 42 years of age. The majority of the participants (61.5%) were 18 to 29 years old. Almost all participants (12 out of 13 or 92.3%) were Mexican or Mexican-American and identified themselves as white (53.8%). One participant considered herself of Puerto Rican origin. With regards to their race, besides white, some were considered American Indian or did not know their race. Eleven out of thirteen participants reported that their preferred spoken language was Spanish. Most women have been living in the United States for up to ten years (69.3%), with almost thirty nine percent of them having lived here for up to five years. Ten out of 13 (76.9%) had delivered only one child during the last three years. About forty percent reporting being married and being separated during the last pregnancy, the rest were either never married, divorced, or cohabiting but not married.

Table 1: Demographic Characteristics

Variables		Frequency (*n=13)*	Percentage
Demographic Chracteristics			
Age in years			
	18-29	8	61.5%
	30-39	2	15.4%
	40-49	3	23.1%
Origin			
	Mexican or Mexican American	12	92.3%
	Puerto Rican	1	7.7%
Race			
	White	7	53.8%
	American Indian and Alaska Native	1	7.7%
	Other: Do not know	5	38.5%
Preferred language			
	Spanish	11	84.6%
	English	1	7.7%
	Other: Spanish and English	1	7.7%
Years in the United States			
	0-5	5	38.5%
	6-10	4	30.8%
	11-15	1	7.7%
	20-25	2	15.4%
	25+	1	7.7%
Children delivered in the last 3 years			
	1	10	76.9%
	2	3	23.1%
Marital status during last pregnancy			
	Married	5	38.5%
	Never married	1	7.7%
	Divorced	1	7.7%
	Separated	5	38.5%
	Cohabiting, not married	1	7.7%

9.2 Healthcare Characteristics of Last Pregnancy

As depicted in Table 2, public insurance was the most common type of health insurance among participants with 61.5%; two participants reported not having health insurance during the last pregnancy. All the participants gave birth to their last child in a hospital. Regarding prenatal care, an equal number (46.2%) reported having a female and a male doctor, only one participant did not remember the sex of her prenatal care provider. Most women, 84.6%, began accessing prenatal care during the first trimester while the rest of participants reported utilizing prenatal care services from the second trimester. The more common settings of the prenatal care were doctors' offices and clinics, while 23.1% reported receiving it at a hospital. All the participants received care in the United States; with ten participants having received care in El Paso, Texas, two other participants in another location in the United States and one participant reporting having received care in El Paso, Texas and Ciudad Juarez.

Table 2: Healthcare Characteristics

Variables	Frequency (*n=13*)	Percentage
Healthcare characteristics of last pregnancy		
Type of insurance		
Private	3	23.1%
Public	8	61.5%
No insurance	2	15.4%
Type of delivery		
At hospital	13	100.0%
Sex of prenatal care doctor		
Female	6	46.2%
Male	6	46.2%
Don't remember	1	7.7%
Start of prenatal care		
First trimester	11	84.6%
Second trimester	2	15.4%
Setting of prenatal care		
Hospital	3	23.1%
Clinic	5	38.5%
Doctor's office	5	38.5%
Location of prenatal care		
El Paso, TX	10	76.9%
U.S.	2	15.4%
Other: Cd. Juarez & El Paso, TX	1	7.7%

9.3 Survivor's Definition of Violence

The most common definition of violence among participants included a physical, emotional, and a verbal abuse component. All the participants identified physical aggression as violence. Almost all participants referred to emotional aggression as a form of violence, one participant referred to this as *"making you feel less".* Another common form of violence identified was verbal abuse; women defined verbal violence as insults and offenses.

Psychological violence was also identified as a form of violence. However, it was often associated with emotional and verbal violence. Sexual violence was mentioned by one participant. Financial violence/control was identified a few times. It was defined as not receiving money from the partner and having to wait for them to buy groceries. One of the participants mentioned violence as *"depriving one from freedom".* The perception of violence and domestic violence specifically was negative. There was mention about a pattern that followed survivors, referring to a cycle of violence prevailing even with different partners. Similarly, witnessing domestic violence during childhood was identified as a probable cause or excuse for a male to become a perpetrator: *"I don't excuse him but he has tried to be a good person because he watched lots of violence while young. When they were little, his dad used to hit his mom a lot. They almost killed each other".*

9.4 Support from Social Networks

When asked about the support from their social network, some women (n= 4) reported being physically distanced from immediate family and friends and lacking their support. In most of these, the immediate family and friends were living outside of town, sometimes across the border in Mexico and a non-immediate family member or an in-law relative acted as a figure of support. In three cases, besides being the figure of support, non-immediate relatives also referred survivors to the Center Against Sexual and Family Violence. Referrals were made to the center's hotline. The telephone number was obtained from a fair at a mall and from a conversation about the case with a third party. In one case, the in-laws were reported to not believe the victim and to blame it on a mental illness. Support from in-law relatives sometimes ended to protect the interest of the perpetrator, other times they helped survivors escape.

As seen in Table 3, the majority of the participants (61.5%) said their family acted as a figure of support during the last pregnancy. Five participants reported that their immediate families advised them to get out of the abusive relationship: *"They would tell me leave him alone just break up with him", "They gave me all their support. They used to say to calm down, to not fall in despair. They knew that he was aggressive. So they feared. They always said that I didn't have to keep up with it, that I was strong and I could make it on my own always. They made me strong. Especially with the child, my sister helped me a lot".* Four participants reported that the mother was specifically identified as a source of unconditional support, for the decision to endure violence or throughout the process of leaving the abusive relationship. In four instances women talked about their mother's experience of intimate partner violence. Two of them conveyed their disapproval for the mother's decision to stay with an abusive man and her own decision to follow the cycle. In some cases the cycles of abuse involved mothers, aunts, and sisters. Siblings were reported to warn about the presence of abuse, but to be supportive of her autonomy and provide encouragement.

Table 3: Figures of Support among Participants

Variables		Frequency (*n=13)*	Percentage
Figure of support			
	Family	8	61.5%
	Friends	1	7.7%
	Non-profit	1	7.7%
	Other: Two or more of the above	3	23.1%

Non-familial sources of support were friends, churches, and faith-based organizations. Friends were regarded as sources of moral support and advice, as well as company to doctor's

appointments, and were identified as a figure of support by one participant. In all cases where friends supported, they were able to recognize abuse in the relationship and expressed it. Churches and faith-based organizations provided aid in the forms of baby clothing, diapers, money for rent, and sometimes classes.

About half of participants tried to hide the abusive relationship from the social network, except from the figure of support, expressing that *"Nobody else knows"*. The reasons for not talking about it with family members, friends, or other people included wanting to keep the perpetrator's reputation and the family's approval of him, fear of possible pressure to leave the perpetrator, not wanting to worry family members, embarrassment, and feelings of responsibility to stay in the relationship for getting pregnant: *"I was embarrassed. I was very depressed when I found out I was pregnant so I separated from them. I had a very low self-esteem, I wasn't talking to them. So I thought I didn't have options that I had to keep up with it"*. In most responses, there was a reluctance to divulge their situation to someone. Recognizing the need for help and perceiving potential for support from the individual seems to be the factors which aided most participants in discussing their abusive relationship with someone in their network. One participant reported receiving death threats for communicating abuse to anyone.

