# Addressing Domestic Violence During a Pandemic

DISSEMINATION PLAN

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**Verification Statement:**
This is to certify American Samoa Alliance against Domestic & Sexual Violence, also known as "The Alliance" is the dual coalition in American Samoa and has received Family Violence Prevention Services (FVPSA) Coronavirus Aid Relief and Economic Security (CARES) supplemental funding in 2020. The CARES Act appropriated $45 million for states, Tribes and state domestic violence coalitions to use the funding to prevent, prepare for, and respond to COVID-19. Although there was flexibility in the usage of the funds, the focus was to prevent, prepare and respond. This project was developed to promote discussions to influence our community to provide support and guidance for services and shelter options to assist victims of domestic violence.

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## FORWARD

The American Samoa Alliance against Domestic & Sexual Violence also known as the Alliance, receives federal grants from the Family Violence Prevention and Services Administration (FVPSA) as the recognized dual Coalition for domestic and sexual violence in American Samoa[1]. In May 2020, the Alliance received supplemental funding of $80,357 for FVPSA Coronavirus Aid Relief and Economic Security (CARES). As this funding was released American Samoa had just completed a measles vaccination campaign which required the local Department of Health (DOH) to ban public gatherings and close schools through December 16, 2019. American Samoa incurred 12 cases of measles as of January 19, 2020, and zero deaths. In January 2020, the neighboring island country of Samoa reported over 5,700 cases of measles and 83 deaths in a population of 200,874. In the following months COVID-19 was detected in U.S. cities, prompting swift action from American Samoan's Governor at the time, Lolo Matalasi Moliga.

Governor Moliga was proactive in declaring a State of Emergency to prevent the spread of COVID-19 to the Territory by enforcing travel restrictions on all commercial flights as of March 26, 2020. The stories of COVID-19 related deaths in the world, and the impact of the disease on vulnerable populations, like American Samoa, reminded many of our citizens of the devastating effect of the 1918 Influenza pandemic in Samoa. The disease had spread rapidly through the island, resulting in the deaths of 22% (n=8500) of the population.[2] American Samoa had banned travelers in 1918 resulting in no cases of Influenza in the Territory. It was an easy decision for the American Samoa Government to apply the same protective measures between March 2020 through today.

On March 20, 2020, Jessica Fuimaono was admitted to the local hospital for life threatening injuries sustained after her husband hit her the head with a sledgehammer and set her on fire. The Alliance received an influx of calls for help from domestic violence victims as they shared their stories of violence: an increase of 71% in requests for assistance from female victims. One victim shared:

> *"I'm still stupid enough not to call the police on him even though he held a knife to my face and tried to stab me with it and he told me to open the door or he'll break it down and cut me into pieces" (personal conversation, April 7, 2020).*

The following manuscript provides a road map for disseminating information to the American Samoan community that will help victims, their families, service providers, and community advocates prevent and address domestic violence during a Pandemic. It is *our hope* that gathering relevant information regarding COVID-19, which changes on a daily basis, will help to *inform organizations* on the best way to stay safe during this and any future Pandemic. Through this project we will be developing a toolkit to be shared with the community. We look forward to sharing the toolkit as well in the near future.

In Community,

Jennifer F. Tofaeono, MHSA, MBA,
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[1] Family Violence Prevention and Services Grants to State Domestic Violence Coalitions; https://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services, 2021.

