

Project Summary/Abstract

Annually in the US, intimate partner violence (IPV) is responsible for 40 to 50% of all murders of women, approximately 1,300 deaths, (CDC, 2003). In Hawaii, between 1995 and 2004 there were 57 murders of women from IPV (Hi. St. Dept. of A. G., 2005). Annually 5.3 million IPV victimizations occur among women. Nearly 2 million injuries result with 550,000 requiring medical attention (CDC, 2003). Significant health and social consequences are related to IPV and include acute and long-term psychological, physical, social and economic effects (Draucker, 2002). The costs of IPV in direct medical and mental health care services exceed \$4 billion each year (Max, Rice, Golding, & Pinderhughes, 1999). Differences between cultural perspectives may lead to barriers that prevent women from receiving effective care (Campbell & Fishwick, 1993). Campbell and Campbell (1996) suggest that clinical interventions for abused women should be based on principles that include cultural competence and empowerment. Consistent with the need to develop culturally appropriate approaches to address IPV, and the previous research of this team, the purpose of this study is to understand how IPV and culture come together for selected cultural groups. The specific aims of the study are to examine the following: cultural perceptions, responses and needs regarding IPV; perceptions of the acceptability of violence; reasons women may or may not disclose IPV, and perceptions of the influence of specific elements of culture regarding IPV. The theoretical foundation for this study is Critical Social Theory (CST), a post-modern philosophical perspective that acknowledges that some voices are privileged and others are marginalized (Boudreau, 1997). The use of the community based participatory research (CBPR) approach to this study is consistent with the perspective of CST. An expected outcome of CBPR is the attainment of new knowledge that guides actions. This investigation is a descriptive study using both quantitative and qualitative methods. It will be conducted over a two year period in two phases: 1) Individual Interviews; and 2) Focus Groups. Women, 18 years and older, will be recruited through a variety of programs that are affiliated with the three participating CHCs. Data will be collected between the 4th-15th months. Analysis of qualitative data will be accomplished using content analysis (Downe-Wamboldt, 1992). Quantitative data will be analyzed using descriptive methods: frequencies; means; and standard deviations. Data from both qualitative and quantitative findings will be integrated to better understand individual and group perceptions of IPV. Comparisons will be made across the 3 cultural groups. Findings will be used to develop culturally appropriate IPV screening and interventions. This study is consistent with the priorities of NINR, and is a form of health promotion and injury prevention (IPV) research using a multidisciplinary approach to improve the general health of underserved minority women (NINR, 2006).

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A. Specific Aims

Intimate partner violence (IPV) is a complex health and social issue affecting 25% of the women in this country (Alpert, Freund, Park, Patel, & Sovak, n.d.). **Annually in the United States, IPV is responsible for forty to fifty per cent of all murders of women, approximately 1,300 deaths (CDC, 2003). In Hawaii, between 1995 and 2004 there were fifty-seven murders of women from IPV (Hawaii State Dept. of Attorney General, 2005).** In approximately 75% of murders related to IPV the man physically abused the woman before homicide (Campbell, Webster, et al., 2003). **Estimates are that annually 5.3 million IPV victimizations occur among women 18 years and older.** As high as these figures are, it is consistently accepted that IPV rates are underestimated (Walton-Moss & Campbell, 2002). **Nearly 2 million injuries result from this violence with 550,000 of them requiring medical attention. In 2003 one in three women injured during a physical assault or rape required medical care (CDC, 2003).** Significant health and social consequences are related to IPV and include acute and long-term psychological, physical, social and economic effects (Draucker, 2002). The costs of IPV exceed \$5.8 billion each year with \$4.1 billion providing direct medical and mental health care services (Max, Rice, Golding, & Pinderhughes, 1999). Intimate partner violence impacts both the lives of women and providers caring for them.

Differences between cultural perspectives related to IPV may lead to barriers that prevent women from receiving effective care (Campbell & Fishwick, 1993). Campbell and Campbell (1996) suggest that clinical interventions for abused women should be based on principles, which include cultural competence and empowerment. **Consistent with the need to develop culturally appropriate approaches to address IPV, the purpose of the study is to understand how IPV and culture come together for selected cultural groups (Native Hawaiian, Ilocano (Filipino); and Chuukese (Micronesian)). The research question is, "What are the cultural perceptions, responses and needs of selected individuals and groups served through a variety of programs that are affiliated with the three participating CHCs regarding IPV?"** The theoretical foundation for this study is Critical Social Theory, a post-modern philosophical perspective that acknowledges that while there are many truths and many voices to express those truths, some voices are privileged and others are marginalized (Boudreau, 1997). **The use of the Community Based Participatory Research (CBPR) approach to this study is consistent with the perspective of Critical Social Theory. An expected outcome of CBPR is the attainment of new knowledge that guides actions.**

The Specific Aims of this study are to:

Aim 1. Examine the perceptions of individual women **served by three CHCs** regarding five topics: (1) their individual, their partner's, and their family's understanding of IPV; (2) their individual and their family's response to IPV; (3) their individual needs regarding IPV; (4) the reasons they may or may not have disclosed IPV to providers in the past; and (5) their perception of the influence of specific elements of their culture regarding IPV by conducting interviews with **individual** women who have experienced IPV, who are Native Hawaiian, Ilocano (Filipino), or Chuukese (Micronesian).

Sub Aims:

- a. Explore the perceptions of women **served by three CHCs** regarding their individual, their partner's, and their families' understanding of IPV.
- b. Identify the perceptions of women **served by three CHCs** regarding their individual and their families' responses to their experience of IPV.
- c. Identify the perceptions of women **served by three CHCs** regarding their needs, satisfaction with and access to IPV services in the community.
- d. Elicit the reasons these women **may or may not have disclosed IPV to providers in the past.**
- e. **Explore the perceptions of women served by three CHCs regarding their perception of the influence of specific elements of their culture regarding IPV.**

Aim 2. Examine the perceptions of individual women **served by three CHCs regarding:** (1) their individual, family, and cultural group's perception of the acceptability of violence between intimate partners; (2) their partner, partner's family, and partner's cultural group's perception of the acceptability of violence between intimate partners by administering a quantitative tool with individual women who have experienced IPV .

Sub Aims:

- a. Explore and identify on a numeric scale the perceptions of women **served by three CHCs** regarding the acceptability of violence between intimate partners from an individual, family, and cultural group perspective.
- b. Explore and identify on a numeric scale the perceptions of women **served by three CHCs** regarding the acceptability of violence between intimate partners from their partner's, partner's family, and partner's cultural group perspective.

Aim 3. Examine cultural perceptions, awareness, responses, and actions recommended about IPV by groups of women **served by three CHCs** who are Native Hawaiian, Ilocano (Filipino), or Chuukese (Micronesian). These women may or may not have experienced IPV personally.

Sub Aims:

- a. Identify cultural perceptions and awareness of specific groups **served by three CHCs** regarding IPV.
- b. Identify cultural responses of women in this group regarding IPV.
- c. Identify actions that the participants believe the CHCs or the cultural group could take to address the problem of IPV.

Definition of IPV

The terms domestic violence and intimate partner violence (IPV) are often used synonymously; however, this study investigates only IPV not other inter-familial abuse. For this study the full definition of IPV is:

a pattern of assaultive and coercive behaviors that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other (Family Violence Prevention Fund, 2002).

Background and Significance

Intimate Partner Violence is pervasive in American society and is the most common cause of non-fatal injury to women in the United States (Kyriacou et al., 1999). In the National Violence Against Women survey published in 2000 (Tjaden & Thoennes, 2000), approximately 25% of women and 7.6% of men reported being assaulted either sexually or physically, or both, during their lifetime. Studies conducted at a large, urban emergency department found that nearly half of the women patients had a history of IPV (Brokaw, et al., 2002). In other studies, battered women make up 18-25% of women who seek care at primary care clinics (CDC, 2000; Coker, Pope, Smith, Sanderson, & Hussey, 2001; Valente, 2000). Murphy, Scheri, Myhr, & Mont (2001) report in their meta-analysis of Canadian research studies regarding the incidence of IPV during pregnancy that 5.5 - 6.6% of women are abused during pregnancy.

The Surgeon General identified IPV as a health problem of epidemic proportions responsible for 30% of female homicides as early as 1985. Decreasing IPV remains one of the objectives in Healthy People 2010 (USDHHS, 2000). The Violence Against Women Act (VAWA, 1998) was first legislated in 1994 and later updated in 1998 to provide coordination of efforts and funding for programs to reduce IPV. Multiple federal agencies (Centers for Disease Control and Prevention, Agency for Health Care Research and Quality, and National Institutes of Health) are currently funding research to further delineate explanatory models and effective approaches for dealing with various aspects of this complex social issue. The National Institute of Nursing Research has funded, through various mechanisms, research focusing on a number of aspects of IPV, including: the experience of IPV during pregnancy and its impact on decision making (Lutz, K); women's perceptions of IPV within the context of intended or unintended pregnancy (Williams, G); strategies for screening for IPV in postpartum units (Renker, P); evaluation of methods of screening mothers for IPV in pediatric health care settings (Lewis-O'Connor, A); description of the experience of children following uxoricide (killing of one spouse by the other) (Steeves, R); stress and the immune response in battered women (Woods, S) (NIH, 2004); community partnered response to intimate violence (Glass, N); domestic violence prevention for African American women (Tyson, S); childbearing health of abused and non-abused women (Records, K); female perpetrators of same-sex interpersonal violence (Smith, C); health outcomes of young teens exposed to violence (Fredland, N) (NIH, 2005). **Later in 2005 NINR funded the following IPV research projects: partner violence defined/women with health disparity (Brackley, M); domestic violence enhanced home visitation program-DOVE (Sharps, P).** In addition, the Center for Health Disparities Research (a partnership between Johns Hopkins University School of Nursing and North Carolina Agriculture & Technology State University) funded by NINR, includes domestic violence as an area selected for the development of faculty expertise.

This study is consistent with the priorities of NINR, and is a form of health promotion and injury prevention (IPV) research using a multidisciplinary approach to improve the general health of underserved minority women (NINR, 2006). The long term goal of this program of research is to develop culturally appropriate interventions consistent with NINR's priorities as evidenced by recent research awards (CRISP, 2004-5) and the Center for Disease Control and Prevention's (CDC) agenda (CDC, 2002). The agenda provides a blueprint for ensuring that high-priority interventions are developed, tested and used. The agenda pinpoints seven areas, including IPV, where additional research can have the greatest impact on preventing injuries and controlling their debilitating effects. The study is also consistent with the goals of Healthy People 2010, increasing quality of life and eliminating health disparities. Injury and violence is also considered a leading health indicator for the implementation of this national prevention initiative (U.S. DHHS, 2000).

Impact of Culture

Reported rates of IPV have a wide range of variation from one cultural group to another (Tjaden & Thoennes, 2000; Magnussen, et al, 2004). There is little data available regarding the incidence and prevalence of IPV in women who are of a variety of cultural or other hard to reach populations (Huisman, 1996; Samuel, 2003; Senturia, Sullivan, Ciske, & Shiu-Thornton, 2000). Differences between cultural perspectives related to IPV may lead to barriers that prevent women from receiving effective care (Campbell & Fishwick, 1993). Campbell and Campbell (1996) suggest that clinical interventions for abused women should be based on principles, which include cultural competence and empowerment.