One participant discussed her family's Mexican background and cultural views of IPV in relation to not being able to leave an abusive relationship. The family was not supportive of the victim, not even after an event of physical violence. The parents did not want the victim to get involved in reporting, pressing charges, and seeking protection, which included a null participation in the legal process after the report was made. This was attributed to the way situations of IPV are handled in Mexico. The participant explained that such incidents stay in the

family without placing police reports: *"So I am the first one that pressed charges and placed a restriction order. I am the first one in my family".*

Four participants reported not having support from anybody or having limited support from friends and family members: *"I don't have anybody here in El Paso", "I was by myself in the United States", "In reality, my stay here has been very rough and sad because I am by myself, I am distanced, I don't have my friends", "Most of them are in Juarez, including my family, nobody can come", "I was affected by it and we fought some times because I didn't feel their support", "I was by myself".*

9.5 Types of Intimate Partner Violence

The reports of IPV among participants included a wide range of physical, psychological, financial, emotional, verbal, and sexual violence before, during, and/or after pregnancy. Physical violence included pushing, pinching, squeezing, battering, hitting against objects, and threats with sharp objects, among others. Psychological violence was present in the form threats, getting deprived of personal documents, threats of perpetrator or his family taking the children away to another country, stocking, and getting separated from the immediate family: *"he didn't like for me to go to my mother's house anymore".* Financial abuse was reported as the perpetrator not being able to keep a job, leaving for an indefinite amount of time, not providing for children, stealing money, not providing for basic necessities of the victim, not allowing the victim to work, and not allowing the victim to make purchases: *"if there were no more groceries I would say, 'Look, let's go buy groceries there are no more', he would say, 'make me list and I will go', or 'wait until the weekend when I have time'".* Emotional violence was present in the forms of being deceived, bearing comments that lowered self-esteem based on physical appearance, choosing friends over the victim, among others. Verbal abuse was mostly offenses, bad words,

and words of discouragement towards the victim. Sexual violence was present in the form of a sexual assault. In the case of five participants, there were threats related to migratory status. Women were threatened not to say anything because Border Patrol would take them or they will not believe them due to being undocumented immigrants. The threats included having the perpetrator take the children to Mexico without the mother's consent and taking children away once mom was deported: *"He used to threaten me saying that if I called police they would take me since I am undocumented and he would take the baby".*

9.6 Experiences of Intimate Partner Violence before, during, and after Pregnancy

With regards to the experiences of IPV prior, during, and after being pregnant, almost all participants reported having experiences some type of IPV in those three stages. One of the participants experienced it before and after pregnancy, but not during, since she left the abusive relationship during the pregnancy to protect her baby and herself. Another woman expressed that she left him during the pregnancy, but experienced abuse before and after being pregnant; another experienced abuse until after the pregnancy.

For experiences of abuse prior to pregnancy, women reported the presence of verbal abuse as "*a word, a detonator, but daily*", they reported jealously, aggression, emotional aggression, *"he always had a word of discouragement for us"*, and financial restrain *"he said that he didn't need to give me anything"*. Physical aggression was also reported prior to pregnancy. It was reported in the form of squeezing, throwing things, battering, pulling of hair, pinching, hitting against objects, and threatening with sharps. Physical violence was reported by 7 women and for 3 out of those, the physical violence and aggression started while dating, along with other forms of abuse.

During pregnancy, all women reported verbal, emotional, and psychological abuse, except for the women that left the relationship during the pregnancy. Women expressed the presence of offenses, partner's indifference, control of time, extra-marital affairs, comments that lowered self-esteem based on physical image, and humiliation: *"that's the first time someone has ever humiliated me like that"*. Three women reported experiencing physical violence while pregnant. One of them said there were more than one instances of physical aggression during the nine months, which required medical attention and left notorious repercussions for the progress of the pregnancy and the health of the baby and the mother. One of the events of physical aggression put the life of the mother at risk and in need of a medical intervention that would have required termination of pregnancy; the outcome of this event also caused complications at the time of birth which endangered the life of the mother. In another event of physical violence, the aggression resulted in damage to the placenta, which was diagnosed by the emergency doctors. In this case, IPV started while dating and severe physical violence was present before and after pregnancy as well. For the two other women that reported physical violence was present during the pregnancy, physical aggression was present before, during, and after the pregnancy. Those two women also experienced a severe event of physical violence and for one of them IPV also started while dating.

Besides the participant's experience described above, there were four other women that had a high-risk pregnancy, a risk for miscarriage, or an abnormal characteristic of the pregnancy such as accelerated heartbeat. These women expressed that those problems were due to the non-physical abuse received or that because of the abuse present and the delicate pregnancy. Four women reported that the abuser was not present or stopped being present in the pregnancy either because women decided to leave the relationship for some time during the pregnancy or because

the abuser was in military service: "*it was a high risk pregnancy and I didn't want to expose the baby".*

For experiences of IPV after pregnancy, all the participants reported the presence of financial, physical, and/or psychological violence in the form of taking the children away, threats of taking the children away to Mexico, and threats of reporting the victims to Border Patrol so they could take them: "*that he would take the kids away when the Border Patrol took me to Mexico, and I wouldn't see them again".* There were also reports of negligence and indifference from the partner in the care of the children: *"I was always alone taking care of the child. Not even right after birth did I count with his support*".

Overall, there were two women that experienced physical violence before and after pregnancy, but not during and without leaving the relationship. Two women reported physical violence prior to pregnancy but not during or after. And three women reported physical violence before, during, and after pregnancy. It is noteworthy to mention that five women received threats of being reported to Border Patrol and/or of authorities standing on the side of the perpetrator due to his legal immigration status were present. In all of those cases, the victim was not in legal standing to reside in the United States, which was used as means to create fear. In some instances, the fear of deportation discouraged women from seeking appropriate medical help and from disclosing IPV to a provider: *"I was lying, but I was afraid of them taking away my VISA. Until I told him the truth".*

There were two instances where drug use was mentioned by participants as a detonator for violence.

9.7 Reasons for Seeking Help

The experiences of the participants were different; they had different motives for seeking help. Some of the reasons expressed for looking for help are fear of the partner taking the child away, having a baby born, *"now that I had the baby is when I made the police report"*, seeing a person who had a similar experience improve, *"so when I experienced the same thing, I had the need to tell her that I wanted to go where she went"*; noticing depression and changes in the care of a child, *"because it got to a point when I wasn't even paying attention to him"*; leaving the house in fear of the presence of the Border Patrol; and in the case of multiple events of physical violence or a very severe event, getting referred by the emergency care doctor: *"Since the first time I was admitted into the hospital. They asked a series of questions on how I had fallen, I answered until I couldn't take it anymore and told them what had happened…They helped me. They referred me to the center".*

9.8 Intimate Partner Violence Screening and Referral

The majority of the participants (n=11) reported that they did not have communication about IPV with their health care provider during prenatal check-ups for their last pregnancy. Most of them express that their prenatal care doctor did not ask them if they were experiencing any sort of IPV, that they did not disclose any information about their situation, and that subsequently were not referred to appropriate resources during their prenatal care. Women also expressed not being asked by the provider in various ways: *"I was not asked, and I did not comment anything"; "In the last pregnancy they didn't ask. I would have answered also"; "He was limited to doing his job and that was it".*

However, there were two reports of IPV screening during pregnancy among participants. One of the women who was screened said the screening was done every month starting in the

first trimester and was incited by an abnormal pregnancy characteristic. There was no disclosure of IPV because the husband was present on the first months of prenatal care visits and then because the mother was present. It was reported that the prenatal care was received in a clinic and the doctor used to spend approximately one hour with the woman. The second woman screened said the doctor asked once during the pregnancy and there was no disclosure from the patient also because the husband was present in the prenatal care visit. None of these cases involved referral because there was no disclosure. Both women who were screened for IPV were of Mexican origin, one identified as White and the other as American Indian.

