DEFINING AN EFFECTIVE RESPONSE TO DVSA IN AMERICAN SAMOA

What unlocks potential is not so much brute force, but a wide-eyed recognition of
(1) where we are and
(2) a vision for where we want to be
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Executive Summary

Gender-based violence is a global health problem requiring a complex, collaborative, and culturally adaptive approach to prevention and treatment (World Health Organization, 2014). Preliminary research conducted by the Alliance between August 2017 and March 2018 revealed an alarming lack of service integration between government agencies and NGOs providing services for survivors of domestic violence and sexual assault (DVSA). The research and literature review emphasize the need for a significant improvement in the general public's knowledge and awareness of DVSA to hold service providers accountable, data collection and reporting, and assessment of gaps between the minimum service provision level recommended nationally and the current service provision locally. Services provided for survivors of sexual assault (SA) were not reviewed during the preliminary examination. SA is included in the current Project.

The first step towards service integration and developing the services and products needed to effectively assist DVSA victims is to identify what exists, and how it can be improved so victims will receive the full range of services they need in a timely manner. **This Project assesses the gaps between what is available and what victims report they need(ed)**. The scope is limited to a strategic level: the results will contribute to the community served by the Alliance and its partners. Often assessments begin with the questions: 'What don't we have? What do *we* need?' from the organization's perspective. In this Project the Alliance focuses on 'What does the best-case scenario look like? How do we get there?' from a victim-centered and community-based perspective. Surveys and key informant interviews identify opportunities to create services and delivery protocols that are unique to this territory, and inform recommendations for integrated service response. This assessment won't tell us what to do, but rather characterize the measures we use to define an 'effective response' to DVSA in American Samoa.

Similar to the assessment of service provision in other areas such as childhood education and cancer healthcare, this Project reviews service delivery along a **continuum of the survivor's experience**: from intervention to service access to 'sustained safety' (post-crisis support), and **compare the victim/client's journey or experience to the mapping of perceived DVSA service provision**:

Service mapping – with data from service provider interviews and surveys

Client journeying – with data from DVSA survivor interviews and surveys

Service mapping will identify available services and determine if they are accessible, easy to navigate, and operate under principles of DVSA service i.e. safety, confidentiality, integrity, et cetera [Exhibit A]. Survivor stories will validate the service map with actual experience of accessing services, visualized using a Client journeying tool [Exhibit B]. Iterative discussions grounded in appreciative inquiry will pinpoint gaps and overlaps in service, and opportunities for improvement in service delivery.

The final report provides the project data analysis, and recommendations for change. The overarching goal is to collaboratively develop a comprehensive plan to establish a continuum of services that are reflective of, and responsive to the holistic needs of victims of DVSA in American Samoa. Issues concerning funding and financial analysis are outside the scope of this project.

Introduction

This gap analysis is the quantitative and qualitative comparison of the service provision and overall response to DVSA in the territory.
It addresses two questions:

- Performance – Where are we?
- Potential – Where do we want to be?

This project aimed to answer the question: '*What does an effective response to domestic violence and sexual assault look like in American Samoa*?' The assessment was designed to systematically collect and analyze data reflecting key indicators of an 'effective response' as recommended in relevant literature (see *Minimum Standards for DVSA Services – Alliance, 2018*) and assess whether these indicators are reflected in the experiences and perceptions of stakeholders. While the data collection effort focused on identifying needs to determine gaps, the process was grounded in appreciative inquiry which in its simplest form focuses on the value added by current processes and stakeholders rather than emphasizing deficits. By identifying what works, and existing assets, the process focuses on finding opportunities to achieve our potential for improved prevention of DVSA, and service delivery to victims (Riger, 2016).

To do this, the Alliance Against Domestic Violence and Sexual Assault, AADVSA, reached out to stakeholders from member organizations who provide direct DVSA services or advocacy, community leaders, and survivors of DVSA. The assessment data was collected using a combination of surveys and in-person semi-structured interviews.

Approach (Process): Assessing Service Gaps for Victims in American Samoa

Existing Data Analysis	•Lists of current service providers, types of services offerred •National DVSA service standards •Identifying continuum of national standard of DVSA services
Interview & Survey of Service Providers	•Services offered, access and delivery compared to minimum standard •Issues concerning disclosure, confidentiality, referral •Unmet needs of clients •Integration of services with other service providers
Interview & Survey with survivors experienced with local services	•Services accessed - how accessed, timeliness, level of integration between referrals •Quality of services received - unmet needs, needs met •Role of Hospital, DOH, DHSS, DPS in initial incident with service providers •Complete individual client journeying (map) and compare/integrate with systems map

True to the tenets of appreciative inquiry, the survey and interview questions sought to elicit what exists rather than what is needed – what is our foundation? What can we build upon? 'Gaps' are identified by comparing what exists to leading indicators of effective responses to DVSA. While the development of solutions is outside the scope of this project, the data informs recommendations, opportunities, which the Alliance may present to stakeholders to improve their response to DVSA and establish a system that supports the needs of victims.

Defining the 'Effective Response'

In 2018 the Alliance completed a report entitled '*Developing Minimum Standards for DVSA Service in American Samoa*'. The literature review produced the following conclusions:

> *Generally accepted national and international standards for DVSA services reflect principles of justice, safety, trust, choice, collaboration, empowerment and cultural competency for victims of DVSA, laying a foundation upon which guidelines and benchmarks for legal, clinical, and social service frameworks may be developed. The needs of DVSA victims are unique to the culture and environment of a people. The way in which services should, and could, be provided is also unique to the economic, political and environmental contexts of the community served.*
>
> *. . .a widespread change in services across sites: a shift towards placing primary importance on active listening and trauma informed approaches. Evaluators noted that 'while tangible needs are important', i.e. shelter, transportation, clothing and referrals, when these needs 'define the nature and mode of service delivery to the exclusion of other needs, emotional support is sacrificed, and other survivors are left unsupported.' The experience of SA victims may differ from DV victims in that they may not need tangible resources, but rather emotional support as a service. By focusing on the trauma, providers practice* ***victim-defined advocacy***.

The definition of an effective response in the literature, which includes assessments from several of the 56 DVSA Coalitions across the U.S., is complex. A varied range of services and responses are required to meet the needs of victims and perpetrators, usually involving multiple interventions (Breckenridge, etal. 2015). Improving access to and coordination among a range of support services in ways that are culturally appropriate, socially relevant, and supportive within the context of the victim's reality are required of an 'effective response'. The 'ideal' system is subject to contextual interpretation.

According to the Duluth informed model the following are key aims of such a response (Duluth 2015):

1. Enhanced safety for victims;
2. Reduction in the re-victimization of victims;
3. Increased accountability of perpetrators for their violence.

The literature suggests these elements are necessary for an effective, *sustainable* response (Bank 2014):

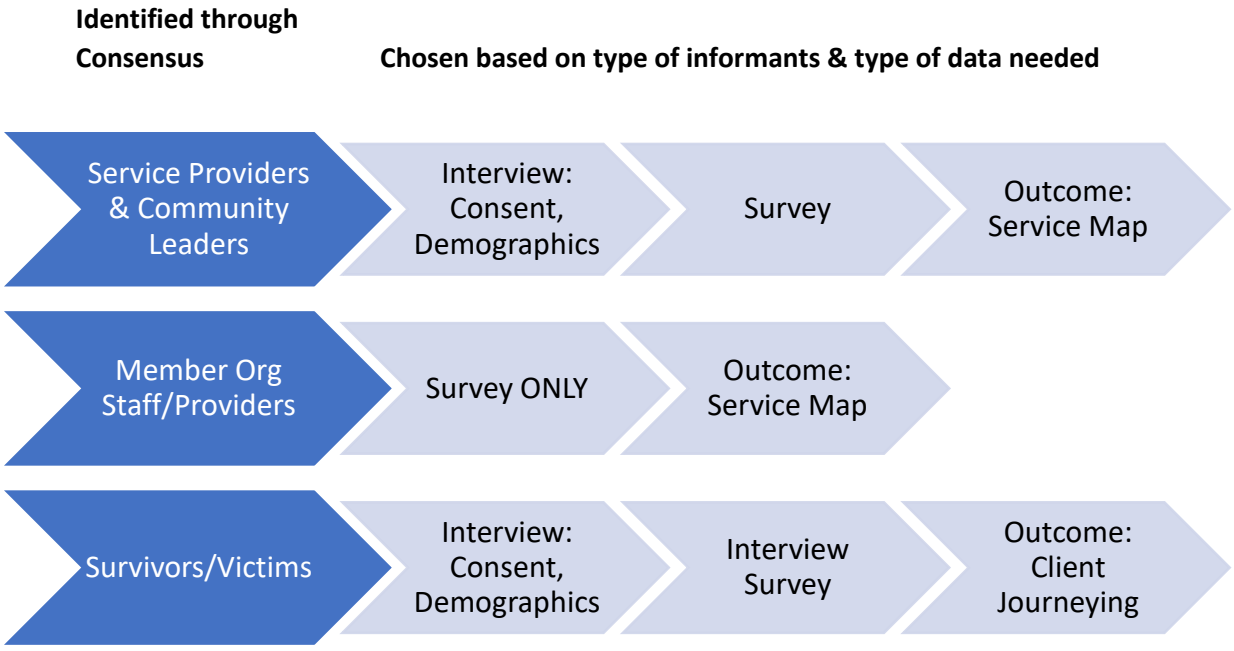
1. Strong leadership and governance;
2. Ongoing case management;
3. Culturally appropriate systems and protocols for sharing information;
4. Culturally appropriate systems and protocols for collecting and managing data.

These key indicators guided the analysis of the key informant interviews and surveys.

Assessment Design

The paucity of data concerning domestic and sexual violence in American Samoa prompted the Alliance to document the community's perception of DVSA and services provided for and treatment of victims. While all service providing organizations were represented in the survey and interview samples, the aim was not to identify shortcomings, or the breadth and quality of services provided. Rather, from their daily work experience, knowing that the complex issue of DVSA is relatively new to social conversation, and that public awareness is low, the Alliance aimed to document perceived and actual needs. By interviewing survivors, the aim is to identify how closely their actual experience aligns with what service providers and community leaders perceive to be happening when responding to DVSA. The existence of services is relevant only if people know they exist, how to access them, and what they're supposed to do (Macy, 2010). A logic model was developed to illustrate the assessment process:

Gap Assessment Data Collection Process Logic Model



Key informant interview questions for DVSA survivors, service providers and community leaders were developed through iterative discussion with Alliance staff, review of the '*Minimum Standards for DVSA in American Samoa*' report, and literature review. Two Alliance staff members – an outreach coordinator and an advocate – were trained in motivational interviewing techniques and conducted all interviews. Together the group identified 20 appropriate representatives from local stakeholder organizations to be interviewed, and nine DVSA survivors willing to share their stories. Interviews were conducted in English and Samoan as appropriate, recorded, translated when necessary, and transcribed verbatim to English. The transcriptions were labeled with code identifiers to replace names, and generic labels were substituted for all identifying material in the interviews.

Key informants also completed **surveys.** An additional 42 providers and community leaders completed surveys only. Nine surveys were completed by survivors, and a total of 61 by providers, leaders and other stakeholders. One survey was developed to record the demographic data for survivors as well as map their journey through the law enforcement, clinical and legal systems.

Another survey was developed for service providers, community leaders and member organizations. These survey questions were designed to assess what respondents perceive to exist in terms of services to prevent DVSA and support victims. Specifically, services identified in the literature as minimum requirements to meet basic needs of DVSA victims were listed and respondents were asked if they *knew* these existed, how they knew; if they *heard* they existed and how they heard of them; and if they knew or heard that they did *not* exist. Further, respondents were asked if these services existed for specific marginalized groups such as elderly victims, the LGBTQ community, the disabled, children.

The surveys were developed in English, translated to Samoan and reviewed for linguistic and cultural validation. A group of five Samoan experts in the field of Samoan language and literacy, and one DVSA survivor, completed an iterative discussion of each survey question to determine the appropriateness of the language in the cultural context, and conceptual equivalence of words and phrases. The survivor was able to interject when terminology did not account for the most common audience and maintained that the questions should consider what the respondent will understand when reading or hearing a question. Colloquialisms, and vernacular terms were identified and removed or replaced after in-depth discussion and upon group consensus.

The translation and adaptation of all materials followed the following steps:

1. Development of questions in English and forward translation to Samoan
2. Expert panel back-translation and pre-testing
3. Final version

The translation process itself was an opportunity for the Alliance to refine its translation protocol and build the staff's skill-set for this work. With a focus on improving performance, the Alliance staff achieved a clearer understanding of how translation validation is operationalized, and establish working relationships with language experts in the field who were willing to donate their time to the process.

A group of member organization staff/service providers were identified for survey participation only. Many of the individuals in this category had participated in key informant interviews for recent, prior projects for the Alliance such as the '*State of Domestic Violence in American Samoa*' (2018). To avoid redundancy, they were asked to respond only to the survey. Those prior transcripts were reviewed for relevant excerpts and compiled to inform the consensual qualitative discussion.

The data from 61 surveys and 29 interviews were analyzed using frequency distributions and grounded theory methods.

Descriptive Data from Member Organization, Provider & Leader Surveys

What organizations were represented in the survey sample?