Although women of Asian and Pacific Islander backgrounds report a lower rate of IPV than other

cultural groups (Tjaden & Thoennes, 2000), researchers who work with Asian women have estimated that the prevalence of IPV is as great in Asian and Pacific Islander populations as in other groups and call for more research to ascertain the extent to which this phenomenon can be explained by the level of willingness to disclose abuse by these groups. Intimate partner violence may be hidden in the context of other civil and criminal complaints such as assault. Violence may also be *hidden* in the skewed proportion of emergency room visits by Asian and Pacific Islander Americans (18% of all visits) versus European American (12% of all visits) (National Asian Women's Health Organization, 1995). Researchers have found that Asian women are less likely to report abuse, possibly because of a patriarchal system that highly values family needs over individual needs (Huisman, 1996). Campbell and Campbell (1996) suggest that clinical interventions for abused women should be based on principles which include cultural competence and empowerment.

Recent work (Bui, 2003; Hindon & Adair, 2002; Ishida & Inouye, 2004; Magnussen, Smith, & Amundson, 2005; Matocha, 1998; Tang, Cheung, Chen, & Sun, 2002; Weingourt, Maruyama, Sawada, & Yoshino, 2001; Yoshihama & Sorenson, 1994) offers additional information about the response of some Asian cultures to IPV. While these studies provide windows of information about traditional cultural perceptions of IPV, they do not address the impact of IPV within the context of maintaining cultural identity outside of the country of origin. Only two studies (Bui, 2003; Yoshihama, 2002) examine the changes that occur in specific cultural groups when they live in a multi-cultural society. This proposed study will include immigrants as well as individuals that were born and raised in Hawaii.

Much of the research and data on women's health issues and IPV categorizes populations broadly into Asian and Pacific Islanders. There is great cultural diversity within broad categories such as Asian or Pacific Islanders. There is little data that dis-aggregates the cultural groups and yet it is important to identify specific values and life ways that influence perceptions and behavior for health care providers to intervene in culturally appropriate ways. Krane, Oxman-Martinez & Ducey (2001) note several authors have argued that broad categorizations related to ethno-racial groups lead to judgments that are made according to pre-defined standards and fail to account for the unique cultural traditions of specific groups. To identify specific values and life ways that influence perceptions and behavior, any research done in the State of Hawai'i requires that groups be dis-aggregated into specific cultural groups.

Members of this research team (Magnussen, Shultz, Oneha, Hla & Brees-Saunders, 2006) recently completed a systematic review of the literature published between 1996 and 2005 focused on the intersection of specific Asian and Pacific Island cultural groups and IPV. The review provided evidence that there is a need for healthcare professionals to be aware of differences between Western notions of independence and individualism and the ideals of interdependence and group harmony found within the specific populations studied. Developing screening and interventions based upon these ideals is one of the greatest challenges in working with abused women from these specific populations. Yoshioka & Choi (2005) also emphasize that health care providers must be willing to look at interventions that involve staying in the relationship and eliminating the violence. Perspectives of specific cultural groups may challenge the traditional, (Western) knowledge base about screening and interventions.

In Pacific Island populations, IPV is generally viewed as a misunderstanding between the husband and wife. Many Micronesians regard IPV as the behavior of an enraged, jealous husband, and others view it as a natural expression when men are not happy with the way their wives serve them (Samuel, 2003). The use of alcohol is consistently blamed for violence. In the past, people within extended families lived in close proximity for survival and protection and male relatives of women made sure that they were well protected. Now that families are forced to move away for economic opportunities, the nuclear family system does not provide the same level of protection for women as the extended family. Since most Micronesian families consider IPV to be a family problem, which is to be resolved by themselves or their family members, they are generally reluctant to seek help outside of the family. There are no known research studies regarding Micronesian women's perception of IPV and services that would be helpful for them when the traditional system of protection has been broken by migration to Hawai'i.

For this study culture is defined as "the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, life ways, and all other products of human work and thought characteristics of a population of people that guide their world view and decision making" (Purnell & Paulanka, 1998, p. 2). However, it should be emphasized that culture is a complex phenomenon. Kasturirangan, Krishnan, &

Riger (2004) observe that culture is not static. Individuals interact with their culture, leaving it constantly changed and redefined.

The impact of other factors

An emerging consideration in the literature is the importance of the socio-economic situation as a precursor for IPV. Rennison & Planty, (2003) note this and stress that care providers should include assessment of the women's economic situation. This is consistent with other economic findings of Campbell, Webster, et al (2003) that unemployment of a spouse is a significant factor in the occurrence of femicide in abusive relationships. Indeed, Rennison & Planty's (2003) research indicated that, although statistics show African Americans having the highest incidence of IPV, when the victim's household income was accounted for, race lost its significance. Socio-economic data will be collected for all participants in the study.

Health care systems and providers may contribute many barriers to the disclosure of IPV. **It is important that providers understand the nature of control exerted by an abusive partner which may have implications for informed consent and reproductive issues (Coggins & Bullock, 2003).** Mayer's (2000) qualitative study of women receiving care at an emergency department demonstrates the lack of appropriate responses on the part of nurses for victims of intimate partner violence. In that study women perceived that nurses and doctors appeared very rushed and did not inquire whether the women's injuries were the result of IPV. Victims claimed they would have felt more inclined to disclose this information if nurses had reassured them that the injuries were "not your fault." Henderson (2001) suggests that a lack of education for nurses (particularly those based in hospitals) about abuse contributes to a wide variation in an individual nurse's understanding of and response to women who have been abused. **Draucker & Madsen (1999) suggest that nurses who seek to understand the effects of violence on a woman's daily life should expand her focus beyond symptomatic responses to consider life history and social context of daily experiences.**

Rodriguez, Quiroga, and Bauer (1996) in their classic report posit that complex psychological, social and health system factors contribute to a lack of disclosure of partner abuse. They believe that the silence represents an "unspoken agreement" between the battered women and others in health care not to address their battering. They identify three ways that this silence is manifested: the inability or unwillingness of the victim to seek help, the patient's lack of openness with the health care provider, and the provider's failure to ask about the abuse. The participants in their study pointed out the importance of a trusting and supportive patient-provider relationship in setting the climate for change.

Intimate Partner Violence in Hawaii

Estimates are that at least 20% of all women in Hawai'i between the ages of 18 and 64 have been victims of IPV (Hawaii State, Dept. of Attorney General, 2003). Additionally, unpublished data from a clinical inquiry survey at a rural Oahu OB/GYN clinic found that 18% of women patients (N=60) indicated that they had been "slapped, punched, kicked, or otherwise physically hurt by an intimate partner" at least once (Kubany, et al., 1996). Between 1985 and 1993, nearly 30% of all homicides in Hawai'i were the result of intimate partner violence (Hawaii State Department of the Attorney General, 1999). **Between 1995 and 2004 there were 57 murders from IPV (Hawaii State Department of the Attorney General, 2005).** Findings from previous studies confirm that only a small percentage of abuse situations are reported to police and by the time an arrest is made, the violence has occurred for a number of years (League of Women Voters, 1996).

It is difficult in Hawaii to obtain accurate statistics regarding IPV. There is no correlation and crossover of data from health care providers, the criminal justice system, family courts or district courts. Consistently IPV is under reported by victims, and accurate statistics are not available from police, prosecutors, judges or other service providers. **Despite these limitations, in 2001 there were 2,368 arrests for violation of temporary restraining orders (TRO's) statewide. This represents a growth of 87% of IPV related arrests between 1999 and 2001 (Hawaii State Dept. of Attorney General, 2003). These figures represent only the reported occurrences of violence and may under report the actual prevalence of IPV. In a 2003 retrospective review of records in four primary care settings (Magnussen, et al, 2004) 16% of IPV occurred in Filipino women although Filipinos make up only 14% of the total population of the state. In that same study 32.3 % of the total reports of IPV were found for Hawaiian women, contrasted with Hawaiians comprising approximately 20% of the population. Finally, other Pacific Islanders comprised 16.1 % or the total reports, contrasted with**

Pacific Islanders being only 4.5% of the population. Although these data are based on a small sample (pilot data) they provide an indication of the scope of this problem in these cultural groups.

The population of women who are victims of IPV is not homogenous, (Critchton-Hill, 2001) yet intervention strategies for responding to IPV are based on Western notions of family and family life. Services are geared to women in general and do not thoroughly take into account the unique perspectives of different cultures. Cultural differences regarding IPV may lead to barriers that prevent women from receiving effective care. Campbell, Campbell, et al. (2003) call for research that considers the role of cultural factors, but does not necessarily assume that an individual identifies with the minority culture of their race or sir-name. This is particularly important for Hawai'i. While people in Hawai'i are influenced by their cultural heritage, these cultural perspectives are often moderated within the multi-cultural context. Caucasians - - known as Haole (Whittaker, 1986), Asians, Native Hawaiians, Pacific Islanders and others live together, inter-marrying and influencing each other's values and behavior. **The Strategic Plan for the STOP Violence Against Women Formula Grant (Hawaii State Dept. of Attorney General, 2003) identifies outreach to underserved populations that are isolated by culture and language as a priority.**

Preliminary Studies of the Research Team

The Research Team

The concern about IPV has led to the development of a CBPR team comprised of community health center personnel from Kalihi Palama Health Center; Kokua Kalihi Valley Comprehensive Family Services; and Waianae Coast Comprehensive Health Center and two nurse scientists from the University of Hawai'i (Shoultz, et al, 2006b). A representative from each partner site, interested in making a difference, became a member of this research team. The mission statement of the research team is:

To move community needs and concerns forward with participation, action, and research through a trusting and respectful long-term commitment between the University of Hawai'i School of Nursing & Dental Hygiene and the community health center partners of Kalihi Palama Health Center, Kokua Kalihi Valley Comprehensive Family Services, Waianae Coast Comprehensive Health Center, and Waikiki Health Center.

Although Oahu is home to multiple cultural groups, the groups to be included in this study represent disparate, challenging, and hard to reach populations with adverse health outcomes. One of the challenges is to gain knowledge of the perceptions of IPV within this very diverse population. The CHCs prioritized that three specific cultural groups were of greatest concern to them. The decision to study these groups was based on a lack of information about the needs of women seeking care at the centers. The participating CHCs identified the specific cultural groups to be included in the study based on questions about the health center's ability to meet the unique needs of the people they serve. **The health centers prioritized Native Hawaiian, Ilocano (Filipino), and Chuukese (Micronesian) because there is documentation of high rates of IPV in these populations, and little is known regarding their perceptions of IPV. The findings will be used to further develop culturally appropriate IPV interventions.**

This study builds on previous studies of IPV carried out individually and collectively by members of this research team. It is part of a series of studies leading to the development and testing of culturally appropriate IPV screening questions and interventions for these diverse populations. Future studies will address the population served by Waikiki Health Center (women who work in the sex industry). The AREA grant will provide the opportunity to include undergraduate and graduate nursing students in this research study.

The proposed study is the next logical step in the research team's program of research to address the issue of IPV in Hawai'i. The proposed study builds on previous studies conducted individually by research team members and collectively as a CBPR group in Hawai'i.