One woman reported there was screening, disclosure of IPV, and appropriate referral. However, the screening and referral were not conducted as part of routine prenatal care, they were done after the incidence of a severe physical violence event: *"They asked a series of questions, I answered until I couldn't take it anymore and told them what had happened".* The physician encouraged the victim to file a police report but she denied due to fear. It is noteworthy to mention that in one case the victim did not engage in communication about IPV with the healthcare provider, instead, she reported to a social worker in the academic arena. In this case, the victim took the first step to initiate the conversation by reporting, but the social worker got help for her from community resources, referred her to make a police report, and started her on counseling sessions.

9.9 Survivor's Perception of Intimate Partner Violence Screening and Referral

Overall, there was a positive perception of IPV screening and referral. When asked how they would have felt if asked about IPV or how they felt if they were asked after birth or during a previous pregnancy, most women indicated positive outcomes. Some of the benefits of IPV communication as perceived by women were getting comments appropriate for their experience

of IPV especially in prenatal visits for pregnancies resulting from sexual assault, increased confidentiality at the doctor's visits, and getting a sense of support. The most common benefit identified was being referred by their doctor to counseling and psychological assistance as explained in the following comments: *"I think that if for example, I would have told this to the doctor she would have had helped me by referring me somewhere else, to another psychologist", "it would have helped me a lot to have some psychological help during pregnancy. I feel it would have been very useful. I was very depressed during pregnancy, I got mad a lot".* Another experience was that getting a sense of protection from a conversation about IPV with appropriate referral was a benefit: *"But it's about increased knowledge. It would have been an important factor to feel more protected".*

In one case, it was expressed that having a doctor initiate a conversation about IPV would not be welcomed because of the unfamiliarity between them and the patient: *"If it had to do about the baby, then I was comfortable, but other than that, rather about my problems or emotional status then no"*. Yet, there were comments of regret from not having disclosed a situation of abuse to the prenatal care provider regardless of any screening done by the doctors: *"Until now I wonder why I didn't tell the doctor, but it never crossed my mind. Now I regret not telling her. It would be good to include something about what their emotional state is, how is everything with their partner, or what they are going through during pregnancy", "So if I had been able to, if time could be rewind, I would talk. Definitely".*

9.10 Barriers to Communication about Intimate Partner Violence with the Health Care Provider

When asked about why they had not talked to their prenatal care doctor about experiencing IPV or what would prevent them from disclosing it when asked, participants gave a

variety of reasons ranging from their own perception of the situation to the characteristics of their providers. Three women explained thinking that everything was normal was identified as a barrier to disclosing IPV. As expressed by participants: *"I loved him so much that everything was normal for me", "I guess because I thought it was normal because of the pregnancy, but at the end I know it wasn't", "I didn't think the maltreatment was wrong, later I learned it was"* were cited as reasons related to normalizing IPV. Another reason to not talk about IPV with the prenatal care provider was wanting to protect the image of the perpetrator: *"I protected him a lot, I always tried to justify him. So, more than likely, I would have told him [doctor] that we were separated, but that he was supporting me or something like that".*

Loving the perpetrator, having hope of the relationship improving, and wanting to children to grow in a complete family were also reasons to not engage in the conversation with a prenatal care provider. Other reasons were a fear of acknowledging a situation of abuse and not wanting to disclose it to prevent having to ask for help from other people: *"I guess I was scared of saying there was something going on because I don't like asking for help".* Another barrier was receiving threats from the perpetrator: *"Maybe that he would have threatened me. He threatened me many times"*. Not feeling protected was another reason to not disclose IPV as well as fear of intervention or referral from the provider's part: *"so I know that if they see someone is in danger they have to intervene, that is why I wouldn't have said anything".*

The presence of the husband was mentioned as the barrier to the disclosure of IPV by the two women screened for IPV as demonstrated by the following participants' comments: *"I told her no, that everything was fine because my husband was with me at the appointment. I told her that everything was fine since he was there. If I had said something he would start to tell me why did you say it?", "He asked me and my ex-husband would tell me 'you lie and you are going to get it worst'. He had me feared. My answer was no. I was scared I didn't want to get beat up again", "My husband would go with me. I was feared, I had to be careful with what I said, what I asked. I got to be very careful"*. Having mothers present in prenatal care visits was also mentioned by one of the women screened; there was no disclosure due to fear of retaliation and

further problems: *"when my mom used to go with me, the doctor still asked but I said everything was fine. He and my mom have a good relationship; my mom could have asked him about what was going on. I didn't want to start a big problem".* The presence of in-law relatives during prenatal care visits was mentioned as a probable barrier to communication about IPV.

As depicted in Table 4, most women (69.2%) agreed or strongly agreed to feel comfortable talking to the provider. Yet, 30.8% or 4 women reported disagreeing or strongly disagreeing to feeling comfortable talking to the provider. The majority agreed or strongly agreed to feeling comfortable asking questions to the provider, asking questions, and getting their questions addressed by the prenatal care provider. Most also agreed or strongly agreed to the provider being nice to them and making time to talk during the visits (Table 4). Yet, there two (15.4%) participants that reported their prenatal care doctor did not made time to talk during appointments; two that did not feel comfortable asking questions; and two that left without answers to her questions.

Feeling uncomfortable and/or analyzed by the doctor was another barrier to the communication of IPV. In one case it was mentioned as a personal opinion of the woman. Yet, for two other women, the physician's actions inhibited communication. One woman reported feeling judged by her physician when she asked why Mexican women had children with different fathers; others reported unwelcomed comments from providers towards the situation of the survivors. Such questions and comments inhibited any further communication. Other women expressed that there was no feeling of trust towards the provider since they did not feel like they were given the medical attention needed: *"Sometimes she would just go into the room and say 'ok'. She wouldn't even get near me. At some point I got a rash from the stress. I told her like four times and she used to tell me 'I already prescribed something for it', but would never check me. Until I couldn't walk anymore, and there I got medicine".*

With regards to the sex of the prenatal care provider, two participants reported that they would have felt uncomfortable talking to a male provider and would not have engaged in the conversation, in this same case, there was a fear of other men repeating the abuse: *"it would be*

difficult to talk to a man, hard and uncomfortable, because all men are different. One never knows if the same thing could happen again. If we tell them, they may think, 'well, if one did it, I can also do it'". In this case, there was a sense of mistrust generalized to all men, which would have limited conversations about IPV, screening, and subsequently referrals. Yet, there were two instances where having a male provider was not identified as a factor that would have made communication uncomfortable.