Q1: Primary purpose of organization you work for		
Organization Type	**Code**	**Total**
SA/DV Crisis Center	1	1
Government Agency	2	15
Hospital	3	8
Health Clinic	4	6
K-12 School	5	3
BH/MH Provider	7	1
Family Support Center	8	1
Church/Faith Based	9	5
DPS/Village Police	10	1
General Social Svc Agency	11	3
Legal Svcs./Court	12	3
Correctional Facility/Parole	13	2
Pulenu'u/Matai	15	4
Other	16	6
Missing Answer	17	2
N=61		61

Q3. Organizations represented
Army Reserve Family Program
AS Chinese Community Assoc.
AS Filipino Community
AS Korean Community
AS Power Authority
AS Red Cross
Catholic Social Services
Dept. of Education
Dept. of Education: Tafuna HS
Dept. of Human & Social Svcs. CPS
Dept. of Human & Social Svcs. VOCA
Dept. of Youth & Women Affairs
Faith: Antioch Intl Ministry & King's Leadership College
Faith: EFKAS Petesa
Faith: Every Home for Christ
Faith: Tongan Church
Faith: Window of Hope
Fono
Health: Community Health Clinic
Health: Dept. of Health
Health: Dept. of Health BCCEDP
Health: Emergency Medical Services (EMS)
Health: LBJTMC
Health: LBJTMC OB Family Planning
Juvinile Detention
Legal - District Court
Legal Affairs
Legal: AS Attorney General's Office
Legal: Probation
Mapusaga Fou Vlge
Media: Samoa News
Media: Samoa Sunrise Broadcasting
Media: Television KVZK
NOAA
OSA - Pulenu'u
SOLOULAASOLELEI

***Who were the respondents*?**

Q7: Respondent's AGE		
AGE	**Code**	**Total**
18-24	1	2
25-34	2	15
35-49	3	21
50-64	4	21
65+	5	2
Missing	6	0
N=61		61

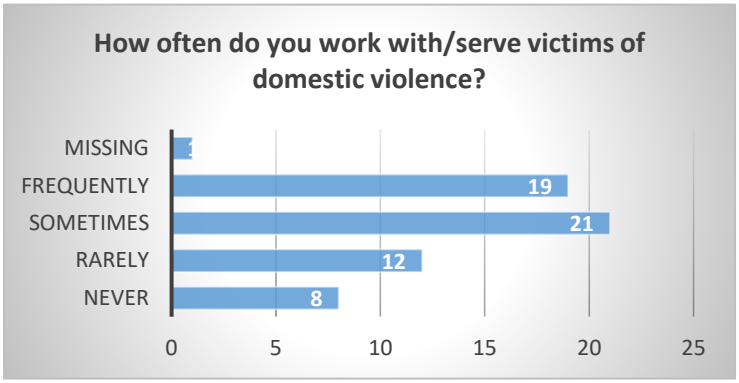
Q8: Respondent's GENDER		
GENDER	**Code**	**Total**
Male	1	25
Female	2	36
Trans	3	0
Missing	4	0
N=61		61

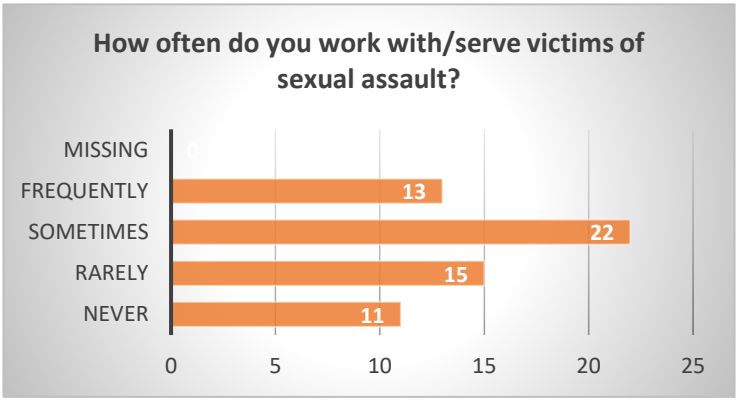
Q9: Respondent's ETHNICITY		
ETHNICITY	**Code**	**Total**
Am Samoa	1	45
Other PI	2	9
White	3	1
Asian	4	4
Black	5	1
Other PI	6	1
Missing	7	0
N=61		61

Twenty-five percent of the 61 survey respondents work for the local government which includes the departments of education, social services, health, and the power authority.

Sixty-nine percent reported they are between the ages of 35 and 64, and the majority are American Samoan females. The populations served by these respondents include a diverse range of ethnic and age groups: from age zero to 18 and over, including the Filipino, Korean and Chinese communities, and as specific as 'females age 21+' and as broad as 'the community'. The sample clearly serves a majority population in the territory.

***Who do you service and to what extent*?**





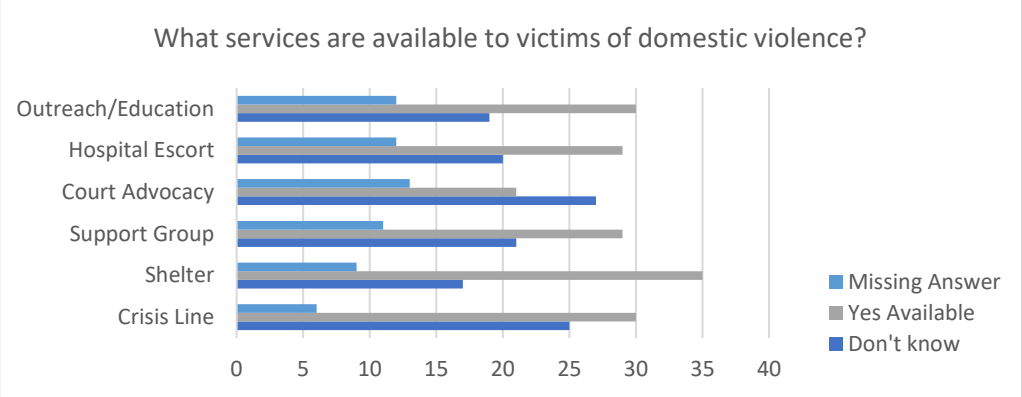
Q4: Who is your target population
11-18 YRS
AGE 0-17
AGE 18-
AGE 18+
AM SAMOA
CHILD/AD
Chinese people in AS
COMMUNITY
CRIM POP
disaster victims
EVERYONE
Faith community
FAMILIES
Family planning, women's health
FEMALES 21+
Filipino Community in AS
fish
Korean people of AS
MALE OFFICERS, FAMILIES
REFERRALS TO COUNSELING
STUDENTS
SURVIVORS OF SA
Tualauta County
village families
WOMEN & GIRLS
YOUTH
YOUTH & ELDERLY
YOUTH & WOMEN
YOUTH EMPOWERMENT

Of concern is the fact that only 13% of respondents frequently work with victims of sexual assault; and only 19% work frequently work with victims of domestic violence. The analysis of interview data shows that many of the interviewees who also completed the survey (N=19) did not 'see' or know of DVSA in their communities, villages or workplaces. This could be contributed to a lack of awareness of what actions constitute DVSA, and/or limited exposure to DVSA because of the authority they hold in the community (incidents are hidden or not discussed in front of respondent).

Six basic services validated as 'necessary' in the literature include a Crisis Line, Shelter, Support Group, Court Advocacy, Hospital Escort and Outreach/Education. Representatives of member organizations and community leaders were asked***: are these services available to victims of DVSA in American Samoa?*** The following are the survey responses which includes who they 'perceive' the service providers to be:

Q10: What services are available to victims of Domestic Violence in American Samoa?

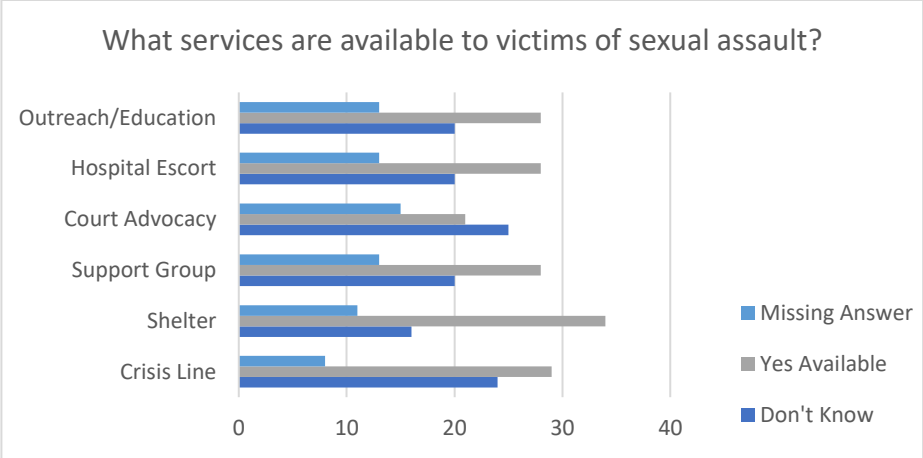
Service	Don't Know	%	yes available	%	Answer Missing	%	N=61	%	Service Providers
Crisis Line	25	41%	30	49%	6	10%	61	100%	DHSS, CSS, CFSD, Catholic Social Svcs., Alliance, DOH, Teen Challenge, LBJ, EMS, LBJ Family Planning, DPS
Shelter	17	28%	35	57%	9	15%	61	100%	DYWA, DHSS, CFSD, VOCA, DV COALITION, DPS, ASADV, WINDOWS OF HOPE, DOH, CPS
Support Group	21	34%	29	48%	11	18%	61	100%	ALLIANCE, CHURCH, REPORTERS, DHSS, LBJ SOCIAL SVC, CATHOLIC SOCIAL SVC, YOUTH COALITION, VA, WINDOWS OF HOPE, AAPFISO, CPS, DPS, LBJ OB UNIT, RED CROSS, TEEN CHALLENGE, AIM
Court Advocacy	27	44%	21	34%	13	21%	61	100%	LEGAL AID, COURT REPORTER, CPS, AS LEGAL SVCS, ASLA, PUBLIC DEFENDER, ATTORNEY GENERAL, WHO, VOCA, WINDOWS OF HOPE
Hospital Escort	20	33%	29	48%	12	20%	61	100%	DPS, DHSS, EMS, IPU LEFITI, CPS, CFSD, VOCA, WINDOWS OF HOPE, PRIVATE ADVOCATE, AG
Outreach/ Education	19	31%	30	49%	12	20%	61	100%	DHSS, , DOE, LBJ, U.S. FAMILY PROGRAM, BHD, VOCS, SORNA, ASADS, LEGAL AID, TEEN CHALLENGE, DOH, SOCIAL WORKERS, YFC MINISTRY, ASCC



Q10: What services are available to victims of Sexual Assault in American Samoa?

Service	Don't Know	%	yes available	%	Answer Missing	%	N=61	%	Service Providers
Crisis Line	24	39%	29	48%	8	13%	61	100%	DHSS, SN, CFSD, CPS, CATHOLIC SOCIAL SVCS, ALLIANCE, DOH, ASADV, WHO, LBJ, ALOFA TUNOA
Shelter	16	26%	34	56%	11	18%	61	100%	DHSS, DYWA, LBJ, CFSD, SSD, VOCA, CPS, COALITION, DPS, WINDOWS OF HOPE, DOH, LDS METHODIST, WORD OF LIFE, ALLIANCE
Support Group	20	33%	28	46%	13	21%	61	100%	ALLIANCE, CHURCH, REPORTERS, DHSS, CATH SOCIAL SVCS, YOUTH COALITION, VA, DPS, AAPFISO, LBJ, WINDOWS OF HOPE, AIM, TEEN CHALLENGE, LBJ OB UNIT
Court Advocacy	25	41%	21	34%	15	25%	61	100%	LEGAL AID, COURT REPORTER, ASLA, CPS, WINDOWS OF HOPE
Hospital Escort	20	33%	28	46%	13	21%	61	100%	DPS, DHSS, EMS, IPU LEFITI, CFSD, VOCA, CPS, WHO, WINDOWS OF HOPE
Outreach/ Education	20	33%	28	46%	13	21%	61	100%	DHSS, ALLIANCE, DOE, LBJ, BHD, LEGAL AID, SORNA, ASADSV, DPS, TEEN CHALLENGE, YM MINISTRY

A majority of respondents who did not answer these questions noted on their survey that these questions were irrelevant because they "*do not work with victims of DVSA*", and/or have never tried to access these services themselves or for others. The Service Providers listed (above) reflect the organizations which respondents 'perceive' to provide these six essential services for victims. 'Perception' is key as the interviews with survivors will show.



The Asian Pacific Institute on Gender-Based Violence (2007) describes the experience of DVSA as one unique to '*the context of additional oppressions based on race, ethnicity, age, sexual orientation, gender identity, type of labor performed, level of education, class position, immigration/refugee status or disability*'.

Respondents were asked if DVSA services such as housing/shelter, free legal assistance, mental health counseling, crisis intervention, and support groups/advocacy are available for specific marginalized and underserved populations in our community. The marginalized groups included adult female victims of DVSA, adult male victims of DVSA, child victims of DVSA, LGBQT victims of DVSA, Elderly Victims 60 years and older, Victims with Disabilities, Victims with Alcohol/Chemical Dependencies, and Adult Survivors of DVSA.

Unfortunately, a majority of respondents did not complete this section of the survey (questions 11-12). Notations made by respondents on these questions were: 'not relevant to me', 'don't know any of these', 'not available' (with a line drawn through all services and groups).

Respondents were also asked how the Alliance could help their organizations with technical assistance and training. The majority asked for some form of training, and 80% asked specifically for help with building effective collaborations to improve DVSA services.

Q13: What training topics would be most helpful to your organization to serve victims of DVSA?

Service	Yes	%	No	%	total	%
Serving LGBTQ victims of DVSA	32	52%	29	48%	61	100%
Trauma-informed services	44	72%	17	28%	61	100%
Protection from abusers	46	75%	15	25%	61	100%
Building effective collaborations to improve services	49	80%	12	20%	61	100%
Evaluating programs	36	59%	25	41%	61	100%
Media Advocacy	38	62%	23	38%	61	100%
Policy Development	38	62%	23	38%	61	100%
Other: education for perps, BH/counsel, education on existing laws	5	8%	56	92%	61	100%

The survey included three questions which asked respondents to rank in order of importance, highest to lowest, the following:

- Legal systems changes needed to help DVSA victims
- Direct assistance most needed by victims the respondent's organization serves
- General/Referral assistance most needed by victims the respondent's organization serves

A majority of the respondents did not correctly answer these questions using the ranking scale. (Interviewers stated that some felt all were equally important.) However, a sufficient number were completed to develop the following comparison:

Q14: Rank legal system changes that need to occur 1=highest, 8=lowest, 9=MA

	RANK:	1st	%	2nd	%	3rd	%	4th	%	5th	%	6th	%	7th	%	8th	%	9th=MA	%	total
A	mandatory jail time	29	48%	4	7%	2	3%	5	8%	3	5%	7	11%	6	10%	2	3%	3	5%	61
B	increased police training	31	51%	7	11%	2	3%	7	11%	8	13%	3	5%	0	0%	1	2%	2	3%	61
C	better supervision of abusers on probation	17	28%	11	18%	6	10%	5	8%	8	13%	4	7%	3	5%	4	7%	3	5%	61
D	improved supervised visitation between abuser	17	28%	8	13%	7	11%	8	13%	4	7%	8	13%	4	7%	2	3%	3	5%	61
E	increased identification and investigation of	20	33%	8	13%	4	7%	3	5%	9	15%	2	3%	10	16%	2	3%	3	5%	61
F	more programs to help abusers	22	36%	7	11%	8	13%	5	8%	5	8%	4	7%	5	8%	3	5%	2	3%	61
G	better referral system between attorneys and service providers	24	39%	12	20%	6	10%	5	8%	3	5%	2	3%	4	7%	3	5%	2	3%	61
H	Other: separate division of law team, more informed public, educational outreach, Matai should support DHSS, moral and financial	2	3%	1	2%	0		0	0%	1	2%	0	0%	1	2%	5	8%	51	84%	61

Q15: Rank direct assistance most needed by victims your organization services 1= highest, 9=lowest, 10=MA

	RANK:	1st	%	2nd	%	3rd	%	4th	%	5th	%	6th	%	7th	%	8th	%	9th	%	10= MA	%	total
A	payment of bills	11	18%	7	11%	4	7%	5	8%	7	11%	6	10%	3	5%	7	11%	4	7%	7	11%	61
B	transportation	10	16%	4	7%	13	21%	8	13%	6	10%	3	5%	6	10%	2	3%	2	3%	7	11%	61
C	professional counseling and group support	25	41%	7	11%	9	15%	7	11%	1	2%	2	3%	1	2%	0	0%	2	3%	7	11%	61
D	cell phone	10	16%	4	7%	0	0%	3	5%	9	15%	7	11%	4	7%	13	21%	4	7%	7	11%	61
E	groceries	7	11%	8	13%	3	5%	1	2%	8	13%	8	13%	10	16%	3	5%	6	10%	7	11%	61
F	tuition for children's school/daycare	13	21%	8	13%	3	5%	6	10%	5	8%	6	10%	4	7%	6	10%	3	5%	7	11%	61
G	rape crisis center	30	49%	11	18%	3	5%	2	3%	3	5%	1	2%	2	3%	1	2%	1	2%	7	11%	61
H	more safe shelters and halfway housing for victims	29	48%	10	16%	8	13%	1	2%	1	2%	1	2%	2	3%	0	0%	1	2%	8	13%	61
I	other: on-call support, job skill development, family support, legal assistance, enforcement, church counseling,	1	2%	1	2%	1	2%	1	2%	0	0%	0	0%	0	0%	0	0%	5	8%	52	85%	61