Studies 1 & 2

Dr. Magnussen is a member of the Oahu Domestic Violence Task Force and the Nursing Network on Violence Against Women, International. She has conducted two phenomenological studies focused on the lived experience of women in Hawai'i who have experienced intimate partner violence. Dr. Magnussen was a co-researcher on the "Lived Experience of Battered Women" (Taylor, Magnussen & Amundson, 2001) that focused on women from Hawai'i who had been abused at some time in their lives. Three major theme clusters emerged from the data: 1) painting the whole picture; 2) describing the violence; and, 3) living with the consequences. Women experienced common issues, motivation, fears, and hopes. In reviewing the impact of culture there were more similarities than differences among the various cultures.

In a follow-up study by two members of the same research team (Magnussen, Smith, & Amundson, 2005) three of the cultural groups studied, Japanese, "Hawaiian", and Korean, yielded unique themes. One of the more distinctive thematic differences "living in a changing society" described the changes that have occurred within Japanese society in the past few years. Generational change may have relaxed rigid gender roles and relationships. There is a less forgiving attitude about IPV and Temporary Restraining Orders are now issued in Japan to victims for perpetrators of violence. Other themes that became apparent during the analysis of the interviews were consistent across cultural groups. Although the participants were marked by their experiences, they showed their resilience by a willingness to face individual situations, and take the necessary steps to set and accomplish goals after the violence had ended. All of the participants described covering up the evidence of abuse and maintaining privacy as much as possible. In both studies Asian and non-Asian participants were alike in expressing their reluctance to report being abused. There is a need for further research regarding the reasons for reporting or not reporting IPV. In addition women's

satisfaction with and access to services, and needs were not elicited in that study.

Study 3

Dr. Shoultz's experience in community health nursing and community based interdisciplinary teams has focused on studies of the perception of women regarding the standardized *Put Prevention into Practice (PPIP)* guidelines within the ethnically diverse population of Hawai'i. Her previous research investigated three topics: alcohol and other drug use (Shoultz, Tanner, & Harrigan, 2000); smoking cessation (Shoultz, Phillion, Noone, & Tanner, 2004) and domestic violence (Shoultz, Phillion, Noone, & Tanner, 2002). The study on domestic violence was a qualitative descriptive study and involved women as participants in focus groups to discuss their perceptions of the standardized guideline. Women from five cultural groups (Hawaiian, Caucasian, Japanese, Filipino and Hispanic) self identified and chose to participate in a specific focus group. The women provided a variety of suggestions for adaptations to the standardized guideline. Differences noted by the women that would be consistent with the need to culturally tailor the guidelines included the following: The Japanese women were concerned that questions from the PPIP guidelines were too direct and "blunt" and may not be answered honestly. The women acknowledged potential differences in their generation's cultural values of non-confrontation and avoidance of shame and noted their children's generation may be more accepting of directness. Hawaiian women described the need to know who the provider was within the context of the network of the woman's friends and family in their community. They stated that providers need to disclose their own connections in the community before women could trust them. The women further believe that the provider needs to understand the beliefs and values of the woman and to base the interventions on the women's beliefs. The women preferred female providers of their own ethnicity or a female provider who understood their values and beliefs. Consistently across cultural groups, women identified that the development of a trusting relationship that is built on a provider's nonjudgmental attitude and assurance of confidentiality are essential to disclosure. Development of this relationship may take longer to establish than during a first visit and may require longer than a typical 12-15 minute visit. **The proposed study uses this information by involving many trusted personnel from specific cultural groups who are long time employees at the CHCs.**

Women's perceptions of IPV, satisfaction with and access to services and unmet needs were not elicited in that study. Further study is needed to elicit women's perceptions regarding those broader topics in specific cultural groups in Hawai'i.

Dr. Shoultz has built on her long experience in working with communities to secure a postdoctoral training fellowship funded by NINR at the Center for Vulnerable Populations Research at UCLA. The focus of her research is the use of community based participatory research to investigate IPV with vulnerable populations.

Study 4

Collectively in 2003 the research team of Magnussen, Shoultz, Oneha, Hla, Brees-Saunders, Akamine, & Talisayan (2004) supported by the School of Nursing and Dental Hygiene (SONDH), completed a retrospective chart review of disclosure of IPV in four community health centers providing primary care on Oahu in Hawai'i. The purpose of that study was to explore disclosure of intimate partner violence in the community health centers. The study included the records of women 19-64 years old seen at the four community centers during a five year period from 1998-2002. In 31 charts or 9.1% of the 337 charts reviewed, IPV was disclosed and documented. Women whose records were reviewed represented fourteen different cultural groups with wide variation (0-32.3%) from one cultural group to another in the range of disclosure of IPV.

Study 5

Dr. Oneha was the principal investigator for a Division of Nursing funded project to develop a self-reflective manual for community health nurses to use in addressing IPV in Native Hawaiian populations (Oneha, Wilcox, Lee, Kohatsu, & Inouye, 2000). Her work has advocated for the need to include cultural considerations in health care planning. As Director of Case Management/ Utilization, Dr. Oneha's work at the Waianae Coast Comprehensive Health Center (WCCHC) provides her with an understanding of the need for this research. As a member of the Native Hawaiian community, she is often called upon to serve as a cultural consultant in both educational and research endeavors. Her individual research (Oneha, 2001) has been qualitative and has addressed the meaning of a Hawaiian "Sense of Place" and its relationship to the healing environment. Her personal nursing practice has given her a first hand view of IPV and the need to further understand the perceptions of women so that appropriate services can be provided.

In 1999, the WCCHC recognized there were a number of women who were presenting to the Perinatal Support Services as being battered, yet were not being identified in primary care. In a review of diagnostic data at WCCHC less than 1% of the total number of women seen at the health center (15 years and older) were identified with a domestic violence diagnosis, much lower than the published estimates of women being battered. Intimate partner violence was not being routinely screened for in the primary care clinics as the majority of women who were diagnosed with IPV during an emergency room encounter, had numerous prior visits to primary care clinics. Dr. Oneha was instrumental in developing IPV screening at WCCHC to increase the opportunities for women to disclose violence. Training was provided to primary care and behavioral health providers, support staff, and case managers.

Subsequently, WCCHC applied for funding, and between 2001 and 2003, the WCCHC was awarded \$100,000 from the Office of Minority Health, and \$95,347 through the Office of Hawaiian Affairs, to screen pregnant women for IPV and to offer and provide follow-up services, and track multiple outcomes. A total of 1,084 pregnant women were screened in two years, approximately 6.9% screened positive in the first year of the grant, and 5.2% screened positive in the second year. The WCCHC is moving towards identifying a process for clients to evaluate the screening tool currently used. Since the Health Center has also implemented an electronic health record, the screening tool is in the process of being placed in this format.

Study 6

The research team has a pilot study funded from the Office of Research and Extramural Programs in the SONDH. (The study is titled "Intimate Partner Violence: Perceptions of Chuukese Women." Dr. Jan Shoultz is the P.I. for the pilot.) The pilot study uses focus group methodology to begin a conversation with Chuukese women served by Kokua Kalihi Valley Comprehensive Family Services regarding IPV. Dr. Campbell and Dr. Shiu-Thornton serve as consultants. This study will be completed October 31, 2006. Findings will be used to refine the focus group questions included in this proposal.

Proposed Study 7

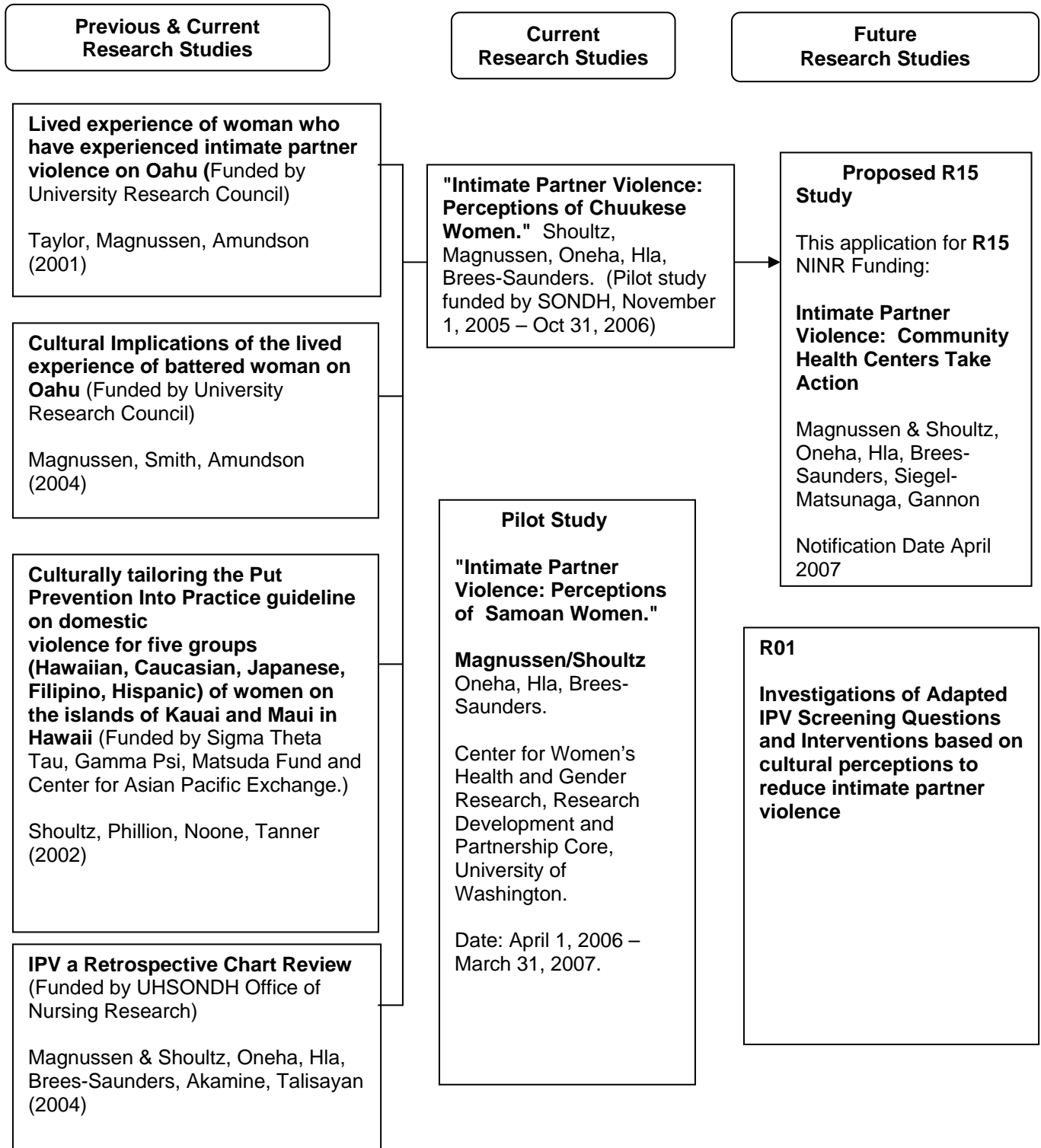
The research team also has a pilot study funded by the Center for Women and Gender Research at the University of Washington School of Nursing Research and Intramural Funding Program funded by NINR. (The study is titled "Intimate Partner Violence: Perceptions of Samoan Women." Dr. Lois Magnussen is the P.I. for the pilot.) The proposed pilot study will use focus group methodology to begin a conversation with Samoan women served by Kokua Kalihi Valley Comprehensive Family Services regarding IPV. Dr. Campbell and Dr. Shiu – Thornton will serve as consultants. This study will be completed March 31, 2007. Findings will be used to expand the research beyond the groups incorporated in this proposal.