Table 4: Experience with Prenatal Care Provider

	Frequency				
Prenatal care probes	Strongly Disagree	Disagree	Neither Disagree nor Agree	Agree	Strongly Agree
I had at least one prenatal care visit				1	12
My prenatal doctor spoke the language I am most comfortable speaking	3				10
I felt comfortable talking to my prenatal care doctor	2	2		1	8
My prenatal care doctor was friendly to me		1	1		11
My prenatal care doctor made time to talk to me during appointments	1	1		2	9
I felt comfortable asking questions to my prenatal care doctor	2	1		1	9
I asked questions during my prenatal care visit or visits	1			1	11
My prenatal care doctor answered the questions I asked	1	1		1	10
I crossed the border to receive my prenatal care	12		1		

With regards to the preferred language spoken, ten women asserted that their provider spoke the same language they did (Table 4). Two participants reported feeling unsatisfied with the care due to the provider not speaking the same language. Participants also reported being uncomfortable using a translator to communicate during the prenatal check-ups, explaining that it inhibited the communication and left questions unanswered, *"They always had to bring in a girl and I didn't feel comfortable. I didn't feel comfortable because I understand a little English and they didn't say exactly what I wanted them to ask. I used to get mad; I just wanted to get out. I was not happy. My questions remained the same. I couldn't speak in my language and ask them*

and get a good explanation from them", "Sometimes when I used to ask her to tell her something she would make faces. I felt bad. She made me feel bad". Most women (92.3%) did not have to cross the U.S.-Mexico border to receive prenatal care (Table 4). All participants received care in the United States, with one participant having received prenatal care in Ciudad Juarez, Mexico and in El Paso, Texas.

One of the women explained that she provided physical signs of abuse and/or stress to the provider but was unsuccessful in getting them across to him: *"I wanted, please read my mind! I wanted them to read my mind somehow. I would try to tell them. I would give signs like 'I am scared here', but he never got the hints. Like I would shrug my shoulders, I would look down. They would ask me, 'how is the pregnancy going?' I would just say, 'okay'. Yes, I was doing it on purpose. Maybe he would get the clues that I was in danger", "Maybe if he would have seen how I reacted to my husband. When you go to your prenatal visits you are supposed to be happy and I was always very quiet and timid".* Another woman explained that there were physical signs of stress initiated by the body but they were not interpreted correctly by the physician: *"I told her once that I thought I was getting a rash from being nervous, she just told me to relax. I didn't say anything else".*

Having different providers provide care during pregnancy was also stated as a barrier to the communication: *"I didn't like it that much because they always changed providers, there was always a different provider…That is why I would almost not go, I was bothered by that, I wanted to continue with the same doctor, for the doctor to know me and to later get to the birth of my baby", "I went to all my appointments, towards the end I almost didn't go but I ended up making the appointment again and going back. They made me mad in that way because they constantly changed providers".* Similarly, mistrust in the health care center for being part of a teaching hospital was identified as a limitation to feeling comfortable with the provider and engaging in conversations about IPV.

A barrier that was mentioned twice was a disconnection between the problems at experienced at home and the role of a prenatal care provider: *"I don't know if she is the right*

person to talk about my problems. She is simply my doctor and is taking care of my pregnancy. I would talk to the people here at the center, people that are capacitated to listen", "I never associated my feelings at home with having to express something. Maybe there is no opportunity to do so. I wouldn't feel comfortable getting to the doctor and telling him because he is a gynecologist. I wouldn't see a reason for me to talk about the problems I have at home. Since he is a gynecologist. Maybe if he asked, I could have answered some things happening at home".

Women also reported barriers to continuing therapy, counseling, and attendance to centers specialized in domestic violence. In one case the participant reported concluding support services due to the partner's pressure to stop going, losing interest, but most importantly, not receiving a promised call from the psychologist to continue the services. In another instance, the participant stopped attending because she was advised to have an abortion due to the poor quality of the relationship with her partner: *"She told me that I needed to abort, that I couldn't have a child at that point in my life, that I was going to ruin my life. She said that I didn't know if my marriage was still or not. At that moment I thought how she was a therapist and was saying those things. I wondered how she was helping me. I never went back to her therapies, regardless of the fact that I had been going with her for a year"*. Lastly, feeling that the services were not working was a reason to stop: *"I was going to counseling but I stopped because I felt that it wasn't working. It wasn't working for me, so I stopped going".*

9.11 Factors Promoting the Communication About Intimate Partner Violence with the Health Care Provider

The factors that would contribute to holding a conversation about IPV with the prenatal care provider included seeing a female doctor: *"For intimate reasons, even for shame. It is easier to talk to a woman about those situations than to a man"*. Having doctors that specialize in treating survivors of violence: *"Actually, for it to improve, there should have doctors specialized in that. So that it is not for every type of women who have not experienced domestic*

violence. There should be more to care for women like that. That would help us feel more comfortable by not having to go the same doctors other women go, women who have not suffered like us. Maybe because they would give us a different kind of support from other women and help us more".

For women to feel comfortable, it was reported that time and efficient patient education were necessary; sometimes the presence of informational pamphlets would indicate the physician is "victim-friendly". Participants' quotes:

"What made me feel comfortable with her was that she always addressed my doubts. For example, one time I went with another gynecologist, but he was very brief. The female doctor took her time to explain to me what I didn't understand. She was dedicated to explaining to me. That is why she made me feel more comfortable"

"Have pamphlets, having them give you pamphlets about domestic violence that refer you to resources and any kind of help. If I see a folder or information in their office I would know that they are contributing to the cause against violence, I would know they are aware of it. If I had seen some type of violence I would have said yes, because I would have known that it was abuse"

"Provide information. Even if they ask and one says no, still give out information, like information about the center. Still pass it around, just in case. At least the information is available".

Making more time, getting involved in more aspects of the patient's well-being, and being active in screening were factors promoting the communication. Participants' quotes:

"Get more involved with the patients. Not all of us want to, or sometimes the doctors don't make themselves available also. I think paying a little more attention to the patients"

"But like it was in the Emergency Room, they kept asking about how I had fallen. Since they opened themselves to talk, I told them. They were very nice. That's how they helped me. They should inspire trust, talk to the patient, talk to them about their personal life, but related to their health"

"Be more comprehensive. Explain more, in a good way"

"Be nicer to people"

Making a statement of confidentiality when screening for IPV was mentioned twice as a characteristic that made disclosure of IPV possible: *"I was experiencing a lot of emotions and couldn't take it anymore, so I asked him if I could say the truth but in confidentiality. He said yes. So I talked to him about my case", "He told me that he didn't have to talk anything that I told him. To not worry. I felt calm"*. Similarly, giving an explanation of the woman's rights and addressing fears was seen as an action that enacted a feeling of being secure and protected after disclosing abuse.

Having translators and giving patients a chance to express themselves was mentioned as something that could make a conversation more inviting: *"Get translators. In my case, if they speak English, give them a chance to try and explain. Not like her that she didn't let me say anything".* Knowing the person beforehand was also seen as a characteristic that inspired trust and contributed to the communication of IPV: *"By knowing her for a long time it would be easier because I would trust her", "Of course, if you are my friend, then I would tell you, but with other people I am a closed book"*. Being *"nice"* and *"willing to help"* were other characteristics that were essential in a person to be able to trust them and hold a conversation about IPV with them.