Q16: Rank services most needed by DVSA victims served by your organization 1=highest, 8=lowest, 9=MA

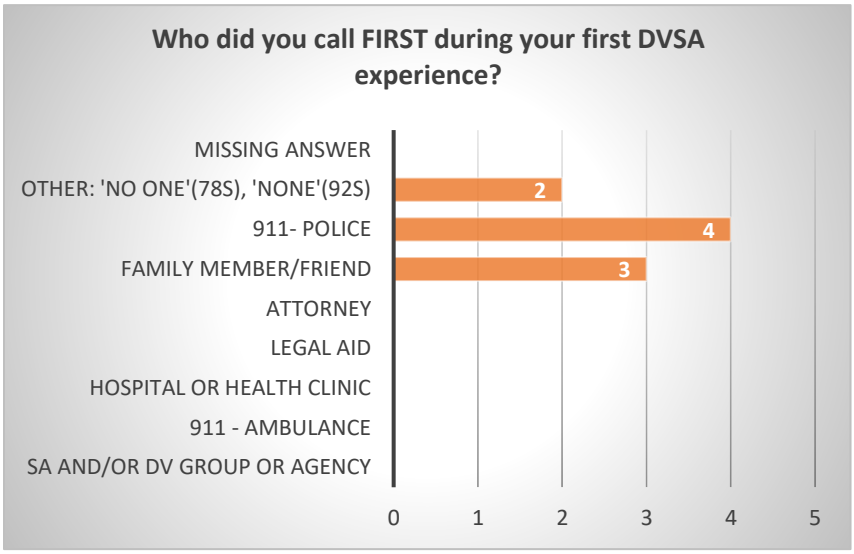
	RANK:	1st	%	2nd	%	3rd	%	4th	%	5th	%	6th	%	7th	%	8th	%	9=MA	%	total
A	immigration	13	21%	7	11%	4	7%	4	7%	7	11%	5	8%	9	15%	4	7%	8	13%	61
B	transportation	12	20%	6	10%	4	7%	6	10%	7	11%	12	20%	4	7%	1	2%	9	15%	61
C	getting into safe shelter/housing	33	54%	8	13%	5	8%	2	3%	3	5%	1	2%	0	0%	0	0%	9	15%	61
D	working with legal system	20	33%	13	21%	8	13%	6	10%	4	7%	2	3%	0	0%	0	0%	8	13%	61
E	working with healthcare and social workers to document SA	18	30%	11	18%	6	10%	7	11%	9	15%	0	0%	2	3%	0	0%	8	13%	61
F	professional counseling and support group	20	33%	11	18%	4	7%	6	10%	2	3%	6	10%	3	5%	1	2%	8	13%	61
G	crisis hotline	25	41%	6	10%	2	3%	4	7%	2	3%	3	5%	10	16%	1	2%	8	13%	61
H	Other: job search, victim advocate, DPS enforcement, church counseling,	3	5%	1	2%	0	0%	0	0%	0	0%	0	0%	0	0%	2	3%	55	90%	61

Descriptive Data from Survivor Surveys

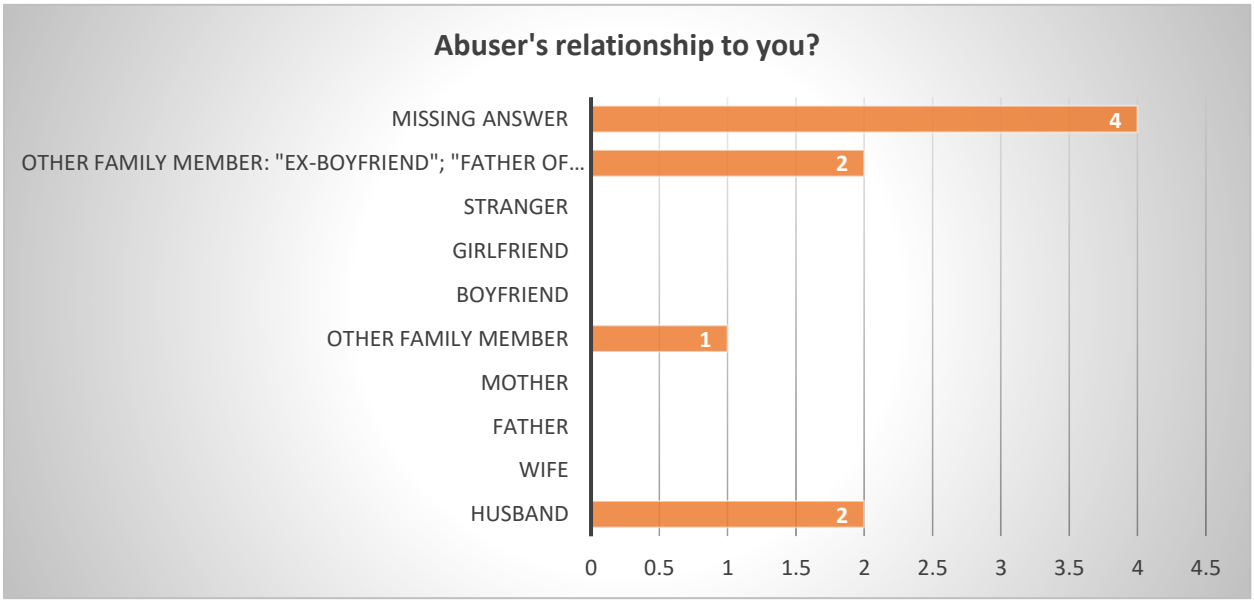
Nine women, self-reported American Samoans, completed surveys and key informant interviews with Alliance staff. The project aimed for a sample size of 15, however it proved difficult to find survivors willing to share their stories. Fifteen is the maximum number of cases recommended to feasibly conduct data analysis using Consensual Qualitative Research methodology (Hill, 1997).

Of these nine women, five were born in American Samoa, three elsewhere in the U.S., and one in the country of Samoa. English is the primary language. The youngest respondent is age 24, and the oldest is 64, with a median age of 28. The majority are unemployed.

Seven women are survivors of both domestic and sexual violence. Four women did not utilize DVSA services during or since their experiences. Notably, two of the women did not feel safe in their homes at the time of the survey. Two women claimed they did not call anyone as a result of the violence, so they did not have experience with the emergency, medical, social service or justice systems in the territory.



Four women did not disclose their relationship to their abuser(s). However, some of this information was shared during the key informant interviews. Rape, rape by multiple men during a single incident, and IPV were mentioned as being 'common'.



Rather than asking survivors for a general recall of their experience, the survey questions asked specifically for the respondent's recall of her first DVSA experience. Respondents were asked to recall their journey from incident to resolution or what is known in the medical field as the 'continuum of care', using 17 'point of contact' references with specific response choices, including 'other':

IF Police were involved – how satisfied where you with their response to your call on a scale of 1 to 5 with number one meaning Not Good/Bad and five being Very Good?

		CODE	RESPONSE
Not good (bad)		1	**3**
Not good		2	0
Mediocre		3	0
Good		4	0
Very Good		5	**1**
Missing Answer		6	0
N=4			4

How long did it take for the police to arrive?

		CODE	RESPONSE
0-30 minutes		1	0
30 minutes - 1 hour		2	**2**
1+ hours		3	**2**
Police NOT involved		0	**5**
Missing Answer		4	0
N=9			9

Was the abuser arrested? 3 of 4 respondents indicated that the abuser was NOT arrested.

If the abuser was not arrested why did that happen?

		CODE	RESPONSE
related to someone in authority over you		4	0
had calmed down		5	**1**
asking not to press charges		6	0
other: *"he ran away"; "they feel I'm mentally unstable*"		7	**2**
missing answer		8	0
N=3			3

Did the police offer you help? 3 of the 4 respondents who called the Police answered 'Yes'.

The 3 respondents who answered 'Yes' indicated they received these types of help from the Police:

		CODE	RESPONSE
Transport to shelter		4A	0
transport to family		4B	**1**
Transport to Friend		4C	**1**
Transport to Hospital		4D	0
Transport to other		4E	0
Took your statement/filed police report		5A	**1**
counseled about your legal rights		6	0
counseled you about a Protection Order		7	0
Called a service for you		8	0
Other		9	0
MA		10	0
N=3			3

Did you go to court afterwards? Only 2 respondents followed through with court filings.

These 2 respondents experienced the following:

		CODE	RESPONSE
the police kept you informed of the case throughout the process		4	**1**
you felt safe during the process		5	0
you got a protection order		6	**1**
you felt the attorney was helpful		7	**1**
you felt supported by your family		8	0
youu got a copy of your police report		9	0
you followed through with pressing charges		10	**1**
Other		11	0
missing answer		12	0
N=2			

Before the case went to court, only 1 respondent felt she received adequate information about what to expect. When asked what type of info she indicated, "how to get a restraining order".

During court did you have to see the abuser or abuser's family at/in the courthouse?

		CODE	RESPONSE
Yes		1	**1**
No		2	**2**
Missing Answer		3	0
N=3			3

During court hearings did you fully understand what was happening?

		CODE	RESPONSE
Yes		1	**1**
No		2	**2**
Missing Answer		3	0
N=3			3

Did you fully understand the outcome of the case?

		CODE	RESPONSE
Yes		1	**1**
No		2	**2**
Missing Answer		3	0
N=3			3

During the court process did you feel safe from harm?

		CODE	RESPONSE
Yes		1	**2**
No		2	**1**
Missing Answer		3	0
N=3			3

How long did it take to finish your court case? "Don't remember"; "3 hours"; Missing Answer

If an Ambulance was involved, how satisfied were you with their response to your call on a scale of 1 to 5 with number one meaning Not Good/Bad and five being Very Good?

		CODE	RESPONSE
Not good (bad)		1	0
Not good		2	0
Mediocre		3	**1**
Good		4	0
Very Good		5	**1**
Missing Answer		6	0
N=2			2

How long did it take for the ambulance to arrive?

		CODE	RESPONSE
0-30 minutes		1	**1**
30minutes-1 hour		2	**1**
1+ hours		3	0
Missing Answer		4	0
N=2			2

Both respondents indicated that EMS offered the following types of help:

		CODE	RESPONSE
transport to shelter		4A	**1**
transport to family		4B	**1**
transport to friend		4C	**1**
transport to hospital		4D	**1**
Other		4E	0
called police		5	0
counseled you about your legal rights		6	0
counseled you about a protection order		7	0
called a service for you		8	0
Other		9	0
missing answer		10	**1**

2 respondents indicated that *they went to LBJ after the EMS arrived*, and *received the following services:*

		CODE	RESPONSE
you were a given a full physical exam		4	**2**
you felt safe during the process		5	0
you felt that your information was protected		6	0
you felt supported by your family		7	0
you had an advocate with you		8	0
you were threatened by someone		9	0
you were referred to more support services		10	**1**
you were transported to safety after your exam		11	0

Note:

The survey data, supported by the survivors' key informant interviews, is used to create 'survivor journey' maps to visually illustrate the respondents' experiences from incident through perpetrator accountability. This approach is used to assess the gaps in service referral/provision and actual need in the response to DVSA in the territory according to informed stakeholders. It does not account for the full range of emotional, financial, familial, social experiences that also influence the survivors' journey and their outcomes.

Survey Data Analysis Summaries

The gap assessment surveys for survivors, member organizations and community leaders comprised multiple components. All questions pertaining to services were divided by domestic and sexual violence to reflect information specific to these categories. The basic design and foundational aspects of the survey were informed by the cumulative experience of the Alliance staff, the language translation experts, and similar reports produced by the New Hampshire Governor's Commission on Domestic and Sexual Violence (2006), Delaware Coalition Against Domestic Violence (2017), the ACT Review (Cussen, 2012), and the Sexual Assault Demonstration Initiative (Townsend, 2017) among others.

The central theme that emerged in key informant interviews, 'low community awareness and support for victims of DVSA,' was corroborated by survey respondents.

DVSA Survivor Surveys

Of the nine DVSA survivors surveyed, four first-experiences involved the police. It took the police between 30 minutes to over an hour to arrive at the scene, and only one abuser was arrested. The other three 'calmed down', 'ran away', or the victim was not taken seriously because 'they (police) feel I'm mentally unstable'. In three of the four experiences the police offered help in the form of transportation to a friend or family member, and in one case – took a statement and filed a police report.

Of nine first-experiences, only one abuser was arrested.

In response to the question: 'why were the police not involved?' one victim stated that she was too shocked and didn't think it was warranted. Another said she was '*too scared of the perpetrator and didn't want to bring shame'* on her family – she felt the situation was her fault. This is not uncommon in the literature, 'battered women who leave their husbands often face hostility from their family and community and victim-blaming can be carried to an extreme' (Dabby, 2017). Another stated that in the moment '*I didn't know what to feel or do, it was complete confusion.*' This victim shared that the experience later led to embarrassment and fear of what others would think of her. She wrote, '*It was like deep loneliness as this was to be brought upon one (person) and I had a fear of everyone and everything – the incident took my mind into a blank space and emptiness.*' Respondents were clearly unable to cope with their experiences and didn't know where to find the appropriate support to make decisions. Obvious 'needs' include counseling, legal advice and general advocacy. However, even if these services were available, if the victim doesn't know that they exist or how to access them they might as well be non-existent.

One of the respondents was under the age of 19 at her first experience and for this reason, and the fact that '*three of the guys were my brother-in-law's first cousins (brothers) and three were friends of theirs so my brain was not all there.'* Additionally, she didn't want her parents to find out. She only told her sister of the incident in fear of retaliation. The incident was '*swept under the rug*.'

Another respondent stated that her first sexual assault experience was as a toddler. She was also a victim of domestic violence – beaten by her husband. She kept pictures of the bruises with the intention of reporting him but decided to divorce him instead. She was also raped as an adult. She didn't explain why, but she didn't report any of the assaults.

When asked why they didn't take their cases to court, the overwhelming response pointed towards self-preservation: '*I didn't want to start a fuss or talk about it; it was easier to ignore*;' '*I got kicked out of the shelter*

so I had to make up with my husband and had to cancel court.'; '*I didn't want to see this guy that did this to me and add on to that – it was for my own safety*.'

Two of the nine victims did go through the court system eventually. Only one felt she was kept informed by the police throughout the process, felt her attorney was helpful, succeeded in getting a protection order filed and followed through with pressing charges. This same victim felt she received enough information to know what to expect in court, understood what was happening during the proceedings, and fully understood the outcome of her case. The other victim stated that she '*didn't show up to court, I asked to have any charges (by police) dropped. I had to return home because I was restricted to the shelter.*' This same victim stated that the police did take a report but didn't seem to want to help. It's unclear how her case ended up in court if she initially stated that no report was filed.

One victim stated that she did have to see her abuser and/or his family in court during the proceedings. This unfortunate situation is noted in various news reports describing local court proceedings involving domestic and sexual violence. One victim stated that she '*did not feel safe' during the court process.* The lack of confidentiality practiced in the court system perpetuates revictimization. This same victim stated that after the court case he (ex-boyfriend) was *'even more angry at me; he tried to destroy my life and steal the baby*.'