Other Preliminary Work

Another site participating in this grant, Kokua Kalihi Valley Comprehensive Family Services (KKVCFS) was officially designated in October 2002 as one of 12 National Community Centers of Excellence (CCOE) in Women's Health by the Department of Health and Human Services, Office of Women's Health. The purpose of this recognition is to encourage the integration of clinical services, preventative care, education and outreach for women across their lifespan. Ms. Hansen, Assistant Clinical Director of the Center of Excellence, and Ms. Brees-Saunders, Program Coordinator, are members of the research team for the proposed study.

This proposed study is a step toward the goal of providing culturally appropriate and sensitive IPV screening and interventions for women of selected cultural groups in Hawai'i. A longitudinal representation of the previous, proposed and future studies is diagramed in Figure 1.

Figure 1. Systematic Research Design



D. Research Design and Methods

Theoretical Framework

Critical social theory is the theoretical framework for this research. This post-modern philosophical perspective acknowledges that while there are many truths and many voices to express those truths, some voices are privileged and others are marginalized. Dominant voices hold power over more marginalized voices. Sources of such dominance tend to be connected to the privileges accorded by gender, race and class. The intent of this theory is to "challenge conventional assumptions and social arrangements to move beyond the 'what is' to the 'what could be' (Mohammed, 2006). Such knowledge is proposed to be emancipatory in that defining the community's own stories and solutions are ways of taking back power. Community based participatory research is consistent with the perspective of critical social theory. An expected outcome of CBPR is the attainment of new knowledge that guides actions.

The CBPR orientation combines research methods and community capacity-building strategies (Green & Mercer, 2001). Participatory research has a rich and honored tradition in community development, contributing to social change and economic development. Three organizations, CDC, NIH, and AHRQ, and fourteen institutes or offices within these agencies have issued a call for research studies using the CBPR approach (NIH, 2006). The purpose of CBPR is to increase the relevancy of studies for both researchers and community members or organizations, and it is particularly attractive for those struggling to address the persistent problems of health disparities (Viswanathan et al., 2004). Hallmarks of this method are the sharing of knowledge and valuable experience between partners that leads to the development of more effective culturally appropriate methods of addressing community issues and concerns. The ultimate benefit is a deeper understanding of the unique circumstances and a more accurate framework for testing and adapting best practices to the community's need (Green & Mercer, 2001).

The research team adopted the definition of CBPR by Israel and colleagues that defines CBPR as a collaborative approach to research where partners are equally involved in all aspects of the research process and contribute unique strengths, sharing responsibilities to enhance understanding of phenomena within the social and cultural dynamics of the community. The goal is to integrate the knowledge gained with action to improve the health and well-being of the community (Israel, Schulz, Parker & Becker, 1998).

Community based participatory action research does not prescribe a certain set of methods; rather it is an orientation to research (Minkler & Wallerstein, 2003). Shared leadership for the research is an important element of CBPR approaches (Israel, Eng, Schulz & Parker, 2005). Wallerstein (1999) cautions that university-based researchers have to be aware of the possibility of acting from a point of academic privilege and power. Such awareness requires that a researcher take stock of her behavior and remember that she is no more than a single participant (one voice with one perspective) in the overall project. Research is not done *on* a community, rather *with* a community. Traditional belief systems may be barriers to conscious action and freedom (Lindsey, Shields, & Stajduhar, 1999). Freire (1990) suggests that the route to empowerment is via questioning taken-for-granted, reflective participatory dialogue, consciousness-raising, and, ultimately, action to redress power imbalances. This attitude, while empowering community participants in the research process, also places an obligation on the community partners in this study to take action consistent with the participants' voices, and to critically reflect on traditional rules, practices, structures, and assumptions which have guided perceptions of IPV and resulting interventions in communities (**Shoultz, et al., 2006b**). Dr. Kristen Swanson who has used CBPAR to study miscarriage will serve as our consultant for this methodology. She will also assist with the analysis of qualitative data and the integration of the qualitative data, field notes and quantitative data.

Research Design

This systematic inquiry is a descriptive CBPR study using both qualitative and quantitative methods that will be conducted over a two year period. Data will be collected between the fourth and fifteenth months. Analysis of qualitative data from individual interviews (Appendix A) and focus groups (Appendix B) will be accomplished using content analysis (Downe-Wamboldt, 1992). Limited quantitative data will be gathered from two sources: Perceptions of the Acceptability of Violence (Appendix C) and demographic data (Appendix D). Demographic data will be collected on all participants of focus groups and individual interviews and will be used to describe the participants. The second source of quantitative data (Appendix

C) will be collected at the end of the individual interviews with questions focused on the women's perceptions of the acceptability of violence. These data will be analyzed using descriptive methods including frequencies, means, and standard deviations. **The perceptions of the acceptability of violence will also be explored in the focus groups with the addition of another question (Appendix B, 1f).** Outcomes from the study are anticipated to be increased knowledge of both individual and group perceptions of IPV from the three cultural groups that lead to the development of culturally appropriate interventions for IPV. Meleis (1992) suggests that individual problems cannot be separated from the broader social and political context; they are influenced and constructed by social, cultural, and historical conditions in the larger community. Combining the individual perspective with the group perspective will provide a more comprehensive description of the cultural group's perception of IPV.

This research design consists of two phases (individual interviews and focus groups) to meet the needs of women from the specific cultural groups in this study. Staff at the individual health centers believed that they could provide more effective care for women who experienced IPV if they had information about women who are served by the health centers. It was believed that the best way to accomplish this was to go to the women, themselves for this information. After the study is completed the findings will be shared with staff at each CHC via a series of in-service presentations.

Individual Interviews

In the first phase of the study individual interviews will be conducted with women **aged 18 and above who have screened positive for IPV and are served through a variety of programs that are affiliated with the three participating CHCs. All of the participating CHCs now conduct screening for IPV as standard care. This reflects a change in practice that has occurred during the last year.** These interviews will examine the perceptions, responses, and needs of women from specific cultural groups, Native Hawaiian, Ilocano (Filipino), and Chuukese (Micronesian), who have experienced IPV. Interviews will explore the women's, their partners', and their family's cultural perceptions of IPV (**including culturally specific protective practices, spiritual and religious practices, family rituals, gender roles, art and music, and the roles of individuals and groups related to IPV**); the women's and their family's responses to IPV; the women's unmet needs, satisfaction with and access to IPV services in the community; and the **factors that have influenced their previous disclosure (or lack thereof) of IPV to health care providers.**

In Part II of the individual interview, women will be asked to rate their perceptions of the acceptability of violence on a Likert scale. The interviews will be conducted by **non-clinical** health center staff members who are of the same cultural group. Investigators who share cultural views with the participants are more easily accepted by them and can more easily establish rapport (Fontes, 1998). This interview will gather both quantitative and qualitative data. Graduate and undergraduate students will assist with transcription, translation, and analysis of interviews.

Focus Groups

In the second phase of this research study, focus groups will be conducted with women who are from the same cultural groups and served by the health centers. **Women 18 years and older will be recruited through a variety of programs and organizations that are affiliated with the three participating CHCs. Examples of these recruitment sites include the clinic sites, mobile vans, public housing, and community churches. The group of 7 – 10 participants will meet at a location convenient to the majority of the participants.** The focus group participants may or may not have experienced IPV personally. Women participating in the focus groups will be asked about cultural perceptions (**including individual and collective approaches, culturally specific protective practices, spiritual and religious practices, family rituals, gender roles, art and music, and the acceptability of violence**). They will also be asked about the awareness of IPV within their cultural group; cultural responses of women in this group regarding IPV; and to identify the actions that they believe would address the problem of IPV in their cultural group. To avoid duplication of data between individual interviews and focus groups, and enhance the safety of the participants, women will not be invited to participate in the **focus group if they have participated in an individual interview.**

Communities and CHC Partners

A brief description of each community, and its associated CHC partner serving as a site for this study, shown by demographics in Table 1, demonstrates the uniqueness of each site. All specific information has been provided by personal communication from internal reports from each site. These community partners will serve as the setting for this research study. Although each site provides an array of different services,

all work towards a common goal of providing quality health care to the uninsured and underinsured populations of Hawai'i.

Kalihi is located at the edge of Honolulu's metropolitan area, and is comprised of densely populated, old neighborhoods situated alongside small businesses, eleven public housing projects, industrial facilities, emergency shelters and the ethnic market places of Chinatown. This overcrowded residential area is bordered by a valley, and divided by a river and the H-1 freeway, the busiest and largest freeway in Hawai'i. Hawai'i has the largest per capita population of resident immigrants in the United States, and Kalihi has the highest concentration of foreign-born recent immigrants in Hawai'i. A majority of immigrants to Hawai'i make their first home in Kalihi. The establishment of the earlier arrivals from these cultures in this community further attracts this population. Both Filipinos and Micronesians who live in Kalihi and are served by the two CHC partners confront barriers to health care typical of foreign born, immigrant and refugee populations in Hawai'i including:

a) Poverty

Like most other immigrants to the United States, the Filipinos and Micronesians originate from countries where poverty is pervasive and the health care systems are inadequate or unable to meet their demands. They arrive in this country with the desire to improve their standard of living, but many lack the resources to survive.

b) Language and cultural barriers in the health care system

For many immigrants, the language and cultural barriers make western health care undecipherable. This is especially troubling for newly immigrated people. Many have a crisis-oriented perspective of health care, and as a result simply do not seek care until their condition reaches a crisis stage.

c) Cultural barriers to achieve healthy outcomes

The fundamental understanding of what conditions require medical attention and what conditions are healthy and acceptable within the different cultures are diverse. Many women rely on advice from older members of their extended family for staying healthy. Kalihi is the only area in the State that has been declared both a Medically Under-Served Area (MUA) and a Health Personnel Shortage Area (HPSA) for Primary Care, Mental Health and Dental Care.

Residents in Kalihi are at risk of health problems typical of low income, Asian and Pacific Island immigrant communities including high rates of diabetes mellitus, hypertension, coronary heart disease, obesity, substance abuse and high blood cholesterol. Additionally, many immigrants arrive with serious, long-untreated chronic and communicable diseases including tuberculosis, Hansen's disease and hepatitis B, and are unaware of the seriousness of their conditions or the risk they pose to the public and to their family and friends. The residents of Kalihi have been disproportionately impacted by the economic recession that has plagued Hawai'i over the past decade. Unemployment in the Kalihi area has remained steady at more than 8%. Compounding poverty is the low educational attainment of residents in Kalihi. The rate of Kalihi residents that have a high school diploma or higher educational achievement is the lowest of any other community in Hawai'i (68.7%).

The diversity of this community, with over a dozen different Asian (Korean, Laotian, Vietnamese, Filipino, and others) and Pacific Island (including Samoan, Tongan, Marshallese, Chuukese, Guamanian) ethnic groups residing in close proximity, creates a challenge to the health centers in providing culturally appropriate services for all clients. Adding to the complexity of the clientele, are the multiple different dialects within each cultural group. For example, the Filipino language includes approximately 70 different dialects (Ponce, 1980). Vast differences exist between and within the different cultural groups in their attitudes towards western and native health care, parenting, marriage, education, and assimilation into American culture.