[2] The 1918 Influenza pandemic. Retrieved: https://nzhistory.govt.nz/culture/1918-influenza-pandemic/samoa

# CONTENTS

Formative Data ....................................................................................................................2

Communication Framework .........................................................................................................3

Figure 1: Communication Model

Terminology .............................................................................................................................3

Components of a Dissemination Plan ..........................................................................................4

Evidence Assessment ..................................................................................................................4

Empirical Evidence ...................................................................................................................4

Table 1: Empirical Evidence Results

Stakeholder Engagement ............................................................................................................6

Table 2: Stakeholder Engagement Results

Figure 2: Stakeholder Engagement Recap

Target Groups ..........................................................................................................................8

Figure 3: Target Audience Defined

Figure 4: In the Context of Social Stigma

Target Group Communication & Information Needs .....................................................................9

Table 3: Target Groups' Needs, Values, Motivations and Expectations

Dissemination Plan ...................................................................................................................11

Stakeholder Engagement in Planning & Execution .......................................................................11

Table 4a: Levels of Stakeholder Engagement

Table 4b: Examples of Current Alliance Stakeholder Engagement Levels

Dissemination Goals, Objectives, Strategies ................................................................................12

Figure 5: Strategies to extend 'Reach'

Table 5: Three Goals with Objectives and Strategies

Table 6: Dissemination Outcomes

Evaluation ...............................................................................................................................14

Table 7: Dissemination Tools, KPIs, Annual Objectives, and Evaluation Goals

Table 8: Data Collection & Reporting

Summary & Recommendations ....................................................................................................16

Resources ...............................................................................................................................18

## FORMATIVE DATA

The **AIM** of this Plan is to effectively disseminate the proposed Toolkit of resources to help the community, first responders, service providers and advocates address domestic violence in the context of a pandemic.

The Plan is informed by a rapid analysis of current literature presented in the document '*The Intersection of COVID-19 & Domestic Violence*' (Alliance, Oct. 2020). The **following is a summary of findings** from the literature and an illustration of the resulting framework used to understand violence in the context of a pandemic.

**Primary Findings:**
1. The increased incidence of domestic/intimate partner violence during the pandemic
2. The insurgence of dis-information, misinformation, and divisive rhetoric

**Primary themes** at the intersection of domestic violence and COVID-19: 1. Fear 2. Safety 3. Stigma

**Evidence-based solutions**:

1. Use mass media strategies to grow awareness and educate the public about the 'findings' to change ideologies e.g. social norms that perpetrate violence

2. Build advocacy and support networks for victims isolated under COVID-related restrictions

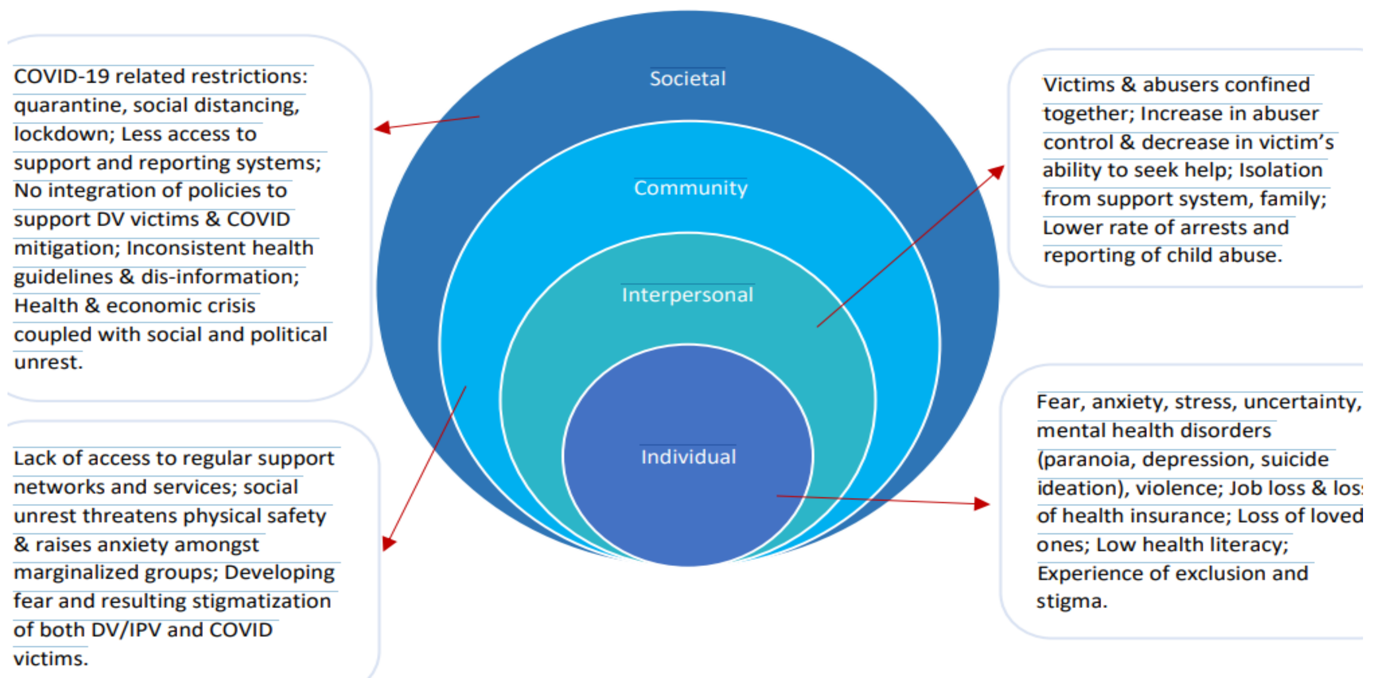
3. Build upon an inclusive framework of social norms that supports efforts to control the spread of COVID-19