Lastly, being aware of surroundings and of the victim's behavior was seen as a factor that could have started a conversation about IPV: *"Be very aware of the females, the way she is acting, how her husband is acting towards her. The way she is acting because there are signs out there that we put out there and they don't get them. Be very aware of how the woman is reacting and how the husband is acting. Make sure, sometimes the woman does need her privacy, to get the husband out of there! I think that is very useful because a lot of women are scared".*

9.12 Services Needed by IPV Victims during Pregnancy

About fifty percent of participants reported that they needed emotional reassurance (53.8%) and financial support (30.8%) during the last pregnancy (Table 5.). One of the participants indicated needing medical assistance, while another expressed the need for more than one of the options.

Table 5: Services Needed during the Last Pregnancy

Variables	Frequency *(n=13)*	Percentage
Service desired during last pregnancy		
Medical assistance	1	7.7%
Emotional reassurance	7	53.8%
Financial support	4	30.8%
Other: Two or more of the above	1	7.7%

When asked what kind of help they were looking for, some women mentioned the need for psychological therapy: *"It is the only thing that can help you assimilate, accept, and notice that really you are wrong…we become dependent on them, without noticing the value a woman has, of striving, of rising up, and striving by herself"*. Other women wanted counseling and emotional help: *"I guess for somebody to help me to bring up my self-esteem".* There was also the need for legal help, employment, an apartment, a place to stay, help getting medicine, and

money to leave the relationship: *"I had to bear because I had no money. Money, I know it is not everything in this world, but it is essential to be able to put at least $10 of gas to get out. It is indispensable, without money you can't do anything but wait and stay there. Act like everything is well, but it is not in reality".* Support groups were also identified as a source of help they would seek: *"in interacting with other women who are going through the same situation and that we are trying to help each other".* Being assured of patient confidentiality at doctors' offices was identified as a need to keep peace of mind. Similarly, protection from the perpetrator was needed at some point. Increasing the knowledge of a victim's rights and benefits was identified as a strong need for women; having brochures or advertisements at government and doctor's offices to educate them on the presence of domestic violence and on their rights: *"More orientation about rights and the help that is available. I was not familiar with any of it. Had I known about all this, I would have ended this cycle. To have a greater focus on the help, the benefits that one can count on. We don't have to wait until there's a disgrace like in this case, battering, an aggression, I wouldn't have waited. There should be more counseling at the doctor's office to exhort people, in this case us as women that are victims of these situations. I can trust, but there are others who can't. Having a brochure at the doctor's office that asks if you are victim of a certain thing, or if something is happening to you, go to that place. To have more knowledge that there are people to help and support us. That in a way, we do have rights. That would have suited me very well. Others could have avoided that. I could have been one of them, who didn't have to wait until the process of aggression, if only I had known*".

Chapter 10: Discussion

The population of the study was women mostly aged 18 to 29 years old, of Mexican or Mexican American origin, whose preferred language was Spanish, and had lived in the United States for ten years or less. The percentage of individuals of Mexican origin was higher in the study, 92.3% than in El Paso, Texas, 77.6%. All the participants received prenatal care in the United States, mostly in El Paso, Texas. Yet, one of the participants received care in El Paso, Texas, and in Ciudad Juarez across the U.S.-Mexico border. Public insurance was the most common type of health insurance among participants and most women started prenatal care during the first trimester in doctor's offices and clinics. However, participants in another study reported that victims of violence commonly deferred prenatal care until the third trimester (Dunn & Oths, 2014). Similarly, another study found that about 31% of Hispanics, mostly Mexican, enrolled in prenatal care at a late onset (Breiding, M. J., Chen, J., & Black, M. C. 2014). In this study, it was found that only 15.4% of women started prenatal care after the first trimester, implying that more participants started prenatal care on time compared to previous studies.

Although financial and sexual violence were mentioned as forms of violence, most women defined violence or domestic violence in the forms of physical, emotional, and verbal violence. All women reported verbal, financial, and physical abuse prior to their last pregnancy; physical violence was experienced by seven out of 13 women before the last pregnancy. Moreover, in three out of those seven cases, physical violence began in the dating stage of the relationship.

A previous study found that the strongest predictor of IPV during pregnancy was IPV experienced prior to it (Dunn & Oths, 2014). Similarly, all women reported some sort of violence during their last pregnancy as well, except for the instances when the perpetrator was not present during the pregnancy for various reasons. Most cases of violence during pregnancy involved emotional, verbal, and psychological violence. However, there were three cases where physical violence was involved and some had health repercussions for the baby and mother. There were

other cases where non-physical violence was experienced during pregnancy and women attributed negative health outcomes of the baby and mother to IPV.

All women reported that IPV was present after their last pregnancy, sometimes in the forms of threats, indifference, negligence, and physical aggression. Thus, the results show that unless the woman left the abusive relationship or the perpetrator was not present, IPV before pregnancy continued through it and after birth, sometimes with reports of negative health outcomes for the woman and baby associated to violence experienced.

Most survivors (62%) expressed having received support from their family during the last pregnancy. In the case of five participants (n=13), families advised survivors to exit the abusive relationship. Yet, there was one participant's experience where the survivor was advised to stay in the relationship and discouraged from making a police report and seeking help. Such advice on dealing with IPV was attributed to the cultural norms related to IPV in Mexico about not calling police and maintaining situations of abuse within the family.

Experiences of abuse were identified among female family members of the participants, including the mother, sisters, and aunts suggesting a familial vicious cycle of abuse. Some survivors seemed to identify their situation with their mothers' and expressed their prior disapproval to their mothers' decision to endure the violent relationship. Yet, they acknowledged making the same decision as their mothers did in their situation of IPV. In some cases the geography and laws unique to the U.S.-Mexico border were a limitation in the support received by the survivor. Families and friends sometimes resided on the other side of the border and were unable to cross it due to lack of proper documentation.

About half of women were reluctant to talk about their experience of IPV with family members, friends, or any other person. There were feelings of shame, fear, responsibility to stay in the relationship, and a desire to keep the good reputation of partners before family members. Once the survivors disclosed abuse to a person they usually relied solely on that person for support, without talking to other people about it. Fortunately in some cases, the family members or friends to whom IPV was disclosed acted as agents of referral for the survivors. It is important

to mention that in these cases the referral was possible due to fairs at the mall where community resources provided information and from conversations with a third party who was informed about organizations providing aid. This highlights the effects of the outreach efforts of non-profit organizations aiding survivors of IPV.

Regarding IPV screening and referral during prenatal care, only two women reported being asked about their relationship with the partner, equivalent to about 15% of the sample population. This is lower than the estimates of 22-39% in some studies (Anderson et al., 2002). The incidence of IPV disclosure and referrals could not be evaluated since the survivors did not report situations of abuse to their prenatal care doctor. There was one report of IPV screening, disclosure, and referral during pregnancy. However, it happened as a consequence of a severe event of violence and was not part of routine prenatal care. The ACOG recommends screening to be performed several times during the pregnancy, and in one of the incidences of IPV screening, it carried out every month during prenatal care visits. Another study found that Hispanics are less likely to report abuse to authorities (Anderson et al., 2002). In this study, the two cases of IPV screening involved women of Mexican and/or Mexican American origin; neither of them reported abuse to their providers.

In the cases of screening, women felt discouraged from reporting abuse because their husbands were present with them when it occurred. In one of the cases, even the presence of the mother prevented the victim from reporting. These findings suggest that in order to improve the effectiveness of IPV screening, women need to be screened in private. Another factor inhibiting communication of IPV was being threatened by their partner. A recurrent threat in the responses involved fear of being taken by Border Patrol, being deported to Mexico, not being given credibility by authorities, and children staying with perpetrator after deportation due to undocumented immigration status.