The community of Kalihi is served by the first two partner health centers, Kalihi Palama Health Center and Kokua Kalihi Valley Comprehensive Family Services. Kalihi Palama Health Center (KPHC) has provided primary health care to patients of all ages since opening its doors over 28 years ago, in 1975, as *Hale Ho'ola Hou* (House of New Life) on the premises of Kaumakapili Church. The clinic was started by concerned citizens who recognized the urgent need for medical services for low income Native Hawaiians and immigrants who faced cultural and economic barriers to healthcare

The KPHC offers comprehensive, integrated, preventive and primary health and social services that are accessible, cost-effective, and culturally appropriate. Services include Adult Medicine, Pediatrics, Women's Health (Ob/Gyn, Midwifery, Family Planning), Osteopathy (Pain Management), Social Services (Behavioral Health, Psychiatry, Community Health), WIC Nutrition, Dental, Optometry, and Health Care for

the Homeless). KPHC's service delivery model is a combination of both freestanding and "mobile" services. In addition to the services provided at the main clinic, services are also provided within six sites serving the homeless, a WIC satellite, and the Women's Community Correctional Center (WCCC). Regardless of location, the principal goal of all departments of KPHC is to seamlessly integrate their services into primary care to improve the patient's overall health outcomes and KPHC's overall efficiency.

Kokua Kalihi Valley Comprehensive Family Services (KKVCFS) was formed in 1972 by community leaders in response to the absence of accessible and appropriate health and human services in Kalihi Valley, with the mission to be an agent of health and reconciliation for the community. The KKVCFS has grown to now include a hundred staff, fluent in seventeen languages, and working out of five main locations, including two public housing projects. Their new Charles Judd Community Health Center was completed and occupied in March, 2001, and is a 12,000 square foot health center located in the heart of Kalihi Valley, within a mile of the three neighborhood public housing projects. The health center currently serves over 6,000 Kalihi Valley residents per year with a broad array of holistic health and human services covering all stages of the lifecycle. Services include dental, medical, perinatal, family planning, women's health, nutrition education and WIC services, immunization, STD/HIV testing and services, mental health, elderly services, health education, social services, transportation, translation, outreach, youth services, and community advocacy. In October 2002 KKVCFS was officially designated as one of 12 National Community Centers of Excellence in Women's Health by the Department of Health and Human Services, Office of Women's Health to integrate clinical, preventative care, education and outreach for women of all ages.

The community of Wai`anae is served by the next health center. The Wai`anae Coast is located on the extreme west (leeward) side of O`ahu. It is separated from the rest of the island by the Wai`anae mountain range to the north, and bordered by the ocean to the south. Entrance into the Wai`anae Coast is from the east on the only accessible highway in and out of the community. Waianae has the largest population of Hawaiian Homelands residents in Hawai`i with three homestead sites (lands set aside for Native Hawaiians by Congress in the Hawaiian Homes Commission Act of 1920). The City and County of Honolulu's 2000 Comprehensive Economic Development Strategy report identified the Wai`anae region as an area in need of economic development based on: 1) poverty rate; 2) unemployment rate; and 3) income. The Hawai`i State Department of Health, Primary Care Needs Assessment Databook (2003) ranks Wai`anae first, on Oahu, in unemployment (8.9%), poverty (21.9%), households receiving Temporary Aid to Needy Families (11.9%), households receiving food stamps (41.5%), and highest in maternal and infant health risk scores, and socio-economic risk scores. Other challenges include prevalent psychosocial issues such as substance use, domestic violence, and mental health problems, lack of partner/family support, and high risk for multiple medical problems including, obesity, diabetes, hypertension, and asthma.

The inception of the WCCHC is credited to many years of community-driven planning efforts focused on bringing health services to this isolated rural coastline. The closing of the Wai`anae Sugar Mill dispensary in 1946 left many residents without medical care, forcing them to drive 1-1 1/2 hours to Honolulu for health care. Designated as a medically underserved area, the WCCHC broke ground with the first phase of the health center in 1972 with one physician and five staff. The WCCHC is a community owned and operated, non-profit, health center which serves the Leeward Coast to Central Oahu through a main clinic and four satellite clinics, offering a range of services including 24-hour emergency care, primary care, specialty services, laboratory and radiology services, dental, transportation, child passenger inspection station, preventive health, case management, adult day care through five sites, mental health and substance abuse treatment, health career training, traditional healing, integrative medicine (pain management, lifestyle enhancement, fitness training), WIC, Healthcare to the Homeless, etc. These services have developed in response to community need over the past 33 years. In order to continue this response, the WCCHC is committed to researching high risk topics, such as intimate partner violence, with its unique user population, to discover and ensure the best possible and most appropriate interventions and outcomes.

The Health Center is a 2002 recipient of the Hawai`i State Award of Excellence, No`ela Po`okela Award which recognizes organizations that systematically achieve positive results and raise the level of excellence throughout the organizational structure. The Health Center has undergone tremendous growth and change over its years of existence, but has maintained its focus to address the multiple and complex health, social and economic needs of the community. Research studies with participants which reflect the demographics presented in Table 1 assist in maintaining this focus and continuing the Health Center's progress.

Table1. Community Partners Client Demographics – 2004-5

Demographics	KKV ¹		KPHC ¹		WCCHC ¹	
1. Users	6,215		12,385		25,263	
2. Encounters	37,184		58,744		137,492	
3. Gender – Female/Male	60%	40%	56%	44%	56.%	43.3
4. Age – Female: 19-29	664		1,375		3,252	
30-39	485		985		1,751	
40-49	336		886		1,580	
50-59	261		649		1100	
60-64	149		271		377	
5. Poverty: 100% and Below	73%		67%		64.3%	
101-200%	9%		6%		6%	
Over 200%	2%		8%		23%	
Unknown	16%		20%		3.5%	
6. Insurance: None	36%		50%		17%	
Medicaid	48%		39%		49%	
Private	12%		5%		26%	
Medicare	4%		4%		7%	
Other	0		2%		0	
7. Ethnicity: Native Hawaiian	7%		8%		51%	
*Pacific Islander (includes Samoan, Tongan, Micronesian, Guamanian, etc.)	43%		20%		9%	
*Asian	41%		35%		16%	
Filipino	31%		18%		N/A	
Black/African American	0		2%		2%	
White	1%		12%		18%	
Hispanic	0		2%		2%	

¹2004-5 Uniform Data System Report

***It is important that these groups be dis-aggregated in order for their needs to be met at each site.

Study Participants (Sample)

Participants will be recruited through purposive sampling for both individual interviews and focus groups. There will be 3 focus groups, each representing a specific cultural group. Each health center partner prioritized the specific group to include at their site, usually representing those at highest risk. The safety concerns are a paramount consideration, therefore a highly select population has been chosen to ensure access to follow up care and referral. Such follow-up is readily available for women served by the community health centers and is within the normal operational procedures. **The number of participants in the interviews and focus groups, while limited, are appropriate for this exploratory pilot study.**

Sample for Individual Interviews.

Inclusion criteria for the individual interviews include: women **aged 18 and above who are served through a variety of programs that are affiliated with the three participating CHCs and who have screened positive for IPV**, and are from the priority group identified by the specific health center. **To further protect their safety, women who have participated in individual interviews will not be recruited for the focus groups.** We recognize that this purposive sample limits the transferability of the findings; however, this limitation is secondary to the safety of the women.

Sample for Focus Groups.

Inclusion criteria for the focus groups include: women 18 years and older, **served through a variety of programs that are affiliated with the three participating CHCs** and who are members of the priority group identified by the specific health center. These women may or may not have experienced IPV.

1) Kalihi Palama Health Center will recruit Ilocano (Filipino) participants. Kalihi is home to Hawai'i's highest percentage of Filipinos (46.7%). The Filipinos began arriving in Hawai'i in 1906 to escape the adverse political conditions and profound poverty in the Philippines. They continue to be one of the fastest growing ethnic groups in Hawai'i, and although they have been immigrating to Hawai'i for almost a century, they continue to hover near the lower socioeconomic strata. **Filipinos in Hawaii number 170,635 (14.1% of the State population).** Seventy different dialects are spoken by Filipinos in Hawai'i, the most widely used is Ilocano. Filipino immigrants maintain close ties to family in the Philippines, and their cultural traditions are strong. The extended family is the basic unit in Filipino society, and the strong sense of interdependence leads to the Filipino concept of reciprocity and balance, or *utang ng loob*. For example, parents take care of children, and later in life the children tend to care for their elderly parents. (Ponce, 1980).

2) Kokua Kalihi Valley Comprehensive Family Services will recruit Chuukese (Micronesian) participants. The Federated States of Micronesia (FSM) have a Compact of Free Association with the United States. Included in the Compact are provisions that allow residents of Micronesia unrestricted travel between their countries and the U.S., and complete access to the health and social services of this country. It is for this reason that many Micronesians venture to Hawai'i to seek medical care, many of them require immediate attention for illnesses allowed to progress to advance stages (Levin, 1999). In 2000, Hawai'i requested \$11.5 million in reimbursements from the federal government for the welfare, health care, education and crime costs associated with the over 6000 Micronesians residing in Hawai'i (Kreifels, 2000). The population of Micronesian (**including Chuukese**) clients has been steadily increasing, and their client profile is startling. According to Kokua Kalihi Valley and Kalihi Palama Health Centers data, Micronesian clients have very high rates of at-risk behaviors and poor outcomes. Their rate of entry into perinatal care in the third trimester is 30.5%, and they have the highest rate of low birth weight infants at 10%, considerably higher than the State average of 7.6%. Micronesians also have a disproportionately high rate of positive STD test results (13.8%), teen pregnancy and early sexual activity.

3) Waianae Coast Comprehensive Health Center will recruit Native Hawaiian participants, the indigenous people of the State of Hawai'i. Western sociopolitical domination has devastated Native Hawaiians and displaced them from their lands and culture. Because their land and health have been devastated, their pursuit of self-determination has been unrelenting as a means of survival. Since the late 1960's, they have seen a resurgence and revival of their culture. Many are becoming reacquainted with cultural practices, values, and rituals. Achieving balance or harmony, *pono*, for Hawaiians, meant maintaining a relationship with *akua* (supernatural god, spirit), the *āina* (land), and the *ʻohana* (family). It was through the *ʻohana* that cultural values, history, rituals, and traditions were communicated. However, there are also many that remain alienated from their cultural values and traditions as a result of Westernization. As described previously, Native Hawaiians/part-Hawaiians have a significant proportion of IPV incidents for both the victim and the offender. **In the 2000 Census Native Hawaiians and Part Hawaiians included 239,655 individuals, approximately 20% of the population.** A retrospective chart review of disclosure of IPV completed by Magnussen et al. (2004) revealed that the percentage of Native Hawaiian women who reported IPV was the highest of any other ethnic group (32.3%), however they represented only 19% of the total population reviewed.

Likewise, the health status of Native Hawaiians is known to be among the poorest in the nation, particularly when dis-aggregated from the general Asian/Pacific Islander category. Native Hawaiians have higher prevalence and mortality rates of diabetes and cancer, one of the shortest life expectancies in the State, and striking disparities in cancer mortality rates between part-Hawaiians and pure Hawaiians (Busch, Easa, Grandinetti, Mor, & Harrigan, 2003). Despite these challenges, Native Hawaiians, particularly from the identified community, have been outspoken in taking action to resolve problems that they have identified, retain strong family connections, are protective of perceptions of their community, and are very tied to their land – Waiʻanae.