Only two victims called for an ambulance during their first-experience and both recalled mediocre to very good responses. The ambulance arrived within an hour in both cases and did offer help to the victim in the form of transportation to safety and/or the hospital. Both victims did go to LBJ via the ambulance and given a full physical exam. One victim indicated that she wished she '*was referred to more support services*.' One victim shared that no ambulance was involved because '*there was minimal physical harm – mostly mental abuse*.'

The open-ended follow-up questions in the survey allowed respondents to explain their actions and provide context to their survey responses. The recall of actual experiences as a DVSA victim in American Samoa reveals how the existing system of services and service providers realistically respond to DVSA. Survey responses are supported by the survivor key informant interview data, expanding upon these narratives by creating a tangible setting from which the Alliance can extract meaning, emotion and develop a more prolific understanding of the survivors' perspectives.

Member Organization/Service Provider, and Community Leader Surveys

Fifteen of the sixty-one respondents (25%) represented a local government agency. The majority of respondents worked in their field for five years or more and represent a diverse group of organizations which includes ethnic communities, faith-based and social service non-profits, health, legal, media fields.

About two thirds work with victims of domestic violence 'rarely' or 'sometimes', and 21% work with sexual assault victims 'frequently'. Two thirds of the respondents are between the age of 35 and 64, and the majority are female American Samoans.

While the majority of respondents report that a Crisis Line, Shelter, Support Group, Court Advocacy, a Hospital Escort and Outreach/Education are available, the 'service providers' they listed do not corroborate their responses. For example, LBJ, EMS, LBJ Family Planning and DOH do not provide a Crisis Line, and most definitely not as defined by national minimum standards for a DVSA crisis line. According to the Review of State Service Standards (2010), 24-hour crisis intervention via a hotline should be manned by a live person, and include 'information about the effects of sexual violence (and domestic violence) and possible reactions; general

information about medical and legal issues; offering advocacy and information about other services available in the community; active listening end empathic responding; exploring options and follow-up.' A crisis line, as defined here, does not exist in American Samoa according to interviews with survivors and providers. The respondents may be assuming these organizations provide these services because they 'should', not because they 'do'. The Dept. of Human and Social Services does have a single phone manned alternately by one or two staff members, but this number is not public, and is used primarily by Child Protective Services. In order to access the local government operated shelter for DVSA victims, the victim must be referred by a police officer or call the number (personal interview with Social Service administrator, 2018). This example applies to responses concerning the other five core services.

This leads us to believe that (1) respondents do not know what a crisis line is and (2) they perceive that these types of services are being provided when they in fact are not.

The crisis line service received the most recognition – only 10% of the respondents did not respond to this question, however about half responded that they '*did not know*' if a crisis line exists. **The least recognized is court advocacy for victims of sexual assault.** 41% of respondents didn't know if this service exists, and those who did listed the American Samoa Legal Aid (ASLA) and the Attorney General's (AG) office as the primary providers. Unfortunately, based on key informant interviews from prior projects (*The State of Domestic Violence in Samoa and American Samoa*, 2018) the Alliance knows that advocacy is not provided by ASLA or the AG's office as defined by national standards. Advocacy is 'supporting and assisting a victim/survivor to define needs, explore options, and ensure rights are respected' (Bein, 2010). ASLA and the AG's office provide basic legal services to support victims in obtaining protection orders and following through on legal charges against abusers. Court advocacy should include protecting the safety and welfare of the victim i.e. protection from exposure to perpetrator and his/her family during court proceedings; appropriate referrals for safety planning, transportation and shelter during trial.

The majority of respondents believe that training to build 'effective collaborations to improve services', 'trauma-informed service' development, and how to establish 'protection from abusers' are most important and helpful for them. One respondent also believed that education for perpetrators and job training was important, as well as education on existing laws regarding DVSA.

Service	Yes	%	No	%	total	%
Serving LGBTQ victims of DVSA	32	52%	29	48%	61	100%
Trauma-informed services	44	72%	17	28%	61	100%
Protection from abusers	46	75%	15	25%	61	100%
Building effective collaborations to improve services	49	80%	12	20%	61	100%

While most of those surveyed did not use the ranking responses correctly, because they felt that all options were equally important, all responses were used as indicated on the surveys. **51% think that increased police training is the most important systems change** required in the local legal system, followed by mandatory jail time, increased identification and investigation of alleged cases, and a better referral system between attorneys and service providers.

Professional counseling is the top priority in **improving direct assistance to victims**, followed by a rape crisis center and more safe shelters and halfway housing for victims. A primary service provided by a rape crisis center is professional counseling - to be a certified center one must employ at least one professional counselor. There are two shelters in the territory, operated by the Dept. of Human and Social Services, however manpower and funding are only available to run one shelter full-time. Additionally, one victim reported that she was *'kicked out of the shelter'* and therefore forced to return home to her abuser. A halfway house or longer-term shelter is a definite need. Culturally, providers may believe that victims should return home to extended family members and receive help from this resource. However, as noted by several victims, their experiences are not shared with family for fear of retaliation, or out of shame or guilt. The 'cultural response' to DVSA is an important factor identified in the CQR discussions. During the analysis of survivors' stories, the participants pointed out how different aspects of the Samoan culture, i.e. collectivism, familial interdependence, etc. perpetuate violence and negate the emotional and psychological needs of the victim. **The lack of culturally competent professional, accessible, long-term counseling and therapy is found to be a major need**. What exists now does not meet a national minimum standard.

Member organization representatives and community leaders also **perceive safe shelter and a crisis hotline to be services most needed by DVSA victims.** These are followed in equal part by professional counseling and help working with the legal system.

The qualitative data analysis provides context to these survey results. A critical lesson was learned in the process of conducting the project: while surveys are easier to administer and therefore achieve higher response rates, they do not capture the details needed to truly understand the depth of respondents' values and experiences which are critical to understand DVSA.

Qualitative Data Analysis: Survivors

Several steps were taken to identify the main themes embedded in the key informant interview data combined with responses to open ended survey questions. Coding strategies involved open coding for specific phenomena which were labeled and developed into domains using a qualitative analysis software called Dedoose.

The first stage of the analysis began with an independent evaluator's review of all 29 interview transcriptions (9 survivors, and 20 service providers/community leaders) to develop preliminary thematic domains using those from the interview protocol to start. The second stage involved identification of the thematic frame work by codifying descriptive statements. Each transcript was coded separately by the evaluator. The third stage involved highlighting and sorting the excerpts. The domains and excerpts were compared to those developed during the final stage: Alliance's team of interviewers and surveyors convened with the evaluator to implement a consensual qualitative research (CQR) protocol (Hill, 1997).

The CQR protocol uses comparative methodology to arrive at consensus judgements and agreements on findings without a priori hypothesis or assumptions (Todahl, 2009). First, the coded data is categorized into domains by the team of reviewers, and then core ideas are teased out as excerpts to summarize the information under each domain. The themes are then discussed amongst the team until each domain is agreed upon by consensus: domain, code and descriptive excerpt. The data is reviewed and compared systematically across all interviews and the number of cases that fit into each domain are tabulated.

Due to time constraints, the CQR methodology was applied only to the nine survivors' interviews. The transcripts were read by four of the staff: two interviewers, the executive director, and office manager. Using a

template (Van den Berg, 2017), relevant excerpts were identified and recorded in the domains according to the staff members' understanding of the survivors' stories. The group then discussed the excerpts under each domain, consensually determining whether an excerpt was assigned appropriately. The themes identified under each domain were then tallied and ranked (highest total = highest priority) based on the number of times the call-words or ideas were noted in the excerpts (Dagirmanjian, 2017):

- **General** – identified by all or all but one participant
- **Typical** – identified by more than half of the participants
- **Variant** – identified by more than one through half of the participants
- **Rare** – identified by one participant

Positive Interaction with Government Agency	Negative Interaction with Government Agency
General (8x): none	**General (8x):** none
Typical (5x): none	**Typical (5x):** Four of the respondents claimed that they initially didn't call a government agency for help. However, throughout their experiences, DPS and the DHSS Shelter were most often cited for providing '*poor service'* i.e. "*I had to complain so many times for them to help me*."
Variant (2-4x): DHSS provided assistance (including Dr. McCutchan, referral to Vocational Rehab. And Pua Center), LBJ Hospital, and EMS	**Variant (2-4x):** The suspected lack of confidentiality was a barrier to accessing services. "*I heard that they don't keep things confidential* (at DHSS)" is the type of reputation which fosters distrust amongst victims for service providers.
Rare (1x): Court system, DPS	**Rare (1x):** none

Only one survivor recalled receiving services in a coordinated fashion. She remembered that the police and ambulance arrived at the incident. The ambulance took her to the police substation and the police transported the abuser elsewhere. The police then transported the victim to the emergency room. The victim recalls the hospital staff being '*helpful and supportive'*, informing her about the temporary restraining order process. The police then transported her to a friend's home. During one negative encounter, when the victim asked for shelter, the police responded: "*don't you have family to go to*?" Three of the victims never shared their experiences with family for fear of shame and retaliation. Four claimed they didn't do anything immediately following the incident because they were in shock, confused, and didn't know how to respond. One victim stated, "*The people who knew of the situation didn't want me to tell anyone because of the trouble it might cause between everyone and the family*." Clearly, going to family or friends, while normal in the Samoan culture under other circumstances, is not an option for all victims of DVSA. While collectivity is a core strength of the Samoan culture, it does not recognize the individual needs of the victim.

LBJ and EMS were very helpful. They took me seriously.

The survivors' survey responses provide a focused examination of self-reported experiences of DVSA in American Samoa. Their interviews provide context and depth to the analysis of how their experiences were responded to by the recognized 'first responders' to DVSA crimes. The following data reflects how service provision by non-government agencies is perceived by survivors. Because they are not 'first responders' or may not be designated to provide specific forms of medical, legal and protective assistance, they must rely on a

referral system in order to access the victims. Based on the interviews, this system is 'word of mouth' – or basically non-existent.

Positive Interaction w/Non-Government Agency	Negative Interaction w/Non- Government Agency
General (8x): none	**General (8x):** none
Typical (5x): Interaction with the Alliance was mentioned most often in a positive light as a starting place to find assistance: "*I look at the Alliance like family.*" This respondent felt that the Alliance was a 'safe space'; another said "*The Alliance was part of my support system."*	**Typical (5x):** none
Variant (2-4x): Grassroots Advocates received the second highest number of mentions – specifically Ipu Lefiti (2x out of a total of 5). Faith-based groups received 3 mentions, including the Catholic Sisters. Legal Aid was mentioned twice.	**Variant (2-4x):** none
Rare (1x): none	**Rare (1x):** one respondent stated that the "Alliance didn't know the protocols" for dealing with the police and courts. This led to "a lot of running around" and feelings of frustration.

The survivors clearly recalled more productive, and positive, experiences with non-government agency providers. However, the NGOs were accessed after the fact, usually after the victim was already engaged with the court system. Victims did not recall seeing 'collaboration' between government and non-government providers.

One stated, *"they need to work together more and understand their own processes – have a concrete system*."

Another recalled, "*they're always clashing, caught up in the politics so they don't see the help they can be*."

When asked **who they thought the responsible agencies were** for providing assistance to victims of DVSA crime the majority felt that government and NGOs should work together. Three respondents cited the lack of '*protocols*' and processes as a major barrier to collaboration: "*If we all know the processes to help victims they will not get discouraged"; "everybody needs to know the protocols to make it easier for victims"; "we're a small office so no human resources department but that's what we needed to report what happened*." Their comments point to the need for a coordinated response to DVSA crime, comprised of all first responders, following a territorial strategic plan addressing DVSA.

In terms of **timeliness of service provision**, only one respondent received a full range of immediate services within the first 72 hours of experiencing an assault. However, she was unable to locate and access counseling for a long period of time – the resources she had heard of did not sound confidential and she distrusted them. When reviewing the client journey map, [see Exhibit B], service proved to be inconsistent: one victim received outstanding service compared to the other two who reported their assault. There are also specific services lacking in the community: sustained safety (legal aid, long-term shelter, counseling, safety planning, etc.) and post-crisis support are inconsistently provided by various resources including 'church', VOCA, and Dr. McCutchan (psychologist formerly with DHSS).

The American Samoa Legal Aid (ASLA) was the most commonly cited resource for **legal advocacy**. Three of the respondents received restraining orders, one didn't seek legal assistance. Notably, one respondent admitted that ASLA '*gave up on me'* because she was a no show, canceled meetings, or wasn't ready to follow through. However, ASLA is a non-profit whose sole funded purpose is to provide legal assistance to the indigent and therefore once the case is in their hands, they have a responsibility to follow through until resolution. The respondent didn't state whether she had signed an agreement with ASLA or if there were terms set regarding their assistance for her.

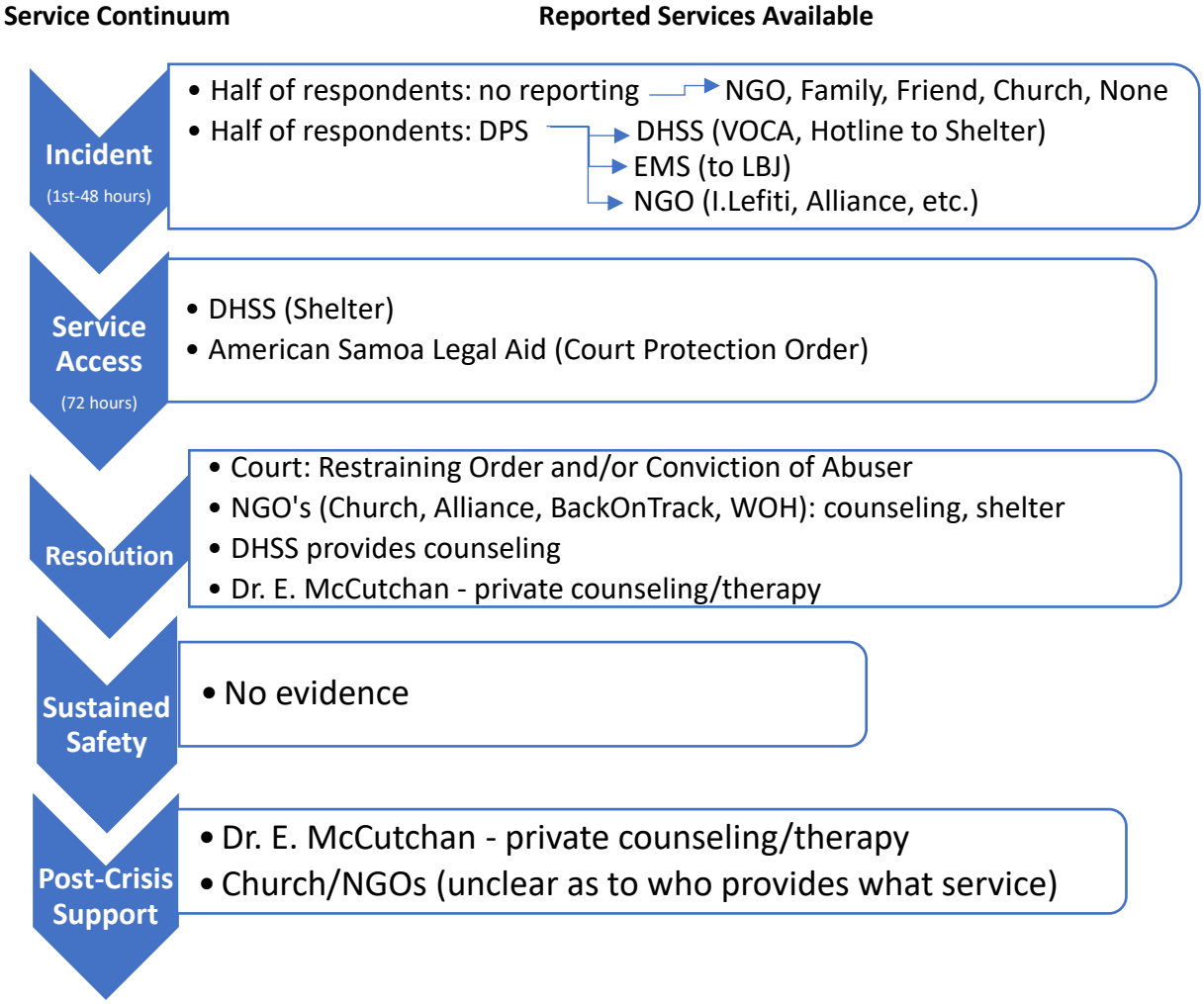
Safe housing is a critical element in the coordinated response to DVSA (Carolina, 2011). The single shelter on island is run by DHSS. A second shelter sporadically, when manpower and funding are available. Three respondents mentioned that they stayed with friends, at the Pua Center (short-term shelter), or with the Catholic sisters. Another stated that she didn't go home until her abuser left the island because "*even the restraining order sometimes is just a piece of paper. Abusers don't even care about that.*" One respondent recalled a "*horrible experience*" at the shelter because they "*weren't clear with their rules.*" At one point she was locked out of the shelter and had to return home to her abuser. Another respondent claimed that she was "*revictimized*" at the shelter. The majority of the respondents who needed safe housing found it with friends or through a referral from an NGO.