4. Focus on safety planning and implementation using web-based platforms (MyPlan, iSafe) and low-tech reporting methods (code words, neighbor-watch)

5. Create coordinated access to services needed by victims of chronic intimate-partner and family violence

6. Improve surveillance of domestic violence (this could be an outcome of #5)

Socio-Ecological Framework (adapted from Sanchez, et al., 2020)[27]



## COMMUNICATION FRAMEWORK

> "*Disease outbreaks are inevitable, and unpredictable events. They are frequently marked by uncertainty, confusion and a sense of urgency. Communication is another feature of the outbreak environment. The World Health Organization believes it is time to acknowledge that* ***communication expertise has become as essential in outbreak control*** *as epidemiological training and laboratory analysis*." WHO Outbreak Communication Guidelines, https://www.who.int/csr/resources/publications/WHO_CDS_2005_28/en/.

The **course of communication** is illustrated by Brownson, et al. in the following model[2]:

Figure 1:

The model incorporates three propositions:

1. Diffusion of Innovation Theory - the 'innovation', or **message,** must communicate an **advantage over existing practices**.
2. Social Marketing Theory - applies commercial marketing principles to influence target audiences to voluntarily accept, reject, modify a health behavior because **message-based communication of knowledge alone is unlikely to lead to sustained behavioral change**[14].
3. Multiple Streams Model - asserts that '*policy makers are on the receiving end of sometimes disconnected, random, and chaotic messages*' making the **source of information critical to effective dissemination**[17,21].

In summary, effective communication incorporates innovation, engagement, and efficient delivery of empirical information. Dissemination of information involves a long-term, cyclical relationship between information sources, message producers, and the audience.

### Terminology

**Dissemination** is defined as "*the means through which information is presented to a targeted audience by means of press, TV, radio and other large-scale media, events, and online media*."[6] The **targeted audience** describes the groups of stakeholders who are interested in, or impacted by, the information presented and the reason behind its dissemination. **Stakeholders** are organizations or individuals who have an interest in the outcomes and impacts of the dissemination activity and/or the information content.

Dissemination creates and heightens awareness among the targeted audience members and stakeholders, building momentum towards positive change that can be ratified by policy makers and leaders. This Dissemination Plan aims to widely communicate the needs of victims and people at risk for exposure to domestic violence (DV) during a pandemic and promote action by decision makers to implement DV-specific protocols in response to those needs.