Sample Size

All women who are receiving services from the CHCs are currently screened for IPV. Women who have screened positive for IPV will be invited to participate in the individual interviews. Due to limited resources, multiple languages and sites, 5 women from each of the three cultural groups will be

recruited to participate in the individual interviews. Morse's (1991) criteria for sample size in a qualitative study requires that there be enough participants (and text produced) to assure adequate representation (enough participants to have a range of experiences) and appropriateness (capacity to be articulate and reflective about the experience). Although saturation may not be reached with five participants, it is anticipated that the data gathered through the focus groups will expand the understanding of cultural perspectives of IPV. **When very little is known about a topic, exposing even some of the variation is a very important first step.** In addition, the insights gained from the individual interviews will provide valuable information on which further studies can be based

Each partner site will conduct two focus groups (an initial and a validation member-checking group) with their identified population. Focus groups will consist of 7 – 10 women. **Women aged 18 and above will be recruited through a variety of programs and organizations that are affiliated with the three participating CHCs.** According to Morse and Field (1995), "a focus group is typically composed of 7 to 10 participants who are selected because they are knowledgeable about the topic of the research." (p. 32)

It is anticipated that the projected number of participants is sufficient to achieve representation and appropriateness regarding the research questions. The Filipino, Micronesian, and Native Hawaiian groups will be comprised of women who self identify with each ethnic group. Group interviews will facilitate people building off each other's stories and allow the observations of what emerges when people talk amongst themselves about IPV. Cote-Arsenault and Morrison-Beedy (1999) interviewed groups of women experiencing pregnancy after loss and claimed the greatest contribution of group interviews was the way women spontaneously compared, contrasted, and validated each other's stories. They claimed that this dynamic, while fascinating to observe as it unfolded, was most illuminating in that it made quite evident how similar topics or events were experienced quite uniquely based on each woman's life context. Because people will build on each other's stories in a group setting, it is possible that the group interviews may make it more obvious when a cultural norm or expectation is salient to the experience of IPV. Limitations of focus groups are recognized and procedures have been included to minimize the drawbacks. For example, ground rules are described in Procedures for Focus Groups (e).

Procedures

Procedures for Individual Interviews

1. Two individual interviews (initial and validation interviews for member checking) will be conducted with women who have experienced IPV personally (**at any point in their lives**) and are **recruited from a variety of programs and organizations that are affiliated with the three participating community health centers.**
2. All research staff **will be women from the specific cultural group studied, who do not provide direct clinical services but are trusted and respected community members who work at the CHCs.** They will receive IRB training as well as specific instruction regarding IPV from Dr. Jacqueline Campbell, a nationally known expert. Specific training on conducting individual interviews using culturally appropriate strategies for women will be conducted by Dr. Sharyn Shiu-Thornton, who has conducted similar studies in the Seattle area. This training will provide for greater reliability of the findings and safety of the women.
 - a. All instruments will be translated for Ilocano and Chuukese women. The questions for individual interviews will be translated from English to the language and then back translated from the language to English to assure the validity of the translation.
 - b. The community health center staff will screen each participant for their eligibility to enroll in the study. The interviewer will explain the purpose and the procedures of the study to the potential participants and ask the women to sign the informed consent. **The informed consents will be kept in a locked file accessible only to the researchers. Codes will be assigned for each individual participating in the individual interviews and records will be kept separately from the informed consents. The purpose of the interview (IPV research) will be clearly described. The session is not part of the treatment plan, and will not be used to solve clinic-level problems for other issues unrelated to IPV.** The participants who meet the inclusion criteria and voluntarily sign the informed consent will be enrolled into the study. The investigators will apply for the NIH Certificate of Confidentiality to further protect the participant's safety. Women who are interviewed individually will be given an honorarium (\$20 value) after each interview.

- c. Individual interviews will be conducted by **women from the specific cultural group who are** fluent in the language appropriate for the session in conjunction with the research team. (See Appendices A and C). All interviews will be audiotaped. Measures will be taken to conform to ethical principles and safety considerations suggested in IPV guidelines for each woman enrolled in the study. The participants will also be informed about the NIH Certificate of Confidentiality to further assure them that researchers will not divulge to authorities the information shared in the interview; **however, women will be informed that if child abuse is disclosed it is mandatory for it to be reported.** All participants will be offered information and referral if appropriate. Should painful feelings occur for participants the researchers will debrief with them and refer to health center personnel as needed.
- d. Interview proceedings will be translated as appropriate. For example, the audiotape for the Ilocano interviews will be transcribed into Ilocano by the clinic staff member fluent in the language. A second Ilocano translator will translate that transcript into English. Both bi-lingual translators will verify this translation by back-translating the English document into Ilocano. The Chuukese interviews will be translated using the same procedure.
- e. The English language interviews will be transcribed in English.
- f. Following transcription of the audiotapes, content analysis using procedures suggested by Downe-Wamboldt (1992) will be done by at least three members of the research team manually. The data will be entered into NVIVO, a qualitative program for data storage and management.
- g. A second interview for validation and member checking regarding the initial analysis will be carried out with the same participants and research personnel. Another honorarium (\$20 value) will be given to each participant at this time. The procedures for non-English speaking women will be the same as indicated above.
- h. Initial analysis will be revised, based upon validation and member checking.
- i. Additional questions may be added to the core focus group questions based upon the response to the individual interviews.
- j. Demographic data and responses to the numeric scale in the Perceptions of the Acceptability of Violence Tool will be entered into SPSS for quantitative analysis.

Procedures for Focus Groups

2. Women aged 18 years and older who use the community health centers or **participate in a variety of programs and organizations that are affiliated with the three participating community health centers** will be asked to participate in the research study as a participant in focus groups that will be discussing IPV. Focus groups will be conducted at sites that are convenient and safe for the women.
 - a. All research staff **will be women from the specific cultural group studied, who do not provide direct clinical services but are trusted and respected community members who work at the CHCs.** All research staff will receive IRB training. Group leaders and interpreters will receive specific training on focus groups and their implementation using culturally appropriate strategies for women. The training will be conducted by consultant, Dr. Sharyn Shiu-Thornton who has substantial experience in conducting qualitative studies in cross-cultural settings and other members of the research team. The group leaders will also receive training from well known IPV researcher, Dr. Jacqueline Campbell who will provide instruction about the sensitivity of the research subject. This training will enhance the reliability of the data collection and will further ensure the safety of the participants. Additionally, the members of the research team will monitor the focus groups to ensure trustworthiness of the data.
 - b. All instruments will be prepared in English, Ilocano, and Chuukese. The questions for focus groups will be translated from English to the dialect and then back translated from the dialect to English to assure the validity of the translation (Brislin, 1986).
 - c. At the focus group, the research team will explain the purpose and the procedures of the study to the potential participants who will be asked to sign the informed consent and a confidentiality agreement. **The informed consents and confidentiality agreements will be kept in a locked file accessible only to the researchers. Codes will be assigned for each individual participating in the focus group and records will be kept separately from the informed consents.** The participants that meet the inclusion criteria and voluntarily sign the informed consent and the Confidentiality Agreement (Appendix E) will be enrolled into the study. The investigators will apply

for the NIH Certificate of Confidentiality to further protect the participants' safety. Focus group participants will be given an honorarium (\$20 value) after each focus group.

- d. Focus groups will be conducted by **women from the specific cultural group who are** fluent in the language appropriate for the session (group leaders and interpreters) in conjunction with the research team. See Appendix B for the Focus Group Interview Guide. Morgan (1988) suggests beginning with a list of questions and translating them into a summary of topics for discussion designed with a natural progression or flow across topics. All focus groups will be audiotaped. Sessions are expected to last from 1 – 2 hours with a break offered at a point that will not disrupt the flow of discussion.
- e. Measures will be taken to conform to ethical principles and safety considerations suggested in IPV guidelines for each woman enrolled in the study. **A statement will be made that the researchers can request, but cannot guarantee that what is shared in the group will remain confidential.** Participants will have signed the Confidentiality Agreement, acknowledging their responsibility in not sharing the information discussed in the group. The participants will also be informed about the NIH Certificate of Confidentiality to further ensure that researchers will not divulge to authorities the information shared in the group; **however, women will be informed that if child abuse is disclosed it is mandatory for it to be reported.** The session will begin by the moderators introducing the agenda and sharing ground rules for participation (rules include respecting the confidentiality agreement, turn taking, there are no right or wrong answers, the researchers will not be seeking personal information (therefore participants are not expected to share personal information), and that everyone's perspective counts). **Even though women are instructed not to disclose personal information pertaining to IPV during the focus groups, there is a possibility that this could occur. If any of the participants begin to share personal experiences of IPV, the group leader will immediately remind the participants that confidentiality can be requested but not guaranteed. In addition, one of the investigators will approach the participant and offer her the opportunity to speak privately away from the group. The purpose of the group session (IPV research) will be clearly described. The session is not part of the treatment plan for the women, and will not be used to solve clinic-level problems for other issues unrelated to IPV.**
- f. Should painful feelings occur for participants the researchers will debrief with them and refer, as appropriate, to counselors within the CHCs. All participants will be offered information and referral if appropriate. Such follow-up is readily available for women served by the community health centers and is within the normal operational procedures.
- g. Each focus group will have at least two research staff members present during the session, including: 1) a group facilitator to propose the questions to the group; and 2) a recorder who is responsible for audiotaping, securing informed consent, taking field notes, and general troubleshooting as required.
- h. Focus group proceedings will be translated as appropriate. For example, the audiotape for the Ilocano group will be transcribed into Ilocano by the clinic staff member fluent in the language. A second Ilocano translator will translate that transcript into English. Both bi-lingual translators will verify this translation by back-translating the English document into Ilocano. The Chuukese group proceedings will be translated using the same procedure.
- i. The English language groups will be transcribed into English.
- j. Content analysis using procedures suggested by Downe-Wamboldt (1992) will be done by at least three members of the research team manually. The data will be entered into NVIVO, a qualitative program for data storage and management.
- k. A second focus group for validation and member checking regarding the initial analysis will be carried out with the same participants and research personnel. Another honorarium (\$20 value) will be given to each participant at this time. The procedures for non-English speaking groups will be the same as indicated above.
- l. Initial analysis will be revised, based upon member checking.
- m. Demographic data will be entered into SPSS for quantitative analysis.

Instruments

Table 2 presents an overview of instruments, aims, sub aims, questions and methods.