In summary**, timeliness and consistency of service appear to be the primary issues reported by the interviewees and applies to all recalled experiences**. About a third of the interviewees are dealing with subsequent incidences and various forms of mental health issues. Half of the incidents were experienced in the last two years according to the interviewer. One survivor reported 'revictimization' and this was in relation to her stay at the government shelter. majority of victims didn't access the shelter because they distrusted the agency, or didn't know how to access it. In terms of the need indicators, there is no evidence of 'strong leadership/governance' in the response to DVSA, there is no evidence of systems for 'collecting and managing data' (i.e. no case management), there is no evidence of 'providers sharing data' (i.e. no referral system), and no evidence of 'ongoing case management'. Therefore, the indicators point to a definite need to rectify these gaps in service.

On a positive note however, a heightened awareness of protective/restraining orders has led to a significant increase in orders filed per the interviewer's discussion with the Attorney General's office (2018). Also, bolstered by an increase in organizational training and partnership building activities provided by the Alliance and other member organizations, the NGOs appear to be collaborating more often and communicating on a regular basis. This is reflected in almost all of the interviews.

After the discussion, the evaluator and Alliance staff constructed a Systems Map to identify, based solely on the interview data, where the service gaps lay.

Exhibit A: Service Map



The consensus judgements are validated in three ways (Van den Berg, 2017):

1 – reviewers remained as close as possible to the participants' perspective of their experience rather than interpreting the implicit meaning of the data – they made no inferences and interpreted the data verbatim

2 – reviewers understood that the domain established by consensus is based on the summary experience and skill of each team member

3 – cross analyses by the team using a deductive process ensures the findings are built from the data rather than imposing theory or testing.

Qualitative Analysis: Community Leaders & Member Organizations

An adapted method of CQR was used to analyze the interview data from 20 community and member organization representatives (Van den Berg, 2017). Using the interview protocol questions to start, the evaluator identified broad categories of responses (domains), then developed specific categories using supporting excerpts. Cross analysis consisted of reviewing the interview summaries to understand the interviewer's reflections on the collected responses, and inform and validate the final categories. Data was tabulated for consistencies in the core ideas within domains and a thematic summary developed.

DOMAINS	CATEGORIES	N=20	FREQUENCY
Perceptions of sexual violence			
	In the home		4
	Force/No consent		11
	Child sexual abuse		7
	Sexual harassment		6
	Unseen where I serve		15
Perceptions of domestic violence			
	Caused by miscommunication		3
	Happens in the home		11
	Involves fighting or hitting		8
	Involves verbal abuse		5
	Involves 'other' people		4
	Unseen where I serve		7
Perceptions of who victims of SA are	Females		6
Perceptions of who victims of DV are			
	Unempowered/Females, Minors		32
Perceptions of who the offenders are			
	People in Power and Authority		5
	Family members/Adult males		27
Perceptions of why violence happens			
	Samoan Culture		19
	Temper, anger		5
	Poverty and related stressors		9
	Parental discipline		5
	Violence in schools		3
	Mental illness		2
Perceived impact on victims of DVSA			
	Emotional effects		18
	Development of a cultural norm		34
	Daily functions		10
Perceived victim needs			
	Empowerment		7
	Education		9
	Practical needs		2
	Counseling/Peer support		16
	Forgiveness		5
	Culturally appropriate resources		4
	Anonymous referral hotline		2

DOMAINS	CATEGORIES	N=20	FREQUENCY
Perceived resources for victims of DVSA			
	Ethnic communities		6
	Social services		13
	Peers/friends		7
Issues of DVSA at work	Key informant notified of DVSA crime		39
Needed Policy Changes			35
Perceptions of how to approach victims of DVSA			
	Overall approach		36
	Decreasing fear		14
	Need for confidentiality		15
	Messaging and methods		
	Focus on home/family		22
	Educational system		2
	Support groups		3
	Family leadership/village structure		16
	Religious community		16
	Social and traditional media		19

The CQR methodology is ideal for in-depth studies of life altering experiences of individuals, especially those which are normally out of public view such as DVSA crimes (Hill, 2005). By tallying the categorical excerpts across domains and all interviews the qualitative analysis is quantified. Normally a category that applies to less than two interviews would be merged with another or disposed of. However, in the case of these interviews, the method unveiled discrete but illuminating personal values and perspectives about DVSA and its victims which must be noted to understand the possible underlying cause of gaps in response to these crimes.

A domain titled 'Red Flags' developed over the course of the data review. Because they contrast so intensely with the basic precepts of trauma-focused, victim-centered care such as safety and justice they are listed here separately from the thematic summary.

> Female pulenu'u/matai age 50-64: "*victims need to solve these on their own, keep quiet about it, and if it gets bad then talk to the bishop and he will bring the perpetrator and try to resolve things*."
>
> Male disaster responder age 35-49: "*the face of sexual assault is never apparent, something that I wouldn't be able to easily see, or easy to identify…for the women they need to solve their problems by themselves first*."
>
> Male from the Fono age 35-49: "*some people say that's what you get when you are asking for it*."
>
> Female from a Health Clinic age 35-49: "*in my eyes it wasn't sexual assault but to them it was…we shouldn't go out there and tell everyone our problems, we have to solve them ourselves*."

The same female pulenu'u/matai made another, disturbing statement: "*You don't want people to make fun of you after things are back to normal; they need to solve their problems by themselves*." This individual clearly sees DVSA as single incidences which may or may not impact the victim's life long-term, rather than a symptom or result of a much deeper and complex phenomena.

In contrast, another male from the Fono stated, "*Survivors need to share their stories publicly. There is no better connection to the truth than the real thing, and survivors can mention how the system supported them*." This individual endorses transparency and believes that by sharing their stories survivors will encourage victims to find help. While well intended, his statement contradicts the majority of the survivors interviewed for this project: they did not want to tell anyone about their experiences, not even the police, and for primary reasons such as shame, embarrassment and fear which have nothing to do with accessibility to or knowledge of helpful services.

More domestic violence rather than sexual violence is perceived to be happening in the community.

As the thematic summary will show, many of the interviewees claimed that DVSA is not happening where they work or serve. A female from the LBJ Family Planning program disagreed, saying "*it's common and it's usually male doing it to females*."

A Fono representative echoed her sentiment: "*A lot of it I'm finding out is not being reported. Sexual violence is an actual problem, it exists, and most of those cases we find out about – it's too late or not reported*."

Thematic Summary

The purpose of the thematic summary is to categorize and explicate the perceptions that interviewees have regarding DVSA: what it is, who the victims and offenders are, why it happens, how it impacts victims and the community, what are victims' needs and available resources, and types of systems changes needed to effectively help victims and prevent DVSA.

The summary will expose what individuals perceive. Compared to the analysis of the survivors' interview data which reveals what actually happens to a victim of DVSA, **gaps between what leaders and providers believe is available and provided and what is actually available and utilized, will be identified**. These are also viewed as 'opportunities' and directives for positive, sustainable change.

Perceptions of Sexual Violence/Assault

It is unclear what percentage of people in American Samoa experience DVSA, making it difficult to prioritize needs and appropriately focus resources. So, the interviewers first asked community leaders and service providers what they thought sexual violence looked like to determine whether they've seen it and understand what it is. The **majority stated that they do not see sexual violence in their communities or where they serve**.

Church/Faith-Based respondents:

35-49 year old Samoan male – "*within my community there is no sexual assault because it's a small community and everyone is educated . . . they know what circumstances there if something were to happen.*"

35-49 year old Tongan female – "*not something common within our community, as a matter of fact I've never dealt with it within our community*."

Government Administration respondents:

50-64 year old Samoan male – "*there are really no cases or sexual assault incidents, except that a young girl got pregnant, but aside from that there are not any sexual assault going on*."

50-64 year old Korean male – "*I have not seen anything yet in our community because our community (Korean Community) is so small*."

35-49 year old Chinese male – "*I have not seen any incidents of sexual assault within our (Chinese) community*." This interviewee described sexual assault as "*unwanted touching, unwanted advancing" and "rape"* demonstrating that he understands what sexual assault is.

35-49 year old Samoan male – "*I haven't seen it happen within the community I am in.*" This interviewee also clearly defined sexual assault as "*forcing someone to have sexual contact*" and "*sexual contact without any agreement between two parties*."

35-49 year old Samoan male – "*the face of sexual violence is never apparent, something that I wouldn't be able to easily see or identify*."

25-34 year old Samoan male – "*sexual assault in my community looks like rape, incest*."

Interestingly, a male Samoan pastor stated, "*I really don't see it but I realize that is the beginning of it – it's when you DON'T see it*."

The descriptions of child sexual abuse corroborate his sentiment. Two female healthcare workers at a local clinic have experienced parents hiding the abuse when bringing their children in, saying that the kids are "*complaining…telling stories of someone touching them*" but these workers say they refer them to 'another area'. The parents don't "*say it straight out of what happened*" but the workers see physical abuse primarily on the '*genitalia area'*. If children are not taken seriously, if parents are bringing their child in for a physical exam but only want to 'fix' the physical problem, then the abuse is not acknowledged, documented, and addressed.

Sexual harassment is also considered sexual violence by some of the interviewees. One hospital worker stated that sexual harassment could be "*any verbal attack or joke being passed through to another person*." Another hospital worker described harassment as "*not just touching, but verbal as well*."

Interviewees felt that sexual assault occurred primarily in the home, "*within families*". While a pulenu'u stated he had not seen "*anything of such*" he had *heard* of many "*issues and cases where the people of our village have been involved*". A Chinese male thought, "*relatives pressure each other to do things sexually*."

A Filipino male stated that because "*there is not much privacy within family homes the structure itself can possibly promote sexual assault*." The traditional open living spaces in Samoan and Asian homes supports this premise. Indeed, court stories recounting how victims are sexually assaulted by intruders through open doors and windows, as well as by extended family members living in the home, supports this theory. Forced sex, rape, incest, child abuse and sexual harassment were the primary definitions of sexual assault by the respondents across all interviews.

Perceptions of Domestic Violence/Assault

The majority of domestic violence occurs in the home according to interviewees. It involves fighting and hitting, and verbal abuse and is considered common in households.

A Tongan female stated that it is "*quite common and many families are very good at hiding it but we all know what's going on and a lot of it is violence*."

A Chinese male agreed that it happens "*within families and relatives*." Verbal abuse is recognized as a form of domestic violence as well. A Samoan pastor thought that parental discipline could be seen as child abuse. One interviewee defined domestic violence as "*neglecting your children; beating on each other*." Primarily, domestic violence was seen as happening in a household, between couples, involving physical hitting and verbal attacks.

The causes of domestic violence are thought to be centered around miscommunication or poor communication and jealousy as well as "*getting carried away*" with child discipline or while in an argument. Interestingly, some respondents referred to domestic violence as something that happened to '*other people'*, i.e. people not of their village, non-Samoans, people who have bad tempers or are frustrated. A pulenu'u stated that "*sometimes it's not the people originally from our village but people who migrated into our villages that are causing most of this violence*." It would seem that from his perspective the original Samoan inhabitants were 'above' that type of behavior. Distancing himself from the violence would be a form of denial, a dangerous perspective to have as one with responsibility for law and order in his village.

Few people stated that they had not seen domestic violence – most had at least heard of incidents in their villages. Domestic violence appears to be more prevalent than sexual violence according to the community leaders and service providers. Herein lays **an opportunity to focus education and outreach to raise awareness about sexual violence**, especially with the increased number of cases going through the local court system and reported in print media.

Perceptions of Who the Victims of DVSA Are

Two non-Samoan interviewees, a Chinese male and Filipino male, stated that victims are "spouses" and "wives". They had also felt that violence was centered in the home, between couples. Two female health workers stated that "*sexual violence is mostly towards young girls*". This may be a reflection of their experience when parents bring their children in for what was described earlier as 'complaining about someone touching them'. In these cases, the victims were not seen in the emergency room but at the community health clinic or in the hospital's pediatric clinic. Adult females, as evidenced by the survivor interview data, are less likely to go to the hospital for sexual violence.

Overall, respondents felt that the victims of sexual violence are females, and minors; victims of domestic violence could be males or females. Thirty-two responses mentioned women and children being beaten, including the elderly and people with mental illness. These excerpts were merged under one category: unempowered females and minors. A Samoan male working at the Fono stated, "***victims are individuals who don't have the strength or the courage or the power to stand up for themselves, and so they are taken advantage of***." An insightful perspective.

A Filipino male added, "*the one lower than the head of the family*." Interesting viewpoint on familial status and 'power' which is not unlike a Samoan family.

The majority of the responses focused on married females who are "*treated as objects*" and often the target of husbands who are "*drinking and stressed out*." Most were comments concerning domestic violence rather than sexual violence. Notably, a Samoa male working with DHSS stated that "*last year there was a decrease of referred cases for sexual violence*." Perhaps the increase in media coverage of sexual assault cases is deterring victims from reporting rather than encouraging them?

Perceptions of Who the Abusers Are

The majority of respondents felt that the abusers were adult male family members abusing other family members, mainly their wives. An adult male respondent who 'frequently' works with victims of DVSA stated that "*domestic violence has expanded to include others, not just the parents* (abusing children or each other) *but others within the families including older people who live in the house*." Elderly abuse is not a common issue in the Samoan culture where elders are revered and cared for, and who are usually the heads or matai of the family (the persons in power). Elderly abuse would be a contradiction in the fa'aSamoa, and a contradiction of the interviewee responses to who victims are – the unempowered. It would be worth the effort to investigate the prevalence of this type of abuse and who the abusers are.