## Components of the Dissemination Plan

I. **Why** – the purpose of disseminating the proposed messages/information supported by evidence
II. **To Whom** – the targeted audience based on their needs, priorities, concerns
III. **What** – the message/information that can help the audiences make decisions
IV. **With Whom** – the stakeholders and Plan partners who will help and those who will benefit
V. **How** – the method of implementing based on context, protective and risk factors
VI. **When** – the timing

## Evidence Assessment: Why

The Plan is informed by both empirical research and stakeholder engagement. *(See COVID-19 Literature Review 2020 and DV Gap Assessment 2019 for detailed synthesis of information.)*

**Resource** **Empirical Evidence** **Table 1**

| Resource | Empirical Evidence |
|---|---|
| United Nations (UN) Intl. Children's Emergency Fund and the World Health Organization (WHO)[37.39] | • The pandemic has worsened existing **uncertainties and distress**.<br>• Containment measures and school closures have **isolated children and adolescents from their social networks.**<br>• Self-isolation can result in **anxiety and sleep problems among adolescents**, including because of increased screen time, irregular eating habits and reduced physical activity.<br>• Specific stressors linked to quarantine, **fear** for one's own health and infecting others, isolation and boredom, financial loss and **stigma**<br>• can lead to negative and long-lasting psychological effects, such as post-traumatic stress symptoms, confusion and anger. |
| UN[32] | "violence against women, especially domestic **violence, has intensified** due to the following exacerbating factors: security, health and money worries; cramped living conditions; isolation with abusers; movement restrictions; deserted public spaces" |
| WHO[39,40] | "priority messaging should **focus on developing targeted messaging and guidance for communities** on social distancing, home based care, self-isolation, and messaging that supports inclusion and access for persons at risk for violence." |
| Alliance for Child Protection[20] | "repercussions of COVID-19 and the strategies to deal with the pandemic have **increased risk of violence against children . . . erosion of social support** especially schools; competition for limited health resources, and partial functioning of many services for the victims of violence can increase the risk of violence." |
| JSI Research & Training Inst. (2016)[4] | "domestic violence is associated with **adverse health outcomes** including physical injuries, chronic health conditions, mental health deterioration, high risk behaviors i.e., smoking, substance use; psychological and emotional abuse." |
| UN Women[32] | "Previous epidemics illustrate the **value of engaging with women when communicating about risks** to tailor community engagement interventions. **Pressure to respond to COVID-19 cases will disrupt care and support for gender-based violence survivors**." |
| U.S. Congressional Research[12] | "In the context of COVID-19, abusers may exert further power and control over their partners because of economic and other uncertainties. Victims are more socially isolated. Changes in court standards and safety protocols further **complicate the criminal justice response and police responses to a DV incident**." |
| Su, Z. et al. (2020)[31] | "**factors influencing women's increased vulnerability to COVID-19 include elevated domestic violence**, increased mental health challenges and lack of access to healthcare services." |

The American Psychology Association's website cites ***'stress and social isolation'* as risks for DV**[1]. Researchers have found that **stress is a manifestation of the socioecological impacts of COVID-19** including job loss, perceived and actual fear of the disease itself, uncertainty of the future, reduced access to coping resources like therapies and group support[5,15]. One narrative review identified three empirical categories of precipitating COVID-related factors to DV: economic instability, alcohol and drug use, weaker women's support networks[5]. In a U.S. study (n=2045), job loss/economic stress was the COVID-related factor most associated with DV[4]. Job loss preceded financial hardship, loss of health insurance and confinement in a stressful home environment.

Mental health experts find that **domestic violence *is* an '*environmental stressor'*** and that people exposed to DV while confined in their homes with their abusers will more likely develop neurocognitive impairment[10,11]. A cross-sectional analysis of data from an online survey conducted in California (n=2081) two weeks after the state shelter-in-place order, revealed that moderate to severe mental health symptoms were experienced by 20% of respondents. Depression and anxiety were the primary health outcomes, and the amount of time spent sheltering in place was significantly associated with greater mental health symptom severity and DV[20, 25,26]. A narrative review of DV risk factors found that having a previous history of exposure or experience of violence is the most significant link to neuropsychiatric disorders reported by DV victims, describing '*stress and frustration'* as '*standard fuel for violence*'[22].