Table 2. Overview of instruments used in the study organized using the aims, sub aims, questions and methods of analysis. Complete instruments are found in **Appendix A to E**

Aims	Instruments	Data Collection	Analysis
<p>Aim 1: Aim 1. Examine the perceptions of individual women served by three CHCs regarding five topics: (1) their individual, their partner's, and their family's understanding of IPV; (2) their individual and their family's response to IPV; (3) their individual needs regarding IPV; (4) the reasons they may or may not have disclosed IPV to providers in the past; and (5) their perception of the influence of specific elements of their culture regarding IPV by conducting interviews with individual women who have experienced IPV, who are Native Hawaiian, Ilocano (Filipino), or Chuukese (Micronesian).</p>			
<p>Sub Aim 1 a: Explore perceptions of women served by three CHCs regarding their individual, their partner's, and their families' <u>understanding of IPV.</u></p>	<p><u>Individual Interview Guide (Part 1) (Appendix A)</u> 1a. Tell me about IPV? How do you understand this? 1b. What about your partner? How do you think your partner understands IPV? 1c. What does your family think about IPV?</p>	Individual Interviews	Analysis of transcripts from individual interviews will be done using content analysis of qualitative data by members of the research team, manually and with NVIVO.
<p>Sub Aim 1 b: Identify perceptions of women served by three CHCs regarding their individual and their families' <u>responses</u> to their experience of IPV.</p>	<p><u>Individual Interview Guide (Part 1) (Appendix A)</u> 2a. How did you deal with IPV? Did you talk with anyone? 2b. How about your family – what did they say or do?</p>	Individual Interviews	Analysis of transcripts from individual interviews will be done using content analysis of qualitative data by members of the research team, manually and with NVIVO.
<p>Sub Aim 1. c. Identify perceptions of women served by three CHCs regarding their <u>needs, satisfaction with and access to IPV services in the community.</u></p>	<p><u>Individual Interview Guide (Part 1) (Appendix A)</u> 3a. Was there support (outside of your family) that you needed? 3b. What was it? Was it helpful to you?</p>	Individual Interviews	Analysis of transcripts from individual interviews will be done using content analysis of qualitative data by members of the research team, manually and with NVIVO.

Sub Aim 1. d. Elicit the reasons these women may or may not have disclosed IPV to providers in the past.	<u>Individual Interview Guide (Part 1) (Appendix A)</u> 4a. Did you talk with your doctor or nurse about IPV? If no, how come? If yes, why did you decide to talk about this? Did he/she ask you questions about IPV or did you just tell them? What was this like for you?	Individual Interviews	Analysis of transcripts from individual interviews will be done using content analysis of qualitative data by members of the research team, manually and with NVIVO.
Sub Aim 1 e. Explore the perceptions of women served by three CHCs regarding the influence of specific elements of culture regarding IPV.	<u>Individual Interview Guide (Part 1) (Appendix A)</u> 5.a Tell me about ... (the following topics will be individually introduced: cultural protective systems, spiritual and religious practices, family rituals, gender roles, art and music, and the roles of individuals and groups related to IPV).		
Aim 2: Examine perceptions of individual women served by three CHCs regarding :: (1) their individual, family, and cultural group's perception of the acceptability of violence between intimate partners; (2) their partner, partner's family, and partner's cultural group's perception of the acceptability of violence between intimate partners by administering a quantitative tool with women who have experienced IPV. Appendix C, "Perceptions of the Acceptability of Violence" tool will be used.			
Sub Aim (2. a.) Explore and identify on a numeric scale perceptions of women served by three CHCs regarding the acceptability of violence between intimate partners from an individual, family, and cultural group perspective.	<u>Individual Interview Guide (Part 2) (Appendix C) Perceptions of Acceptability of Violence Tool</u> a. The American culture as a whole seems to think that it's understandable and sometimes OK for partners to hit each other in certain situations. Within your cultural group, on a scale of 0 to 9, how ok is it for partners to hit each other in certain situations? b. On a scale of 0 to 9, when you were brought up, how ok was it to believe that partners could hit each other? c. On a scale of 0 to 9, how ok do you think it is for partners to hit each other in certain situations?	Individual Interviews	Analysis of Quantitative data will be done by members of the research team using descriptive statistics with SPSS. These data will be compared to qualitative descriptions of individual, family, and cultural group perceptions of the acceptability of violence.

<p>Sub Aim 2. b. Explore and identify on a numeric scale perceptions of women served by three CHCs regarding the acceptability of violence between intimate partners from their partner's, partner's family, and partner's cultural group perspective.</p>	<p><u>Individual Interview Guide (Part 2)</u> (Appendix C) Perceptions of Acceptability of Violence Tool</p> <p>d. On a scale of 0 to 9, how much of _____ (your partner's cultural group – <u>identify cultural group</u>), think it's OK for partners to hit each other?</p> <p>e. On a scale of 0 to 9, how ok does your partner's family think it is for partners to hit each other in certain situations?</p> <p>f. On a scale of 0 to 9, how ok does your partner think it is for partners to hit each other in certain situations?</p>	<p>Individual Interviews</p>	<p>Analysis of Quantitative data will be done by members of the research team using descriptive statistics with SPSS. These data will be compared to qualitative descriptions of individual, family, and cultural group perceptions of the acceptability of violence.</p>
<p>Aim 3: Examine cultural perceptions, awareness, responses, and actions recommended about IPV by groups of women served by three CHCs who are Native Hawaiian, Ilocano (Filipino), or Chuukese (Micronesian). These women may or may not have experienced IPV personally.</p>			
<p>Sub Aim 3. a. Identify cultural perceptions and awareness of specific groups served by three CHCs regarding IPV.</p>	<p>Interview Guide for Focus Groups (Appendix B)</p> <p>1a. What do people think about IPV? Do they know what it is?</p> <p>1b. How much do people talk about IPV? What kinds of things do they say?</p> <p>1c. When IPV occurs, how would you know about it? Who would you most likely talk to about it? Who wouldn't be told about it? What are the reasons?</p> <p>1d. How do you teach your children/grandchildren about IPV? When would you do this?</p> <p>1e. Tell me about: cultural protective factors, spiritual and religious practices, family rituals, gender roles, art and music, and the roles of individuals and groups related to IPV.</p>	<p>Focus Groups</p>	<p>Analysis of transcripts from focus groups will be done using content analysis of qualitative data by members of the research team, manually and with NVIVO.</p>

	1 f. How ok is it for partners to hit each other in certain situations		
Sub Aim 3. b. Identify cultural responses of women in this group regarding IPV.	Interview Guide for Focus Groups (Appendix B) 2a. How do women cope with IPV? 2b. Do you think there is a difference between how you understand/experience IPV and how your culture understands/experiences IPV? If yes, what do you do about it? 2c. How come people don't want to talk about IPV?	Focus Groups	Analysis of transcripts from focus groups will be done using content analysis of qualitative data by members of the research team, manually and with NVIVO.
Sub Aim 3.c. Identify actions that the participants believe the CHCs or the cultural group could take to address the problem of IPV.	Interview Guide for Focus Groups (Appendix B) 3a. What are the actions women participants would like the health center to take? 3b. What are the cultural systems that can help when there is IPV? 3c. What are the roles of individuals or groups in dealing with IPV?	Focus Groups	Analysis of transcripts from focus groups will be done using content analysis of qualitative data by members of the research team, manually and with NVIVO.
	Demographic Information to describe the study participants (Appendix D)	Focus Groups and Individual Interviews	Frequencies of specific elements such as, age, marital status, pregnancy, ethnicity, employment status, income, education, primary language & residency status of participant and partner using SPSS.

Instruments (cont)

The Institute of Medicine report on health literacy notes that cultural context contributes to perception of verbal and non-verbal health messages (IOM, 2004). The population of women served by the community health centers has unique and specific characteristics that guided the instrument development. The members of the research team from the community health centers have found in the past that when they attempted to utilize standardized assessment "tools" they were unable to find relevance or "fit" for their populations without culturally and linguistically adapting the tools. Consequently, because this study is designed to increase knowledge of this population no standard IPV "tools" are used. One tool, the Perceptions of the Acceptability of Violence Tool, has been modified based on local advice from the health center staff representing the identified groups, the adaptation involved changing the scale from 0 – 100% to 0 – 9. **This tool will only be administered to the women during the individual interviews.**

Community health center personnel were aware of a domestic violence study conducted in Seattle (Senturia, et al., 2000) with the same cultural groups. A phone conference was held with one of the research team (Dr. Shiu-Thornton) and she advised that the questions used in the Seattle study were in the public domain. In addition, our research group had been in consultation with Dr. Jacqueline Campbell and had been interested in questions used by her research team in another study (Torres, et al., 2000). Questions used in similar research and/or with similar populations from both Dr. Shiu-Thornton and Dr. Campbell's studies, were used and modified for both the individual interview and focus group

interview guides (Appendices A, B, C). These questions will be translated into the appropriate languages. Drs. Shiu-Thornton and Campbell are also acting as consultants for this project.

Data Analysis

Several in nursing research literature (Berman, Ford-Gilboe, & Campbell, 1998; Knafelz, Pettengill, Bevis, & Kirchhoff, 1988; Sandelowski, 2000) have described methods of combining qualitative and quantitative data. The approach utilized in this study follows Berman et al.'s (1998) description of "Stories foreground, numbers background." Stories are the primary source of data, numbers take a peripheral place in the research study. However, both contribute to the overall strength of the design. Table 2 diagrams the specific instruments and the methods of analysis to be used.

Qualitative data analysis. Data will include transcripts of audiotapes from both group and individual discussion, **and extensive field notes.** Both manual and computerized methods will be used to manage the data. Initially, at least three of the investigators will manually analyze the transcripts. In addition, "NVIVO," a qualitative software program will be utilized to store and organize the transcripts from both individual interviews and focus group interviews. The goal is to summarize what was said, determine recurrent themes, and, validate with the participants. This process will be an inductive content analysis where participant comments are categorized and counted. According to Downe-Wamboldt (1992, p. 315) content analysis generally encompasses the following steps:

1. Selecting the unit of analysis (responses to questions and topics that come up spontaneously)
2. Creating and defining the categories (a classification schema - includes definitions of categories)
3. Pre-testing the category definitions and rules (utility of the schema, inter-rater agreement)
4. Assessing reliability and validity (the exhaustiveness and exclusivity of schema)
5. Revising the coding rules if necessary (tightening or redefining schema rules)
6. Pre-testing the revised category schema (as in 3)
7. Coding all the data (applying schema to classify data, count occurrences, and determining salience of emerging claims about the data)
8. Re-assess the reliability and validity (reliable = consistency in coding decisions; validity = congruence between claims about the data and reality as recalled by the group moderators).

The research team will maintain comprehensive field notes, including a description of events, media reports, or other indices, that occur during the period of study and pertain to the identified communities' response to IPV. This data will be reviewed and integrated together with the other qualitative and the quantitative data.

There are established criteria for judging efficacy in qualitative research that are different than those used in quantitative studies. "Trustworthiness" is a term proposed by Lincoln & Guba (1985) that is widely used to evaluate qualitative research. Credibility focuses on evaluating if the researchers have presented the data in a way that does not distort the participant's experience. The translation of the instruments and discourse will contribute to the credibility by providing accurate data on the participant's perceptions and experience. Additional techniques that will be used to increase credibility are the researchers' prolonged engagement with the topic, and persistent observation of the participants to give greater depth and understanding of culturally diverse women's experience. The researchers' combined experience in working with women who are culturally diverse and prior research regarding IPV have provided the necessary background for prolonged engagement and persistent observation

Transferability is a criterion used to judge qualitative research that is equivalent to external validity or generalizability - evaluating the usefulness of the data for the reader. This is established by providing a "thick description" or enough data about the context, methods and results so that the reader can make a meaningful judgment about the work.

Dependability is similar to "reliability" in positivistic research, and it is concerned about stability over time (Lincoln & Guba, 1985). Confirmability can be compared to "objectivity" and refers to results that "are rooted in contexts and persons apart from the evaluator and are not simply figments of the evaluator's imagination" (p. 243). Audio-tapes and an audit trail documenting the processes used and the data collected will be kept to provide dependability and confirmability.