Abusers were predominantly identified as '*people in power and authority*'. These include parents towards their children, husbands towards their wives, and any person in a position of authority such as the "*matais or sa'o of the families where the pule is mostly referred to*." This perception is not limited to the fa'aSamoa. A Filipino male representing his community stated that the abuser is "*the one who has the authority, who feels that he is the head among the group – it's like the way they see the father figure, they are the ultimate power and can do anything – slap the kids, beat the wife*."

Abusers are perceived to be men for the most part, especially in the case of sexual assault. A Samoan female health worker stated, "*it's always the men*."

A Samoan male from DHSS stated, "*I don't know why fathers do that to their own daughters – it could be alcohol, or pornography, or that they are single and without a partner who can fulfill their needs. Most of the sexual assault cases – the perpetrator is the stepfather or head of the household*."

Perceptions of Why Violence Happens

Respondents verbalized very strong ideas about why DVSA happens. **The majority felt that the culture – both Samoan and non-Samoan, is the primary reason.** A Filipino male admitted that "*it's part of our culture*", especially from the "*male or head of the household*." He also felt that it was "*passed down the generations.*" This is validated in the literature regarding the fa'aSamoa as well:

"*The social structure of Samoan society is held together and actively maintained by an adherence to unwritten but universally understood cultural conventions that dictate how Samoans are meant to behave. . . the individual's sense of identity is based on divisions of power, status, labor and expectations*." (Crichton, 2001)

Violence could be a cultural, and therefore 'normal' response to stress, rebellious or disrespectful behavior, anger; or a 'normal' outcome or product of "*close-knit living, like it's part of the way of life."*

Other aspects of the culture and lifestyle were identified:

A 50-64 year old male pulenu'u: "*mayors are sometimes to blame because they are afraid to tell or talk of what they see therefore continuing the violence*." He also thought that "*Christianity has become weak.*" Where social controls against overt violence are weak or absent, and self-control is less developed as in a collectivist culture like the fa'aSamoa where individual behavior is heavily influenced by family, violence may be more likely to occur.

A 65+ year old Samoan female health worker: "*it's their living environment – are they (children) alone at home? That's why I am really against bingo – we didn't have bingo back then so parents were at home protecting their kids and girls. Now parents play bingo and kids are home alone*."

This same female also pointed out the lack of "*quality time with their parents*", and a weak "*spiritual life*". Another respondent stated, "*these are issues that happen to people who don't go to church*."

Respondents were more likely to describe reasons for domestic violence than sexual assault. The primary reason for DV was temper and anger born out of miscommunication, or lack of communication between married couples. Another respondent felt that "*no peace and harmony within families, people not trusting each other*" is why "*families use domestic violence to discipline each other*." Anger and frustration in response to poverty and other economic and social stressors are also key.

A male worker at ASPA suggested that "*poverty plays a big role, finance drives why it happens* (DV)".

A male pastor agreed, "*financial reason and not making ends meet*."

A female hospital worker supported these statements, "*A common answer I've been given is that its usually financial, finance stress within the homes.*"

Parents are the primary abusers of children. A Samoan male social services worker stated, "*women normally physically and verbally abuse the children.*" Four other respondents echoed his statement, agreeing that parental discipline can become child abuse. This violence can trickle over into child behavior in the schools. Bullying, fighting, negative attitudes are cited as behaviors that abused children then emulate in school.

Mental illness was mentioned twice by a male Fono employee who thought that lack of medication or diagnosis could cause a mentally sick person to become violent and abusive.

Perceived Impact on Victims

Initially four categories materialized under this domain: developed cultural norm, embarrassment/labeling, broken families, and impact on community/work. The majority of the excerpts were reassigned under one category: 'develop cultural norm' as they indicated that the primary impact on victims is within the context of the victims' relationships with family, friends, in the village and how it affects their lives growing into adulthood.

A young Samoan male working in the Fono reflected, "*to some people that are affected by sexual and domestic violence – its just part of the norm of how they were brought up so that as adults themselves they become either victims or perpetrators of this kind of violence*."

Three other Samoan respondents agreed that children learning violence in the home, watching adults beating adults and predators sexually abusing children, without "*rehab*" or counseling or seeing a different lifestyle will think that this behavior is 'okay'. Another Samoan male stated, "*students are being victimized at home so they grow up thinking it's an acceptable behavior to fight and get into trouble.*"

The community and workplace are viewed as 'victims' of DVSA as well. A Fijian respondent stated, "*anything that's happening out there involving any Fijian, it affects the entire community – there is shame, embarrassment and it reflects on all of us a whole*."

A Samoan male agrees, "*if it happens to one person the whole community will know and it impacts the individual that way.*" As part of a small, cohesive community the victim's fate impacts everyone. How the abuser is held

accountable, how the situation is viewed, how the victim is helped are all outcomes of abuse and will affect the entire community.

Another Samoan added, "*Everyone is affected, all strong communities that exist, it's because there are strong members – so if some are not functioning as part of the community because of abuse, then that abuse affects the rest of us as a whole. You can't say you are a strong community when part of your community is being violated and abused*."

Further, a Samoan female states, "*victims are unable to fulfill their duties, tasks, that they need to be at or fulfill for the betterment of the community*."

Finally, a male pulenu'u stated, "*We are being held back because we are affected by sexual or domestic abuse*." Clearly the respondents recognize the impact that violence has on the community through the abuser and the abused. A Tongan female added, "*violence affects their education, employment, socialization, their ability to be part of anything or be anywhere*."

Other interviewees directed their responses to impact on the victim as an individual, especially as a female. A Samoan female representing a church thought, "*Samoa has a shame culture…the community tends to talk and judge."*

Shame is not specific to ethnicity. A Chinese male stated that victims are "*embarrassed and if being labeled a victim there is that shame which is the biggest impact – they now live in fear*." Interviewees perceive embarrassment and labeling as impacts on the victims' ability to function normally in society.

Respondents stated that violence "*stops one from utilizing gifted talents*", "*victims become insecure and don't want to talk to anyone – they lose trust and their self-worth is degraded*." Education and attendance in school are definitely impacted. A female health worker thought that when victims miss school it leads to "*poor performance – victims who cannot cope then isolate themselves and withdraw from their usual activities*."

A Samoan male tied it altogether by saying, "*it all leads to poor academic performance which leads to alcoholism, etc. and the young children then live in fear*." **In general, respondents felt that the impact of violence is primarily emotional – no respondent mentioned the physical impact of rape and sexual assault.**

Emotional impact includes suicidal thoughts, no peace of mind, fear to talk with anyone about it or seek help. This is substantiated by the survivor data which identifies feelings of shock, fear, confusion, anger, and shame. 'Demoralization' is a category merged with 'emotional effects'. A Chinese male stated that the violence "*demoralizes them, I think they've been violated so they feel cheated*."

A Samoan male felt that "*some* (victims) *feel oppressed and there's no freedom. They live in fear, especially the women and children*." Fear is another major theme merged with 'emotional effects.'

A Samoan female described the impact as "*victims change from being confident to having low self-esteem."* Some respondents felt that the victims are "*scarred for life*" leading them to becoming sexually active at young ages to "*block out the pain*", and perhaps because they are "*blaming themselves*" for what happened. Verbal abuse was also mentioned repeatedly, but mostly concerning children. Respondents felt that verbal attacks from parents, perpetrators, and teachers leads to poor academic performance and negative behaviors.

A Filipino male specifically used the word *"traumatized*" as an impact on victims, adding that they then become "*useless to others and weaker which makes them open to more abuse*."

A Samoan male stated, "*victims have a sense of hopelessness which forms the beginnings of depression, overall confusion, loss of focus and drive*."

These responses are corroborated with the actual experiences of the interviewed survivors. Their experiences can inform the development of appropriate types of counseling and therapy, education and outreach focusing on the impacts articulated in the data.

Perceived Victim Needs

The respondents perceive that **the most significant impact of violence on victims is emotional**. Their perception of victims' needs aligns with this as they articulate **counseling and peer support as priorities**. Forgiveness is a category merged with counseling as it is described in the context of emotions and viewed by respondents as a 'need' in the healing process.

A Samoan female health worker felt that victims "*need to not feel guilty of their experiences*." Another health worker focused on children and thought that they would fear the adults in the home after their victimization is discovered, so they would apologize for what they did, essentially taking the blame for having been victimized, and asking for forgiveness. Interestingly, no respondent mentioned the need to 'forgive' the abuser as part of the healing process.

Another Samoan female "*assumed that they* (victims) *will blame themselves and it will affect their way of thinking so they might not even get the support they need*." Support is described as '*someone to talk to, who really understands what happened to them – they don't need police officers asking them questions over and over, or doctors telling them it's a mental illness.*'

Another respondent added, "*they* (victims) *need somebody to listen, to defend them, to tell them they are right and then refer them to resources. We need more hotlines open for people to call, and they someone they can trust.*" **The presence of an advocate throughout the DVSA experience is a need**.

A pastor offered, "*victims need education and counseling and support groups so survivors can share. I use my pulpit to advise my congregation that counseling is available*."

A respondent suggested that victims need "*a consistent friend, someone who knows when to step away and not be overpowering – a good friend who understands that there are some things they cannot get through to you because of the fact that the relationship (of abuse) is much more important*."

Being discreet and trustworthy are two main components of what respondents perceive to be 'counseling' that victims need.

Education and 'practical needs' like food, money, shelter were categories merged under empowerment as these enabled independence and healing. A Chinese male suggested that victims need to be "*educated on what's out there, what their options are because a lot of them feel stuck* (in their situations), *they need outreach*."

Another respondent stated, "*they need to know how to handle things when it happens again*." Education didn't mean school in most instances. Rather, understanding and awareness of resources and how to improve their situation. Respondents definitely felt that encouragement and empowerment are critical to effectively addressing victims' needs.

A Filipino male felt that the "*community and government should have support for people to be able to fight back, they become resilient and not become weaker*." Programs to empower and educate people in general in order to avoid becoming victims is emphasized.

Respondents suggested that any assistance be culturally appropriate – including "*translations from Korean to English*", and someone to help them "*understand the situation – to identify the root cause of the problem and speak to them*." An anonymous referral hotline was suggested by a Samoan male government administrator. He limited his description to a referral source – "*something we can start people off with, and then they can come to a private facility to meet with someone one on one*."

Notably, respondents did not mention brochures, posters, educational classes. All of the suggested types of counseling and support were verbal – talking, one on one, meeting together. This should be addressed during the development of outreach.

Perceived Resources for Victims of DVSA

Social service providers are perceived to be the major source of assistance for victims of DVSA. Respondents referred to both government and NGOs as 'social services', emphasizing that safe housing, prayer/faith counseling and advocacy from the Alliance were the most influential.

Respondents describe an existing 'word of mouth' type of referral process that moves victims towards support services. A female Samoan pastor stated, "*victims normally reach out to their friends (validated by survivors' interviews), then the friends usually lead them to the system. Sometimes they don't want their families involved because of pride or shame*."

Another faith-based respondent said that from his church people will be referred to "*social workers, agencies, and those that can provide the support they need."*

A male government administrator felt that while "*social services and member orgs are trying their best to service the needs of our community, there are still people who are not reached because they have decided themselves to be private, its taboo, they don't want to hurt the people they love*."

Peers and friends are the second most common resource according to respondents. They can be a support group. A respondent speculated that victims will "*avoid families because families tend to blame victims."* Safe housing and long-term shelter are deemed high priority as well – run by a third party, not offered by a friend.

Ethnic leaders representing the Chinese, Korean and Filipino communities claim that "*within our community they go to each other, to those with similar culture and language*."

A Samoan male agreed, "*they go to their own people, they will go to other Fijian communities for support, or whatever community they come from*."

The Filipino leader disclosed that "*we have a grievance committee that deals these issues within our community*." Partnering with ethnic community leadership is an opportunity to expand the network of services and numbers of victims helped – as the immigrant community in the territory grows, they will be a critical partner in the outreach to prevent DVSA and support its victims.

Issues of DVSA at Work

Respondents were asked if they were aware of DVSA amongst their employees both on the job and in their private lives. The majority were unaware and/or unexposed to DVSA at the work place. They '*heard of things*' happening but were not directly told of any incidences. Those in the medical fields stated that they were never directly approached by a victim for help – victims came through the EMS, judicial, or social service system. A Fono representative stated that he is "*honestly not equipped to deal with victims, but as a person in a position of authority, I can assure resources, programs, and that these people get the help they need*."

Needed Policy Changes

First, respondents were asked if they knew of existing protocols in the environments they served and worked in which addressed DVSA – to prevent and/or prosecute. All of the government workers agreed that policies exist in the human resources department to prevent DVSA in the workplace. A hospital employee disclosed that LBJ requires annual training of all employees on sexual harassment and how to identify and report abuse. A pulenu'u stated that "*those committing violence will be brought before the village council*," however there is no "*official laid out protocols*" other than to go through the "*matai system where families try to resolve things behind the scenes.*"

Second, respondents were asked what types of policies are needed to prevent DVSA and help victims. A few didn't know that there are laws regarding sexual harassment, confidentiality surrounding DVSA disclosure, and mandatory reporting. The most perceptive suggestions were:

Samoan male age 50-46: "*appropriate sentences here, sometimes they are too hard for the drug users compared to the abusers – look into harsher punishments for abusers*."

Chinese male age 35-49: "*victims have to report and not withdraw their cases even if its family. We need good record keeping in American Samoa. We need swifter and harsher laws so that adults don't take advantage*."

Samoan male pastor age 50-64: "*need better and stronger laws regarding child abuse, or maybe it's there and it's just the implementation of the law*."

A Samoan female agreed that "*harsher sentences will teach the perpetrators something. Death cause by domestic violence- the Courts need to take that into consideration especially when sentencing perpetrators.*"

Tongan female age 35-49: "*lawmakers need to understand DVSA themselves, its obvious a lot of them haven't a clue on what's going on within the territory and how prevalent DVSA is here."*

A Filipino male age 35-49 agreed with harsher policies for abusers: "*the court needs to make things harder for the perpetrator to get his family or victims back; victims need to be protected more by social workers programs – the main purpose should be to protect victims.*"

A Samoan female age 65+ stated, "*we need harsher punishments or take some of them to Manu'a as time served, or Swains, do something very harsh*."

Respondents perceive that current laws are not strong enough to hold abusers accountable and obtain justice for their victims. A review and overhaul of current legislation appears to be a priority.

Perceptions of How to Approach Victims of DVSA to Provide Services

The majority of respondents described how victims should be treated, talked to, and what they should be told. These were merged into a an 'overall approach' to helping victims of DVSA. **Respondents felt that victims need encouragement to expose the crimes, and assurance that they will be protected and their experiences will be held in confidence**.

A Samoan female suggested, "*Always a good idea to go to them, it's the only way to do more awareness and provide education; don't wait for them to come*."

Respondents felt that survivors of DVSA "*need to share their stories to help others*", that people need to "*hear the truth straight from the horse's mouth*", that they should share "*the message on how to deal with coming out*" and that these experiences from "*real victims is what people go for*."