Among the survivors who were not screened for IPV, the reasons for not talking with their provider about IPV included individual factors such as not being informed about IPV and not recognizing their situation of abuse. Other individual factors mentioned for not divulging

IPV experiences to the provider were feelings of love for the perpetrator, a perceived dependence on the perpetrator, fear of acknowledging being abused, and disinterest in seeking help. In order for effective communication about IPV these personal factors would need to be addressed.

Other factors were related to the environment in prenatal care such as the sex and language of the doctor. Some women felt more comfortable talking to female doctors about situations of abuse compared to male doctors. Differences in the preferred language between the provider and the survivor also were inhibitors of communication. Other barriers mentioned by participants suggest that in order to generate a more efficient communication, survivors need to be asserted clearly of confidentiality, explained their rights as victims of abuse, and need to be cared for with respect and free of judgement towards their situation. Participants also expressed their need for a provider who is actively involved in their care, that is constant throughout the pregnancy, that spends time with them, and that is trained to talk with women who have experienced abuse.

Although most women did not talk with their provider about IPV, most of them said they felt comfortable talking to them, asking them questions, and that their questions were addressed. Most participants also considered that their doctor was nice to them and that the provider had time to talk with them during appointments. From some of the participants' responses it could be inferred that there is a perceived disconnection between the survivor's personal situations and the role of prenatal care providers in relation to those situations. It seems that survivors do not understand why the health care provider should know about personal issues such as IPV, how the provider can help, and how IPV is related to their health. That could be a factor for not communicating about IPV with the provider, regardless of a perceived good communication and feeling comfortable with the provider. This barrier could be addressed by providing information about IPV during the prenatal care visit. As expressed by participants, pamphlets at the doctor's office or clinic could be useful aids in informing them about IPV and in making them aware of their own experience of abuse. This type of information aids could also associate a situation of abuse with the health care provider and make survivors aware that they can talk about it with

their doctor. For women looking for help, it could be a sign of the provider's interest and support for survivors of IPV.

Although IPV disclosure did not occur in the two incidences of screening mentioned by participants, there was communication from the survivor's part in the form of body language and behavior, which a participant perceived to not be understood by the prenatal care provider. This finding suggests that IPV screening by prenatal care providers could be improved by observing for such cues from patients. A previous intervention provided education about IPV, screening, and referral to health care providers and saw an increase in the identification of cases of IPV (Larkin et al., 1999). In a similar way, these findings might signal a need for training in recognizing signals from the patient's body language and behavior that may indicate possible situations of IPV.

Screening women for IPV has not been recommended or rejected by the U.S. Preventive Services Task Force due to research measuring the effects of screening. Yet, similar to the results in another study (Chang, et al., 2005), most participants perceived positive outcomes from IPV screening, if such screening had happened. Some women considered that disclosing IPV after screening would cause an acknowledgement of IPV from the provider that could result in appropriate comments, referrals to emotional and psychological help, increased confidentiality, and feelings of support and protection. In these cases, during the personal interviews women expressed regret for not communicating IPV to their prenatal care. However, other women consider that screening by their providers would make them uncomfortable and that disclosure could pose a danger to the survivor if police reports were made and the perpetrator responded violently.

Women's responses also highlight the role of professionals outside of healthcare, such as social workers. There was one incidence of disclosed violence, appropriate referral and follow-up done by a social worker. This infers that identification of IPV cases involves active screening and referrals from other professionals besides health care providers.

Subsequent to screening, prenatal care providers should also refer women to appropriate resources such as shelters, support groups, therapy, among others (Shadigian & Bauer, 2004). Most participants expressed that emotional reassurance was their greatest need during the last pregnancy. The help needed was in the form of psychological therapy, counseling, and support groups. Financial support was the second most common type of need in survivors of IPV. The need was sometimes in the form of employment, shelter, getting medicine, and aids to leave the abusive relationship. These are needs that may be met by community organizations aimed to survivors of IPV.

10.1 Strengths

This study was conducted within a mostly Hispanic population, where individuals of Mexican origin represent the greatest minority. The majority of studies involving various ethnicities or races classify all Spanish-speaking and/or individuals with Latin American origin under the same category, most of the times in a Hispanic category. The population of this study sheds light on the cultural and regional norms associated with intimate partner violence and on the structural and social barriers that may be affecting the Mexican community along the U.S.-Mexico border. There have been other studies in the United States aiming to document the frequency of intimate partner violence screening in the health care setting. However, the results represent a variety of ethnicities, including Hispanics and/or a combination of Hispanic sub-groups (Anderson et al., 2002). This study's findings contributed specifically to IPV prevention among women of Mexican origin. In addition, conducting this study along the U.S.-Mexico border led to exploring unique binational barriers such the effect of undocumented immigration statuses and the influence of intimate partner violence norms within the Mexican culture to the

communication of abuse among Mexican or Mexican American women living in the United States.

In addition, the qualitative nature of the study allowed survivors to provide in-depth perspectives related to recommendations for prenatal care providers on initiating and establishing efficient communication about IPV with patients. This study also enabled collection of data about a topic not frequently discussed publicly in study population networks.

Moreover, the one-time personal interviews with the participants may have served as outreach and education opportunities. During the interviews, some of the participants expressed thoughts of regret for not having talked about IPV to their provider; others agreed to not having associated getting referrals to survivors' resources and talking about it with their doctors. Nevertheless, some found help at the Center Against Sexual and Family Violence or other resources by conversing with friends, acquaintances, or family members that encouraged them to seek help. As a result of their discussion during this study, participants may encourage other women in their social network to talk about IPV with their provider, seek appropriate referrals, and that it will be an idea that will spread among survivors. The study findings also have implications for exploring the engagement of men as allies in preventing IPV, particularly by utilizing the positive connotations of machismo (Galanti, 2003) (Center Against Family Violence, 2015). This study also contributed to advancing HP2020 objectives related to Injury and Violence Prevention such as objective IVP-39 aiming to reduce violence by current or former intimate partners (U.S. Department of Health and Human Services, 2013).

10.2 Limitations

This study gathered data from women who had already sought and/or had already received services from the Center Against Sexual and Family Violence. This group of women could represent a group with different beliefs, perceptions, and levels of self-efficacy to seek help than the rest of the survivors who have not utilized services from the center, or who have received such services for a different period of time. This could be a limitation in the results presented. Another limitation is that it provides insight about the barriers and factors contributing to the communication about IPV as perceived by the survivors only, while some barriers to communication might also come from the health care provider. A relevant step in identifying and properly addressing barriers to the communication about IPV during prenatal care would be identifying the barriers perceived by the providers.

The results of the quantitative data analysis cannot be generalized directly to the study population. However, the traits discovered from the qualitative data may be prevalent in the study population and can be generalized to the same.