Quantitative analysis. Quantitative data will be analyzed using descriptive methods including frequencies, means, and standard deviations with SPSS. There are two sources of quantitative data, demographic data and responses to the numeric scale in the "Perceptions of the Acceptability of Violence Tool." Responses to the acceptability of violence questions will be plotted on the tool and, later, categorized

as Torres and Campbell did into groupings of low, medium, and high. Initially, to ensure validity of quantitative data from Appendix C, the numeric responses of individual women will be compared to their description (on the transcript) of their reason for choosing a particular number on the numeric scale.

Statistical consultation will be purchased through the Office of Research and Extramural Programs within the SONDH.

Integration of qualitative and quantitative analysis. Composite quantitative data will be compared to the themes generated by the analysis of qualitative data of women's understanding regarding their individual, their partner's, and their family's perceptions of IPV. **Data from field notes will be integrated into the composite analysis.** Although it is recognized that the small number of participants (n=15) in the individual interviews will preclude the ability to reach statistical significance, the quantitative data can be compared to patterns of the qualitative data to provide further descriptions of the findings. The quantitative data also will be helpful in determining the feasibility and usefulness of the adapted tool within these specific populations. **Comparisons will be made between the three different culture's responses.**

Student Involvement

Graduate and undergraduate students will assist with transcription, translation, and analysis of interviews. A graduate student will provide assistance with data collection, management and analysis and will be integrated into the research team. Students will spend time at each site to understand the context of the community and the health center.

Timeline

The study will begin on 4/01/07 and will continue through 3/31/09

Months	Year 1												Year 2											
	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
1. Hire Staff	X	X	X																					
2. Confer with consultants	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
3. Translation of Tools	X	X	X																					
4. Conduct training sessions with staff				X	X	X																		
5. Recruitment starts				X	X	X	X																	
6. Conduct individual interviews and transcription				X	X	X	X	X	X	X	X	X	X	X	X									
7. Conduct focus groups and transcription						X	X	X	X	X	X	X	X	X	X	X	X							
8. Analysis of data - researchers meet weekly for analysis and debriefing (both qualitative and quantitative)				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
9. Individual participants and focus group provide member checking of transcripts							X	X	X	X	X	X	X	X	X	X	X	X	X	X				
10. Analysis of final qualitative and quantitative data									X	X	X	X	X	X	X	X	X	X	X	X	X	X		
11. Writing of manuscript and report														X	X	X	X	X	X	X	X	X	X	X

E. Protection of Human Subjects

1. Risks to Subjects

Human Subjects Involvement and Characteristics

Approval of this study will be sought from the University of Hawai'i Committee on Human Subjects. Participants will be approximately 45 women from specific cultural groups who are 18 and over, who live on Oahu, and are willing to participate in the study. Pregnant women may be included if they are willing to participate. **Women will be recruited through a variety of programs and organizations that are affiliated with the three participating community health centers.**

Sources of Materials

Participants will respond to questions from the Interview Guides posed in either individual interviews or focus groups and will complete the Demographic Data Form (Appendix D). All material will be obtained specifically for research purposes.

Potential Risks

Although there are potential risks identified with the study of IPV, the World Health Organization's (WHO) Ethical and Safety Recommendations for Domestic Violence Research (1999) guidelines for the ethical and safe conduct of the research will be followed. (See next section). **An additional protection will be the development of a safety protocol by the CBPR team following the guidelines developed by the Nursing Research Consortium on Violence and Abuse (Parker & Ulrich, 1990).**

In addition to safety risks, possible fatigue associated with participating in the interviews, focus groups and demographic data form may be associated with participation in this study. The psychological risks are: 1) that it may be upsetting to disclose one's experience of IPV; 2) worry about the loss of confidentiality; 3) worry about being perceived negatively by the researchers.

2. Adequacy of Protection Against Risks

Recruitment and Informed Consent.

Recruitment will occur by disseminating information about the study within **a variety of programs and organizations that are affiliated with the three participating community health centers. A variety of training sessions will be included based upon research findings (Gollin, Harrigan, Calderon et al., 2005) that successful recruitment of Hawaiians and Filipinos needs to include awareness in those communities of the process of informed consent, research safeguards, and the benefits to family and community. All research staff will receive IRB training. Group leaders and interpreters will receive specific training on focus groups and their implementation using culturally appropriate strategies for women. The training will be conducted by consultant, Dr. Sharyn Shiu-Thornton who has substantial experience in conducting qualitative studies in cross-cultural settings and other members of the research team. The group leaders will also receive training from well known IPV researcher, Dr. Jacqueline Campbell who will provide instruction about the sensitivity of the research subject. This training will enhance the reliability of the data collection and will further ensure the safety of the participants.** At the focus groups and individual interviews, the research team will explain the purpose and the procedures of the study to the potential participants who will be asked to sign the informed consent. **Women will be informed that if child abuse is disclosed it is mandatory for it to be reported.** In addition the focus groups participants will be asked to sign the Confidentiality Agreement. The participants who meet the inclusion criteria and voluntarily sign the appropriate documents will be enrolled into the study.

Protection against Risk

Because conducting research on violence against women raises specific issues of physical safety and mental well-being, the World Health Organization has identified specific precautions to be followed when conducting this type of research (WHO, 1999). The following considerations, taken from Section a) Safety of the respondents and the research team is paramount and should infuse all project decisions. *Ethical and Safety Recommendations for Domestic Violence Research* (WHO, 1999) will be followed:

- Investigators will apply for a Certificate of Confidentiality from NIH to avoid disclosure of information about participants.
- Focus groups and interviews will be conducted only in a private setting.

- Individual interview participants will be women who are served by the health center and are known to have experienced IPV. They will be asked to participate by staff at the health centers. **As an additional safety precaution women who participate in the individual interviews will not be eligible to participate in the focus groups.**
- Focus group participants will be asked to sign the Confidentiality Agreement. (Appendix E)
- Participants in the focus groups may or may not have experienced IPV, but they will not have participated in an individual interview.
- At the focus group, the research team will explain the purpose and the procedures of the study to the potential participants who will be asked to sign the informed consent and a Confidentiality Agreement. All women in the study will already be under the care of the specific health center.
- Interviewers will be trained to terminate or change the subject of discussion if an interview is interrupted by anyone.
- Logistics planning will include consideration of respondent safety.
- Logistics planning and budgeting should also consider the safety needs of interviewers.

These considerations will be followed, with every effort made to ensure the personal safety of both respondents and researchers. All interviews and focus groups will be conducted **by women** in a private space, without the partner present. **Even though women are instructed not to disclose personal information pertaining to IPV during the focus groups, there is a possibility that this could occur. If any of the participants begin to share personal experiences of IPV, the group leader will immediately remind the participants that confidentiality can be requested but not guaranteed. In addition, one of the investigators will approach the participant and offer her the opportunity to speak privately away from the group.** Participants will be offered information about IPV. Because of the sensitivity and safety concerns of participants found to have been abused, care will be taken to provide appropriate follow-up (King & Ryan, 1996). These participants will be referred to the CHC personnel and to a local domestic violence shelter and crisis referral center as appropriate. To protect against psychological risks, participants will be told the following: 1) their participation in the study is entirely voluntary; 2) they are free to refuse to participate and to withdraw from the study or any portion of the study; and, 3) they have the right not to answer any question that they feel uncomfortable with, without penalty of loss of benefits to which they are entitled. The psychological risk of responding to sensitive questions will be partially relieved by telling women that they do not have to respond to any questions that make them uncomfortable. Participants will be instructed that they may stop and talk about their feelings if they become upset while participating in the IPV focus group or individual interview. Participants who become upset will be offered a referral within the community health center and to the Family Peace Center and they will be followed by community health center personnel who would be able to provide service to the individuals on a regular basis.

The risk of loss of privacy will be addressed by the following: **the informed consents and confidentiality agreements will be kept in a locked file accessible only to the researchers. Codes will be assigned for each individual participating in the individual interviews or focus groups and records will be kept separately from the informed consents.** While the research will be published, the participants will not be identified in any way.

3. Potential Benefits of the Proposed Research to the Subjects and Others

No direct benefits are expected for the participants, other than the possible satisfaction of personal contribution to scientific knowledge. In instances where women have experienced IPV, they will be assisted with considerations of addressing the safety of themselves and their children. It is anticipated that this study will contribute to an understanding about a possible relationship between the cultural attitudes of women living on Oahu and their perceptions regarding intimate partner violence. This will provide health care providers with information that can assist them in providing culturally appropriate care and identifying unmet needs.

4. Importance of the Knowledge to be Gained

The lack of knowledge about of the unique factors pertaining to the population of Hawai'i, and recognition of a need to further investigate IPV in Native Hawaiian, Ilocano (Filipino), Chuukese (Micronesian) populations supports the importance of conducting this study. The results of this study will provide pilot information that will guide the development of further, more in-depth research in culturally appropriate IPV screening questions and interventions.

Data and Safety Monitoring Plan

Safety:

Because conducting research on violence against women raises specific issues of physical safety and mental well-being, the World Health Organization has identified specific precautions to be followed when conducting this type of research (WHO, 1999). The following considerations, taken from Section a) Safety of the respondents and the research team is paramount and should infuse all project decisions. *Ethical and Safety Recommendations for Domestic Violence Research* (WHO, 1999) will be followed:

- Investigators will apply for a Certificate of Confidentiality from NIH to avoid disclosure of information about participants.
- Focus groups and interviews will be conducted only in a private setting.
- Individual interview participants will be women who are served by the health center and are known to have experienced IPV. They will be asked to participate by staff at the health centers. As an additional safety precaution women who participate in the individual interviews will not be eligible to participate in the focus groups.
- Focus group participants will be asked to sign the Confidentiality Agreement. (Appendix E)
- Participants in the focus groups may or may not have experienced IPV, but they will not have participated in an individual interview.
- At the focus group, the research team will explain the purpose and the procedures of the study to the potential participants who will be asked to sign the informed consent and a Confidentiality Agreement. All women in the study will already be under the care of the specific health center.
- Interviewers will be trained to terminate or change the subject of discussion if an interview is interrupted by anyone.
- Logistics planning will include consideration of respondent safety.
- Logistics planning and budgeting should also consider the safety needs of interviewers.

An additional protection will be the development of a safety protocol by the CBPR team following the guidelines developed by the Nursing Research Consortium on Violence and Abuse (Parker & Ulrich, 1990).

Data Monitoring

Individual Interviews: The informed consents will be kept in a locked file accessible only to the researchers. Codes will be assigned for each individual participating in the individual interviews and records will be kept separately from the informed consents.

Focus Groups: The informed consents and confidentiality agreements will be kept in a locked file accessible only to the researchers. Codes will be assigned for each individual participating in the focus group and records will be kept separately from the informed consents.

All audiotapes and typed transcripts of individual and group interviews will be kept in a locked file and discarded on the completion of the study.

Inclusion of Women

The proposed study, "**Intimate Partner Violence: Community Health Centers Take Action**" will include women.

Inclusion of Minorities

The proposed study, "**Intimate Partner Violence: Community Health Centers Take Action**" will include minorities. The focus groups and individual interviews conducted at all sites will be comprised only of minorities.