Another interviewee stated, "*People listen intently to victims' stories and they are moved. The face of the message has to be a victim, the face and the voice of the survivor's perspective works – survivors need to be at the frontline of pushing this message out there*." These various interviewees who emphasize the value of survivors stepping into the 'spotlight' have clearly forgotten their responses to earlier questions for which they overwhelmingly agreed that the impact of DVSA on victims includes embarrassment, shame, guilt, and fear.

A hospital employee stated, "*one of our services is DV screening and no one has volunteered their story or shared that there is DV within the homes. I have a social service unit here that I can refer them to and DPS tells them to come here for their examination*."

A pastor stated, "*no mater how hard we try it's their feelings and not ours; it's a matter of communication – they need to know that they are protected – but they will feel however they want to feel*." The emphasis on individualized needs, emotions, responses is validated in the survivors' interviews and surveys.

Decreasing fear surfaced as a 'goal' in communicating with victims. A Samoan female stated, "*people don't come out because of security. They are afraid that the repercussions are worse for them when their cases surface so it's really insecurity of the victim*."

Other interviewees agreed:

"*There is the fear of men, that's why people have a hard time coming forward – they need counseling and go to a service to help them get rid of these fears – there is a fear of being heard, of expressing their thoughts*."

"*When they go back to their family, they apologize for what they did because they are children and have to listen to older folks so they don't talk about it*."

"*Any victim needs to be assured of safety and guaranteed that it will never happen again. They need protection from the perpetrator, they need assurance that things will change*."

"*The bottom line is assurance and guaranteed protection of victims*."

An Asian hospital employee adds, "*there is fear of security of their stay in the island. Legal implications of our stay play a big part of not coming out, especially the repercussions of their work – whether they will be able to keep it or not.*"

A few respondents emphasized the need for prayer, for the victim to find comfort in church, and the fact that "we are a small community" which makes it difficult for victims to feel that their information is confidential.

The **importance of confidentiality emerged as a significant element in the overall approach of DVSA victims**. Several survivors admitted that they did not seek help from DHSS or a shelter because they didn't trust that their situations would be kept confidential. A Chinese male stated, "*Programs need to be made available to all without the entire community finding out*."

A Samoan pulenu'u believes that confidentiality in the Samoan community is impossible: "*With Samoan people when it comes to shame, they are very good at hiding them, I can't think of any possible way where we can't take away peoples' fear about others finding out.*"

A Samoan female from a church suggested, "*Instead of speaking out use a confidential website or something to drop a work there, 'I need help' and have only a few people able to access it, there are ways to discreetly let us know.*"

A Samoan male from the Fono says, "*We need centers where people can come in anonymously, with a survivor at the front line.*" He thought that an anonymous hotline should be started.

A Samoan female from a community health clinic suggest, "*Preach confidentiality, and consent*!"

Informants were asked for their thoughts on the types of messages that should be communicated to prevent DVSA and encourage help-seeking behaviors by victims. They were also asked what types of communication should be used. Interestingly, prevention of DVSA was proposed in the form of messaging to victims, not to possible perpetrators, which places responsibility on the victim rather than accountability on the abuser.

A Tongan female stated, ***"We cannot just decrease people's fear because there is always shame. It will never decrease, realistically this is something we cannot change."***

Respondents felt that the **messaging should be focused on the home and family**, which is where they felt the majority of DVSA occurs. A Samoan male Fono worker thought that "*sexual assault is found mainly within families*", and another male suggested that "*in the home there is not much privacy so the structure itself promotes sexual assault.*"

The messaging should be **routed through the village/family leadership structure, and preached from the pulpit, as well as through social and traditional media**.

Home visits were seen as effective – a pastor stated, "*it's always a good idea to go to them, it's the only way to do more awareness, don't wait for them to come to us*." Several respondents agreed, saying that "*walking the village*", "*making it a community effort*", "*going to families, having tea, discussing things*" would be culturally appropriate and effectual in a Samoan community. Church and village leaders were suggested as the ideal people to do this outreach, but the community as a whole should be involved. One respondent felt that "*the only people that people in a village listen to are the family sa'os"* because *"they are the ones who can remove people from the land*."

A few respondents felt that DVSA prevention and overall awareness should be taught in the schools. One person felt that kids spend most of their time with teachers in school so it would be the ideal place to do outreach for children. A 'women's taskforce' was suggested to focus on child education for DVSA prevention. Support groups

were mentioned as another resource that should be touted to people during outreach so that they know how to access them.

The religious community was mentioned with as much emphasis as the matai/village structure. "*The church can make people scared of doing these bad things, and the faifeau can spread the word"* – Male Samoan government worker. **A respondent from each of the organizations and agencies represented in the interviews recommended a faith-based message in DVSA outreach**.

Social media and television were suggested as methods of communication. Traditional media, including 'word of mouth', posters and newsletters were mentioned. However, the **emphasis was placed mostly on one-on-one interaction with families in their homes and villages, and develop outreach as a community effort**.

In summary, the **responses**, even from those who work with DVSA victims 'frequently', **seemed disconnected from the realities experienced by the DVSA survivors interviewed**. The perpetrator/abuser was rarely mentioned. Responses centered around how the victim should be treated, what messaging should be providing for them, what they should or shouldn't do to improve their circumstances. While respondents expressed empathy, it sounded disengaged. Secondly, while they seemed to understand the emotional trauma that victims experience, they placed a lot of responsibility on the victim to 'get better', to 'deal with it'. Sexual assault was definitely not discussed as often as domestic violence, which seemed more prevalent and which respondents felt more comfortable discussing. These are issues to be considered during strategic planning.

Identifying the Gaps

The project aimed to determine if the minimal level of service provision recommended by national standards was available to them (Exhibit C). Each survivor's journey, from incident to post-incident/resolution, was mapped out using both survey and interview data. The unmet needs were then identified along this continuum of recommended service provision. What the survivors actually received was compared to what the service providers and community leaders perceive is available and being provided, and the results were compared to a general national minimum standard.

Service	Survivors know it exists/utilized service	Leaders & Providers perceive it exists	Minimal Requirement
Crisis Line	No survivor accessed a crisis line or knew if a local crisis line exists	48-49% perceive that agencies like DHSS, LBJ, DOH or NGOs like the Alliance or Teen Challenge provide a crisis line	1 national line covering all violence against women, staffed 24 hours by trained responders to provide direct support, solutions, and possible instructions
Shelter	1 survivor accessed the DHSS shelter; 2 didn't know such a service existed; 6 chose not to go because they didn't report the incident or found shelter with family/friends instead; 2 stated they distrusted the shelter staff	56-57% perceive that a shelter exists and is provided by agencies like DYWA, DHSS, DPS or NGOs like the DV Coalition and Windows of Hope	1 per 10,000 with capacity to house women and children, and provide support from min. 1 Specialist in Violence; crisis support and safety planning should be provided, and a written needs assessment within 3 days of intake

Support Group	The majority of survivors did access a form of support/counseling from an NGO	46-48% perceive that a support group is provided by LBJ and DHSS or by NGOs like the Alliance, churches, and Teen Challenge	Professional counseling services should be provided by a Specialist in DVSA – min. 1 per 50,000 women
Court Advocacy	A formal court advocate was not utilized by any survivor – there were two who received help from ASLA and Ipu Lefiti after the fact	34% perceive this service to exist, and 41-44% didn't know. They assumed that ASLA, the Court, or the AG's office provided this	Minimum 1 advocate per 50,000 women
Hospital Escort	Of the 2 who were transported to LBJ by the EMS, neither had an advocate with her	46-48% believe an escort exists and the service is provided by DPS, DHSS, EMS or NGOs	Typically, 'advocacy' and an Escort would be the same person, or provided separately by a Rape Crisis Center or Sexual Assault Center and this person would be a Specialist with min. 30 hours annual training
Outreach Education	Based on the interview data, all but one of the survivors were unaware of the services provided for DVSA victims. 5 hid the incident; and most harbored feelings of guilt, shame and fear. 1 stated that more outreach/education is needed to make women aware of situations where they could be assaulted	46-49% believe outreach and education are available from the Alliance, Teen Challenge, YFC Ministry and other NGOs as well as government agencies	

When asked to rank the most important systems changes needed to address DVSA effectively in American Samoa, 51% of the community leaders and service providers felt that **'increased police training' is the primary systems change**. This need is corroborated with the survivors' experiences:

- 'minimum one-hour response time' (reported by 3 survivors)
- Experience ranked as 'not good' (reported by 2 survivors)
- 'police took report' but 'didn't seem to want to help'

One respondent had a 'very good' experience with the responding police officers who removed the abuser and transported the victim to the police station, and then to the hospital. However, another reported that the police responded to her requests to go the DHSS shelter by asking her if she had family to go to instead. The police response is overwhelmingly poor, ineffective, and may actualize perpetuate the victimization of women by creating distrust in their protective services.

Community leaders and service providers felt that a **rape crisis center and shelters/halfway houses**, and professional counseling were the **most important direct services needed by DVSA victims**. This need is corroborated with the survivors' experience as well:

- 'I didn't want to shame my family . . . I felt that it was my fault. I went to the Catholic sisters who gave me shelter for 3 weeks.'
- 'I was revictimized at the shelter'
- 'I was embarrassed, and feared what others would think. I found shelter at a friend's.'
- 'The police took me to a friend.'

Community leaders and service providers also felt that a **crisis hotline and safe shelter were the most important services needed by the DVSA victims served by their organizations, and in their community groups**. The survivors' journey maps support this sentiment. Only one survivor recalled knowing who to call for help, and had a positive experience. Three survivors admitted that they didn't know who to call, that they didn't want to call the police, and that they needed help but didn't know where to turn. At the time of the assault all of the survivors were 'in shock', 'afraid' and 'shamed'.

The literature suggests these elements are necessary for an effective, *sustainable* response (Bank 2014):

1. Strong leadership and governance;
2. Ongoing case management;
3. Systems and protocols for sharing information;
4. Systems and protocols for collecting and managing data.

These key indicators guided the analysis of the key informant interviews and surveys. The data analysis reveals a significant need for change in how the community leadership and service providers respond to DVSA crimes. An effective response cannot be established if critical services are unavailable or inaccessible to victims. Some direct services, such as the police and emergency medical care are available, accessible, but ineffective in their response to victims' calls for help as evidenced by the survivors' experiences. Strong leadership and governance is not evident in the data – no respondents could identify exactly who or what agency/NGO is directly responsible for specific services. Service provision is inconsistent. Herein lays an opportunity for a leader to rise and take the helm of a coordinated community response to DVSA. There is no evidence of ongoing case management, no referral system – including protocols for collecting, managing and sharing data.

The ineffective, and somewhat unempathetic responses from the police could be interpreted as 'problems' caused by the Samoan culture. One Alliance reviewer stated that "*it's the culture, that's how our people are and it needs to change."* Culture *could* be a problem-solving tool used to facilitate change (Crichton-Hill, 2001). From an appreciative standpoint, the fa'aSamoa could be used to collectively rally support for change in perspectives, values, and therefore responses to DVSA. **Enlisting the support of male community leaders to drive change is also a viable strategy** – if men are the primary perpetrators then using traditional leadership to influence them and 'speak' to their sensibilities may be suitable. This is supported by interview data from leaders and service providers.

Gaps are evident in the types of services available, and how those services are provided. Prioritizing these needs will help responders focus their efforts on **what victims needs most according to the data**: police trained in trauma-based procedures, immediate and long-term shelter, professional counseling and support services. Any strategy must be sympathetic to the core Samoan understandings of the victim as an individual (mother,

teenager, wife, ex-girlfriend, etc.) in terms of social and economic status, and in terms of her motivation to act on her experience, and perception of self-control over her situation. As evidenced in the data, needs are individualized. Not every victim will need, or want the same types of assistance. Safety, justice and equity are broad underlying principles of trauma-based service provision that should inform culturally competent and responsive services.

Establishing a formal referral system of first-response will ensure timely, effective and holistic service delivery to victims.

Limitations of the Project Design

The primary limitation on the use of data gathered from this project is the construct validity of the survey questions (Polkinghorne, 2005). For example, the high number of 'missing answers' to survey questions 11 and 12 may be interpreted as a lack of knowledge of the content (i.e. what is a crisis center), irrelevant context (i.e. this question doesn't apply to me), or an inability to respond to the type of questions asked in the form that they are presented (i.e. why rank items from one through nine if they're all equally important), or a combination of reasons. Triangulating the data collection process with key informant interviews from a smaller, more discreet selection of respondents added to prior topical research provides a deeper understanding of, and variations within, their experiences.

Secondly, experience is not actually observed. The quality of the data is dependent upon the respondents' ability to recall experiences, and adequately communicate those experiences through language and symbols (survey and interview responses). While self-report evidence is accepted as a necessary source of data in qualitative inquiry, it should not be 'misconstrued as mirrored reflections of experience' (Polkinghorne, 2005). Recall is inadvertently tainted by language, gender, race, politics, culture, et cetera.

Finally, the selection of participants is a critical aspect of this project. The participants in qualitative assessments are not a representative 'sample' of the population in question. Rather, the unit of analysis is experience, not individuals or groups. Participants are chosen based on their ability to contribute to understanding the experience being assessed. Recognizing the limited number of individuals meeting this requirement, the Alliance utilized a *wide net* approach to identify ALL member organizations, DVSA service providers, leadership categories, and DVSA survivors. From these categories, a purposive long list was created and individuals invited to participate. Confirmed participants comprised a short list of respondents who were willing to complete the survey only, or the survey and interview. DVSA survivors were asked to complete both. The selection process inherently affects the depth and scope of collected data in two ways: (1) the probability that respondents have adequate experience and knowledge to significantly contribute to the data; (2) the possible bias towards the Alliance when recalling experiences.

Components of a Recommended Approach

The System Mapping and Client Journeying provide a visual assessment of the response to DVSA in American Samoa. While the minimal services are available – police, emergency medical services, legal aid, peer-based counseling, shelter – the survivors' stories point to several significant opportunities for improvement:

In service delivery – ensuring consistent, culturally competent, confidential, and professionally educated/trained service provision.

In service tools, products, and facilities – providing timely, culturally appropriate, anonymous (when necessary), evidence-based interventions that meet the needs of victims from incident through resolution.

Community Awareness and Advocacy Programs

The purpose of such programs is to 'improve community response, reduce domestic violence, increase public attention, and inform victims of their options (Dabby, 2017).'

Systems advocacy can establish gateways to services through collaboration and policy development.

The Alliance ***is*** a systems advocate. As such the Alliance could emerge as a leader in the strategic innovation of an effective coordinated response to DVSA in American Samoa. Connecting the various 'players' – the direct service providers, support service providers, the leadership identified in the data – is an opportunity that may naturally elevate the Alliance to this leadership position.

Strategic Campaigns

Opposition to patriarchy should be central to advocacy initiatives in American Samoa. The data shows that violence in the territory is no different from violence elsewhere in the world. Men, and persons in power, are the predominant abusers by virtue of their physical strength, and the social, economic and cultural status afforded them. Embracing culture and refocusing media messages to target those most likely to be the abuser is an alternative and locally innovative strategy: i.e. brothers respect your sisters, boyfriends respect your girlfriends, etc. instead of putting the responsibility on those most likely to become a victim – girls 'just say no', don't wear revealing clothing, don't stay out late; or the negative perspective towards males - 'don't hit' et cetera.