10.3 Public Health Implications

The results presented in this study have implications for reducing the risk of IPV among women of Mexican origin, especially along the U.S.-Mexico border by increasing the effectiveness of IPV communication during prenatal care. The low frequency of IPV screening reported by survivors who gave birth during the last three years calls for evaluations of processes of screening by prenatal care providers in the El Paso, Texas region. The attitudes and barriers identified in the study provide opportunities for improvement of the communication about IPV between the prenatal care provider and the survivor. The identification of services needed by pregnant women experiencing IPV as reported by survivors provides useful information to

community organizations seeking to help this population. The involvement of non-healthcare professionals in the communication about IPV and follow-up remark the collaboration needed among the different professionals encountered by the survivor throughout the prenatal care. Moreover, the high mobility of residents across the U.S.-Mexico border, lack of insurance, and availability of culturally similar medical services in Mexico, may suggest the need for binational efforts to reduce the risk of IPV for women of Mexican origin in El Paso, Texas. Lastly, the various referrals to community resources by informed family members and friends and women's recommendation for having informational pamphlets about IPV in the doctor's office highlight the need for information about IPV to be available in culturally appropriate formats in different settings throughout the El Paso, Texas region.

10.4 Recommendations

In order to improve the communication about IPV in the prenatal care setting, providers may have to converse about IPV only with the patient - without the presence of partners or family members. Pregnant victims need to be informed about IPV so they can perceive the risks and act to exit the situation of abuse. In the prenatal care setting, information related to IPV could be provided in the form of pamphlets explaining what IVP is, the forms it can be manifested on, and community resources where help can be obtained. This would not only inform patients about IPV during pregnancy, it may also bridge situations of IPV and communicating those instances to the provider. At the time of screening women need to be explicitly ensured that any communication about IPV will be confidential. Similarly, if the woman were to disclose IPV to the provider, it would be beneficial to give an overview of available help and the rights as a victim of abuse.

Prenatal care providers may also be better able to have patients discuss IPV with them if they pay special attention to their verbal and non-verbal communication so that it does not imply judgement towards the victim. In order to create a rapport with an IPV survivor, providers are recommended to spend time with the patient, check them, and make them feel that they are being

actively cared for. Having providers that speak the same language as the survivor and having the same provider care for her during the whole pregnancy may also contribute to the communication about IPV in the prenatal care setting. Also, if suspicion of a case of IPV arises, it could be of benefit for a female provider to perform the screening since some women reported it would be easier to talk to a woman about IPV.

In addition, prenatal care providers must be trained in attending a victim of IPV, as well as in recognizing non-verbal types of communication they might use to disclose some type of IPV. Providers are also suggested to be open to the possibility of IPV in their patients. This may not only help in identifying IPV, but also in making the survivor feel accounted for and possibly improving the chances of communication about IPV.

Overall, the participants of this study perceived positive outcomes from communicating about IPV with their prenatal care providers. They considered talking with their provider about their situation involving IPV could have made them feel supported and protected, could have increased the confidentiality of their visit, and most importantly could have been referred to the services they needed while pregnant.

Chapter 11: Conclusions

In conclusion, this study provided information about the frequency of intimate partner violence during pregnancy, about cultural and regional norms related to IPV, prenatal care utilization, communication with the prenatal care provider, and barriers and attitudes to the communication about IPV in the prenatal care setting. The population of this study was mostly women of Mexican or Mexican American origin between the ages of 18-29 years old whose preferred language was Spanish. Most participants started prenatal care during the first trimester and received it in El Paso, Texas. Almost all participants reported experiencing some type of IPV before, during and after pregnancy. Among the survivors of IPV, only two said they were screened for IPV by their prenatal care provider during check-ups. These two women did not disclose IPV and were not referred to resources. There were multiple perceived barriers to talking about IPV with the prenatal care provider among participants. Some of these barriers were at the individual level, while others were related to the providers and the characteristics of the prenatal care received. Although the results from the quantitative analyses of the study cannot be generalized to the rest of the population, the interviews allowed IPV survivors to provide in-depth perspectives related to recommendations for prenatal care providers on initiating and establishing efficient communication about IPV with patients. The traits discovered in relation to the factors shaping IPV risk and timely communication of the same with health care providers have implications for future intervention design for IPV prevention in the study population and priority communities.

Chapter 12: MPH Core Competencies

The Biostatistics MPH Core Competencies that were met were to distinguish among the different measurement scales and the implications, and the appropriate selection of statistical methods employed. Applying descriptive techniques commonly used to summarize public health data and descriptive and inferential methodologies according to the type of study design for answering a particular research question were also met. Interpreting results of statistical analyses found in public health studies and developing a written and oral presentation based on statistical analyses for both public health professionals and educated lay audiences were also employed in this study.

The Epidemiology related MPH Core Competencies met were to describe a public health problem in terms of magnitude, person, time and place, apply the basic terminology and definitions of epidemiology, and calculate basic epidemiology measures. In addition, the competencies related to making appropriate inferences from epidemiologic data, evaluating the strengths and limitations of epidemiologic reports, and communicating epidemiologic information to lay and professional audiences were addressed through this study.

Within the Social and Behavioral Sciences, the MPH Core Competencies met were to identify basic theories, concepts and models from a range of social and behavioral disciplines that are used in public health research and practice. This study design also covered identifying the causes of social and behavioral factors that affect health of individuals and populations and describing the role of social and community factors in both the onset and solution of public health problems, in this case intimate partner violence

Finally, the Hispanic and Border Health Concentration Competency addressed through this study were to identify and access the major sources of public health data pertaining to Hispanic and border communities. The population of the study was not restricted to participants of Hispanic origin, but it was anticipated that the majority would be. Having a sample with a majority Hispanic (Mexican-origin) sub-group representation, particularly in the U.S.-Mexico border setting enabled the exploration of barriers embedded in the local, cultural, and regional contexts for the communication of intimate partner violence in the health care setting.

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Appendix A

Interview Instrument

1. What is your age? _____ years
2. How many years have you been living in the United States? _____ years
3. How many children have you delivered during the last three years? _____ children
4. Within the last three years, what year was your last pregnancy? _____

Answer the following questions by selecting all the answers that apply and selecting them.

5. Are you of Hispanic, Latino, or Spanish origin?
    - 5.1 No, not of Hispanic, Latino, or Spanish origin
    - 5.2 Yes, Mexican, Mexican American, or Chicano
    - 5.3 Yes, Puerto Rican
    - 5.4 Yes, Cuban
    - 5.5 Yes, another Hispanic, Latino, or Spanish origin (For example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, and so on.)
6. What best describes you?
    - 6.1 White
    - 6.2 Black or African American
    - 6.3 American Indian and Alaska Native
    - 6.4 Asian
    - 6.5 Native Hawaiian or other Pacific Islander
    - 6.6 Other: _____
7. What language are you most comfortable with?
    - 7.1 Spanish
    - 7.2 English
    - 7.3 Other:_____

Thinking about the last child you delivered in the last three years, answer the following questions by selecting only ONE answer.

8. What type of insurance did you have?
    - 8.1 Private (you paid for the insurance services, non-government based)
    - 8.2 Public (government-based insurance)
    - 8.3 Did not have insurance
9. What type of delivery did you have?
    - 9.1 Delivered in a hospital
    - 9.2 Delivered at home
    - 9.3 Delivered in a midwives clinic
    - 9.4 Other: _____
10. What was your marital status during that pregnancy?
    - 10.1 Married
    - 10.2 Never married
    - 10.3 Divorced
    - 10.4 Widowed
    - 10.5 Separated
    - 10.6 Living with partner, but not married
11. Your prenatal care doctor was:

11.1 Female
11.2 Male
11.3 Don't remember/Other:_____

12. When did you start your prenatal care?
    12.1 During the first 3 months
    12.2 During the fourth, fifth, or sixth month
    12.3 During the seventh, eighth, or ninth month
    12.4 Don't remember/Other: _____

Thinking about the last child you delivered in the last three years, answer the following questions. You can select more than one answer.