How we deal with DVSA in American Samoa is also not unique to this culture. The data shows that victims experience similar emotions and utilize similar coping mechanisms as those described in the literature. **Survivor-centered advocacy** should be utilized in American Samoa, based on this culturally-specific analysis and definition of domestic and sexual violence. The value of 'safety' is a critical need in the data. Victims need safety from multiple perpetrators, and from community-specific forms of DVSA (i.e. in-laws beaten by husband's family, fa'afafine molested, etc.) Long-term housing or modified shelter arrangements need to be addressed as priority needs – these are components of safety.

As a collectivist culture, American Samoa may need **collectivist collaboration strategies** that promote safety, reduce violence, support women – how can we embrace the culture to facilitate unique solutions?

- The current service response is not geared towards helping a woman to leave an abusive relationship and live independently. As the data shows, only one out of 9 survivors was able to have her abuser arrested. Only two made it to court; and all of them stated that they did not feel safe once the initial

incident was over. Only one woman divorced her abuser. Because of shame and/or fear the women avoided shelter with a family member to get away from the abuser.

- To provide meaningful options to all women, an effective response to DVSA must include alternative frameworks which may involve staying in the relationship possibly, and eliminating the violence; honoring the victim's decision to stay, to vouch for husband, especially when she is not financially independent and has children.

Embracing the culture could mean using cultural and community leaders to deliver the message of non-violence, and encourage women to secure their own safety. Advocates can provide non-judgemental options to individuals to lower their risk level *within the context of the family home*: adopt safety rather than leaving, promote economic independence, emphasize prevention – identifying triggers, developing productive coping mechanisms.

More '**action-oriented group services'** may be effective – emphasize developing support settings that use recreational activities, especially those that include children of victims, and maybe activities that provide functional training i.e. life skills, job skills.

With the 'gaps', or opportunities to improve, identified and needs defined the next step is to delineate their causes which is outside the scope of this Project. However, Exhibit D illustrates an approach to identifying causal factors of high-priority performance gaps and performance-improvement activities/solutions to address them. The solid data collected directly from the community now enables the Alliance to develop delve deeper into the experiences of survivors. Follow-up interviews with more developed and focused questions will be helpful. As the overwhelming response from leadership stated, the face of the survivor should be at the frontline of the message or outreach. It is possible to preserve confidentiality by collecting their stories to inform development of interventions without disclosing identifiable data.

Exhibit B: Client Journey Map

AGE	DV	SA	INCIDENT	SERVICE ACCESS	RESOLUTION	FEELS SAFE IN HOME NOW	SUSTAINED SAFETY -	USES LOCAL SERVICES TO COPE WITH THE IMPACT OF DVSA	POST-CRISIS SUPPORT
na	no	X	NO REPORT (work incident) - called family/friend "didn't think it was warranted" "too shocked"	NO COURT - received legal advice from Ipu Lefiti "help found me" "didn't want to start a fuss" "not familiar with law/procedure" "easier to ignore"	No government involvement	YES	"I have to see him every day" (at work)	NO	No evidence
53	X	X	NO REPORT - called family/friend Police not involved because "I was afraid of perpetrator" "I didn't want my mom and siblings to think that I don't think about them - didn't want to shame our family" "Felt that it was my fault that all that happened"	NO COURT - knew about programs ACCESS BARRIERS: distrust/lack of confidentiality (DHSS & Shelter) Confided in EMPLOYER who referred her to Catholic Sisters who provided shelter for 3 weeks	"never pressed charges" no evidence of resolution	YES	no evidence of safety plan	NO	No evidence

AGE	DV	SA	INCIDENT	SERVICE ACCESS	RESOLUTION	FEELS SAFE IN HOME NOW	SUSTAINED SAFETY -	USES LOCAL SERVICES TO COPE WITH THE IMPACT OF DVSA	POST-CRISIS SUPPORT
39	X	X	REPORTED - DPS - experience NOT GOOD 6 calls to get into shelter; min. 1 hour response time; police took report "didn't seem to want to help"	SHELTER - had social worker (for son); kicked out for pipe "revictimized" Per Interview Summary: she 'went through process alone" - later accessed Alliance (haven) and used ASLA	No Arrest because abuser had "calmed down" was kicked out of shelter so "forced myself to go back to husband" and dropped case	NO	Needed 'advocate' - impartial person at shelter - now she's home with abuser	NO	No evidence
24	X	X	NO REPORT - "In the moment didn't know what to feel or do - it was complete confusion" (per interviewer - raped multiple times from young age)	NO ACCESS - "Lead to embarrassment and fear of what others would think" "found shelter at friend's"	Later found Ipu - needed help on HOW TO REPORT	YES	No evidence	YES	NO EVIDENCE but is definitely NEEDED:"fear of everything and everyone; the incident took my mind into a blank space and emptiness"

AGE	DV	SA	INCIDENT	SERVICE ACCESS	RESOLUTION	FEELS SAFE IN HOME NOW	SUSTAINED SAFETY -	USES LOCAL SERVICES TO COPE WITH THE IMPACT OF DVSA	POST-CRISIS SUPPORT
64	X	X	NO REPORT - called Friend - assaulted at age 18 3 of abusers were brother in law's first cousins and 3 were friends - "didn't want my parents to find out just my sister so she told me not to report it so it was swept under the rug - also I was under age 19"	Age 24 in Hawaii accessed counseling through DHSS	No court or arrests - hid incident from family	YES	Protected by sister	YES	Celebrate Recovery
25	X	X	Police & EMS arrived w/in 30 minutes Abuser was ex-boyfriend Police transporter her to sub-station; took abuser elsewhere	Transported to ER Informed of Restraining Order Police rated very good; EMS rated 3 (medium)	NO COURT - "forbidden to return to man who was so cruel" and "did not want to see the man that did this to me" SHELTER at friend's house (transported by police)	YES	No evidence	YES	No evidence

AGE	DV	SA	INCIDENT	SERVICE ACCESS	RESOLUTION	FEELS SAFE IN HOME NOW	SUSTAINED SAFETY -	USES LOCAL SERVICES TO COPE WITH THE IMPACT OF DVSA	POST-CRISIS SUPPORT
28	X	X	Called Police and EMS - 1+ hours to respond - service rated NOT good	ASLA - got temp PO	NO EVIDENCE	NO	No evidence	YES	No evidence
			Abuser was child's father - NOT arrested because he ran away	Alliance - advocacy	Didn't fully understand court hearings, case outcome				Abuser tried to steal baby
			Police did NOT offer help	DIDN'T KNOW SERVICES EXISTED	Did not feel safe from harm during court process; had to see abuser in court				
64	X	X	NO REPORT - SA as child & adult - perp was clergy guest in house	NO ACCESS	"I recall taking pictures of my bruises in case I filed a claim but I did not; instead I filed for divorce"	YES	No evidence	NO	No evidence
			DV as adult - perp is husband Went to Friends/Church		felt distrust of system				

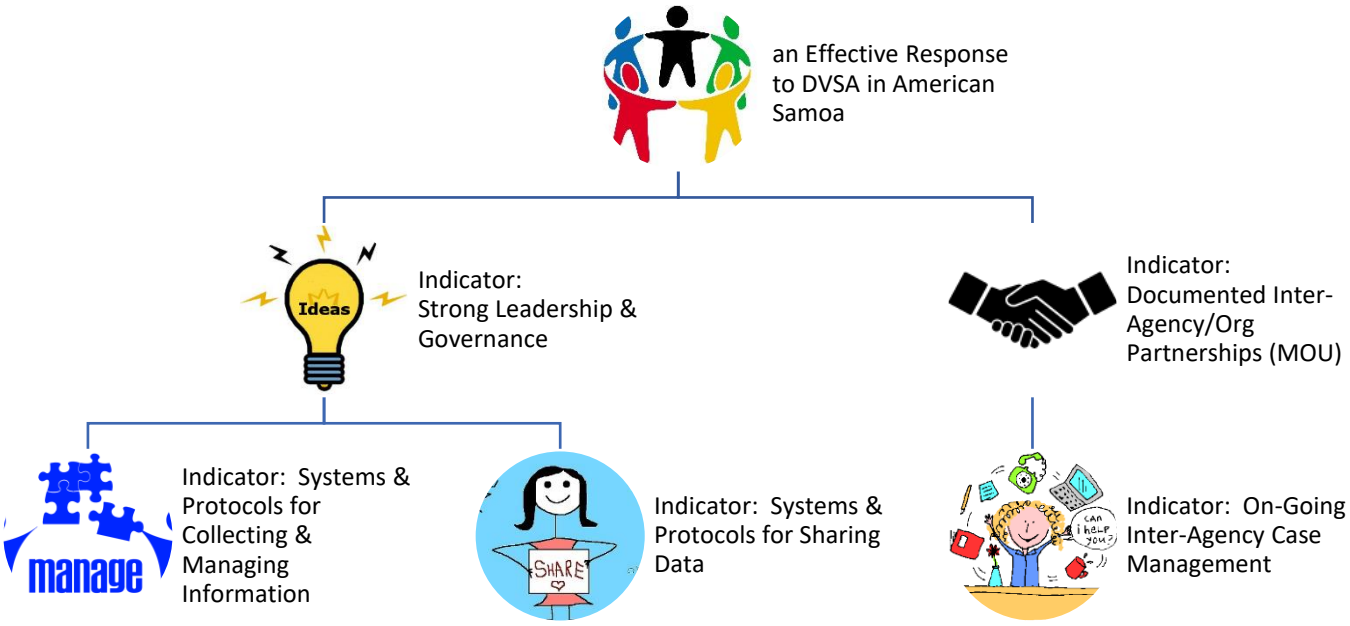
AGE	DV	SA	INCIDENT	SERVICE ACCESS	RESOLUTION	FEELS SAFE IN HOME NOW	SUSTAINED SAFETY -	USES LOCAL SERVICES TO COPE WITH THE IMPACT OF DVSA	POST-CRISIS SUPPORT
na	X	NO	Called police - rated NOT GOOD - responded in 1 hour	DHSS/Eta for mental disorder	Went to court; didn't have to see perp; understood what was happening	YES	No evidence	YES	Provided by DHSS/LBJ
			abuser was brothers - not arrested	Pua Center	Was put on civil commitment				
			Police transported her to family	EMS transport to ER - rated VERY Good, also transported to shelter/family					

Exhibit C: Minimal Levels of Provision for Core Services

Service/Product	Basic provision	Gold standard
Help/Hotline	One national line covering all violence against women staffed 24 hours by trained responders to provide caller with direct support, solutions, and possible instructions if needed.	One national line for domestic violence and one national line for sexual assault/rape staffed 'live' 24 hours by trained responders to provide caller with direct support including direct link to emergency response services; monitoring extent of missed calls
Shelter	One per 10,000 of population, with capacity to house women and children, and provide support from min. one Specialist in Violence; provide basic emergency necessities and transportation. Services should be provided by female staff. Crisis support and safety planning should be provided for each user – preferably a written needs assessment within 3 days of intake.	Range of services: accommodation for women with special needs including migrants, disabled, behavioral health issues, drug abuse; transportation. Written policies and procedures in place to manage the shelter as well as Case Management completed through release. Minimum one qualified childcare worker on staff. A follow-up plan post-release is highly effective – suggest 30-day and 6-month safety checks.
Rape Crisis Center	One per 200,000 women; min. one Specialist in sexual violence. Services should include anonymous phone helpline, individual counseling, accompaniment to other services, advocacy. Min. 30 hours in staff training in all areas of DVSA.	Integration with assigned health provider, law enforcement and forensic services. Should also include advocacy, protocols for suicide and crises, and third-party callers, legal advice, and financial assistance hospital accompaniment
Sexual Assault Center	One per 400,000 women; min. one Specialist in sexual violence. Service minimums should be same as Rape Crisis Center	Integration with assigned health provider, law enforcement and forensic services. Provide equitable access to quality medical care; established age specific protocols.
Professional Counseling Services	One per 50,000 women; min. one Specialist in Violence; can include Shelters, Rape Crises and Sexual Assault Centers	Counseling provider should be integrated with other DVSA service providers; direct contact with emergency services when needed; Counselors should have min. 30 hours training in all areas of DVSA and able to develop individual action plans for clients
Advice/Advocacy Project	One per 50,000 women	Sustainable relationships w/DVSA service providers, media and legislative entities; Advocates have 30 hours training in all areas of DVSA with Certification where available
Education/Outreach	target at-risk groups, especially minorities, and staff trained in cultural competence	Co-location with other service providers; translators and bilingual materials available
Perpetrator Programs	i.e. Batterer's rehab - facilitated by professionals and not provided as an alternative to prosecution, conviction or sentence. Safety and well-being of women and children supersedes benefit to perpetrator, and should not include relationship mediation or counseling or substance abuse treatment.	Protocols should be in place for cooperation with local substance abuse treatment programs. Programs should have active links to child protection and social service agencies. Staff complete 30 hours training.

Exhibit D: Protocol for Cause Analysis and Improvement Activities

NEEDS should be categorized by INDICATOR:



DEFINE: Size, Scope, Distinguishing Characteristics and Relative Importance of the NEED
Example: Current number of victims housed at shelter per month vs.
Current number of victims NEEDING shelter per month

*a need is defined in terms of gaps in what should be and what is i.e. what victims should be receiving, what providers should be providing

1. Establish **prioritization of needs** on basis of size, scope, characteristics and relative importance
   Example: rough estimates of costs to house more victims, including manpower, space, etc.

2. Create a plan for collecting info about **factors leading to** the high-priority **performance gaps**
   A. Analyze each need for the **causal factors/root causes** that are linked to less than desired performance
   B. Identify what IS working and how this can help close the gap – identify opportunities
   C. Categorize causal factors for each need

3. **Collect data regarding causal factors** associated with priority needs i.e. follow up interviews, etc. to identify impact of causal factor on performance/service provision

4. For each priority need and its causal factors **IDENTIFY multiple performance-improvement activities** (solutions, opportunities) that in combination could address the gap
   D. Identify TWO IMPROVEMENT ACTIVITIES linked to each causal factor – compare alternatives by effectiveness, efficiency, probability of successful implementation, cost basis

5. Evaluate each potential performance-improvement activity to **assess its value to your improvement effort:**

*DV Assessment revealed that LACK OF SERVICE INTEGRATION is an issue:
GAP: transfer of victim from incident report to court room

- Wrong perspective: 'we need a state plan for DVSA', 'we need a rape crisis center', 'we need a hotline', 'we need more effective victim-centered laws'
- ANALYSIS: why lack of integration? = lack of communication
- ANALYSIS: why lack of communication? = lack of understanding of integrated systems and coordinated response protocols?
- **Possible perspective**: opportunity to implement better police training? **Opportunity** to build upon existing handful of provider organizations/agencies to establish referral system?

6. **Variables used to determine which activities are 'right'** for your situation:
   a. The type of gap – and its level of priority (strategic, tactical, operational?
   b. Causal factors of the need – lack of clarity, new skills required, conflicting priorities?
   c. What the territory is already doing – what exists effectively?
   d. Ability of proposed activities to accomplish desired results
   e. Appropriateness of activities for organization and culture
   f. Feasibility of activities being implemented successfully
   g. Economic costs of activities relevant to beneficial results

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