13. Where did you receive your prenatal care for that pregnancy?
    13.1 Hospital
    13.2 Clinic
    13.3 Doctor's office
    13.4 Center Against Sexual and Family Violence
    13.5 Other: _____
14. Where did you receive your prenatal care?
    13.6 El Paso, Texas
    14.2 Another place in the United States
    14.3 Mexico
    14.4 Other: _____
15. From whom did you receive support while pregnant?
    15.1 Family members
    15.2 Friends
    15.3 Faith-based organizations (church and/or church members)
    15.4 Non-profit organizations (Center Against Sexual and Family Violence)
    15.5 Other: _____
16. What type of service or support would you have wanted during that pregnancy?
    16.1 Medical assistance
    16.2 Emotional reassurance
    16.3 Social support
    16.4 Financial support
    16.5 Other: _____

Thinking about the last child you delivered in the last three years, answer the following questions by selecting how much you personally agree or disagree with each statement. Select only one.

	Strongly Disagree (1)	Disagree (2)	Neither Disagree nor Agree (3)	Agree (4)	Strongly Agree (5)
17. I had at least one prenatal care visit					
18. My prenatal doctor spoke the language I am most comfortable speaking					
19. I felt comfortable talking to my prenatal care doctor					
20. My prenatal care doctor was friendly to me					
21. My prenatal care doctor made time to talk to me during appointments					
22. I felt comfortable asking questions to my prenatal care doctor					
23. I asked questions during my prenatal care visit or visits					
24. My prenatal care doctor answered the questions I asked					
25. I crossed the border to receive my prenatal care					

26. How would you define violence? (Probe definition of domestic and sexual violence according to participant and participant's networks)
27. Please share your experience in relation to experiencing violence from your partner, husband, ex-husband, or boyfriend before, during, and/or after your last pregnancy and childbirth? (Probe abuse definition duration, and resources sought by participant for the same)
28. Please share your experience at the doctor's visit (during the pregnancy and childbirth) in relation to talking about the abuse? (Probe types of questions asked by health care providers in relation to discussing domestic violence, communication with health care providers, frequency of communication, reactions to the experience, follow up activities by health care provider such as physical examination, information, or any referrals.)
29. Question for participants who indicate that their health care providers did not ask them about domestic violence/abuse: Please discuss how you would have responded if

someone in the doctor's office had asked about domestic violence/abuse? (Probe possible attitudes towards communication of abuse in the health care setting)

30. What would prevent you from discussing your situation with your doctor or someone else in the doctor's office, or what will make you feel comfortable in discussing it? (Probe what would make the conversation more comfortable)

Appendix B

Consent Form

Informed Consent Form: Individual Interview
Research Involving Human Subjects

Protocol Title: **Attitudes and barriers to intimate partner violence screening and follow-up during prenatal care as reported by survivors in the El Paso, Texas region**
Principal Investigator: Luz Maria Luna and Thenral Mangadu, MD, MPH, PhD (Thesis Advisor)
UTEP Department of Public Health Sciences, College of Health Sciences

We are inviting you to be in this research study along with other 15 women because you participated in services from the Center Against Sexual and Family Violence in the last three years, because you are at least 18 years old, you have delivered a child during the last three years and attended at least one prenatal care visit for that pregnancy, and because you are not pregnant at this time.
Please read the information below and ask questions about anything that you do not understand before you make a decision to participate.

The purpose of this research study is:

- To learn about the communication with your doctor when you were pregnant in relation to domestic violence.

If you decide to be in this study the following things will happen:

- Participate in a one-time individual and private interview with the researcher, and possibly her supervisor. The interview will take about one hour and will take place in a closed, safe space at the Center Against Sexual and Family Violence. Your name or any information that may identify you will not be asked during the interview. The interview will be recorded on a digital audio recorder. During the interview, your name will not be said out loud so that no one will be able to connect what is being said with you. There are no risks involved in having you participate in this study.

The audio recordings/files will be kept in a password protected/locked electronic folder. Only Luz M. Luna and Dr. Thenral Mangadu will have complete access to these files at all stages of this study. A back-up database of the recordings will be created in order to protect against loss of electronic data due to technical difficulties and will be accessible only by Ms. Luna and Dr. Mangadu. Your name or any personal information that may identify you with your interview answers will not be used when the findings from this study are written or presented. Only a false name (pseudonym) will be used if it becomes necessary when the findings are written or presented. The recordings will not be directly presented to any individual in an oral or written report or in any meeting.

There may be no direct benefit to you from being in this study. What you tell us may help you to gain further awareness about the communication of abuse between doctors and patients. You will

be compensated with $20 dollars for your time and transportation necessary to take part in this individual interview.
Taking part in this study does not involve any physical harm. The University of Texas at El Paso and its affiliates, nor the Center Against Sexual and Family Violence, do not offer to pay for or cover the cost of medical treatment for research related illness or injury. No funds have been set aside to pay or reimburse you in the event of such injury or illness. You will not give up any of your legal rights by signing this consent form. You should report any such injury to Luz M. Luna at lmluna@miners.utep.edu or 915-760-9846 and to the Institutional Review Board (IRB) at UTEP at 915-747-8841 or irb.orsp@utep.edu. Funding for this study is provided by the principal investigator. There are no direct costs to you for taking part in this study.

Authorization Statement:

I will not get anything from being in this study. Being in this study is my choice and I know that I can stop being in the study at any time without anyone being mad at me. I know that I can skip any questions I do not wish to answer. I will not get in trouble if I stop being in the study or do not wish to answer any of the questions.

I am being asked to be in this research study due to my participation in any services from the Center Against Sexual and Family Violence in the last three years, because I am at least18 years old, because I have delivered a child during the last three years and attended at least one prenatal care visit for that pregnancy, and because I am not pregnant at this time.

I know that to be in this study I will:

- Participate in a one-time individual and private interview with the investigator, and possibly her supervisor.

I know that I can ask questions about this study at any time. I can ask and get answers to my questions. I know that only the people who work on this research study will know my name. I want to be in the study at this time. I can ask about what happened in the study.

Printed Name: _____

Signature: _____ Date: _____

Witness or Mediator: _____ Date: _____

Vita

As an immigrant from Mexico, Luz Maria Luna graduated from The University of Texas at El Paso (UTEP) with a Bachelor of Science in Biological Sciences; she received a University Honors Degree with Cum Laude and Dean's List Honors. She is currently enrolled in the Master of Public Health (MPH) Program at UTEP with an expected graduation date of May 14th, 2016 with recognition as an Outstanding Student. She completed her MPH Practicum at the Centers for Disease Control and Prevention El Paso Quarantine Station and worked as a Microbiologist for the City of El Paso Department of Public Health. Ms. Luna was admitted into medical school for enrollment after graduation. Her long-term plans are to work in the health care field and to work to lessen disparities in the Border population. She plans to complete these plans as a Catholic religious sister.

Contact Information: lmluna@miners.utep.edu

This thesis was typed by Luz Maria Luna.