Between March and May 2020 experts documented a 7.5% increase in domestic violence related calls to police in the U.S. with the largest uptick to 9.5% occurring during the first five weeks[19]. Notably, the COVID-related social distancing mandates led to significant increases in calls from city blocks with *no* recent history of domestic violence calls. Unfortunately, the number of at-home violence cases rose by 22% while the number of arrests declined by 3% indicating that response to calls for help may often be diffused by first-responders as opposed to removing perpetrators from the home. Household stress, disruption of livelihoods, disruption of social and protective networks, limited access to support services and redirected health resources to support COVID-related healthcare will exacerbate this crisis which has earned a new name, the '***Shadow Pandemic'*** [32].

**The Role of Mass Media on COVID-related Outcomes for DV/IPV Victims**

Media is an essential mediator for health communication and plays an important role in changing attitudes and intentions and influencing health behavior. Its effectiveness in health communication lies in strong written, verbal, and visual communication strategies that can impact public views and perceptions. Media has the power to influence mindsets, behaviors, and the emotions of entire populations. Its fundamental role is to ensure accurate information is transmitted efficiently and the masses are kept well-informed[33]. In fact, a key strategic objective of the World Health Organization to manage COVID-19 is to *'communicate critical information to all communities and prevent the spread of misinformation*'[8].

During the early phases of the pandemic, January – March 2020, facts were more accurately referred to as 'BETs' or best evidence at the time[9]. Little was known, and little is known today, about the virus compared to the 'infodemic' of COVID-related publications on social and mass media. An infodemic is an *'overabundance of news mixing facts and fiction'* and is a key driver of social stigma, anxiety, and fear during a pandemic[30]. Public response is closely correlated to the amount of media coverage present[29]. As of June 2020, over 26,000 COVID-19 articles were indexed in PubMed, implying an adoption of protocols to fast-track articles to print. As of September 30, 2020, a Google search for the term COVID-19 produced over five million results. The volume of contradictory news, misinformation and manipulated data on social media is a global public health threat[29,36]. In fact, the WHO refers to **COVID-19 as a '*communication crisis'*** [39].

According to WHO Executive Director Dr. Winnie Byanyima, '*misinformation is **perpetuating stigma and discrimination***' across the globe[37]. In response, on February 15, 2020 the World Health Organization convened a virtual 'crowdsourcing' event to develop a framework for infodemic management (Tangcharoensathien, et al., June, 2020). 50 proposed actions were developed into **six Policy Implications:**

1. Information must be **science based**
2. Information must be translated into **actionable behavior change** messages
3. Messages must **be inclusive**
4. Messages must be amplified through **partnerships**
5. Messages must be monitored and **evaluated**
6. Messages should support preparedness and response to inform **risk mitigation**

An early pioneer of infodemic theory, G. Eysenbach proposed **Four Pillars of Infodemic Management**[9]:

1. Information monitoring or **info-veillance**
2. **Building eHealth Literacy** and Science Literacy capacity
3. **Fact checking** and peer review
4. Accurate and timely **knowledge translation**

Eysenbach also advises that evidence be integrated with economic and political considerations and may be subject to cultural variations and influences. He considers **eHealth Literacy** an '*essential skill'* as 72% of the U.S. population accesses the internet for news and information (Pew Research Center, Feb. 2019). Compounding the issue of volume is the '**dis-infodemic**': *misinformation* entwined with half-truths that fuel pandemic related stress (UN-ICFJ Research, 2020). False media or fake news have shaped U.S. public perspective and opinion on everything from COVID, to politics and social unrest. UN-ICFJ Research '*identifies quality journalism as a major force for identifying and exposing disinformation'* (2020).

**Evidence Produced through Stakeholder Engagement**

On November 23, 2020 the Alliance convened a virtual meeting to engage service providers and first responders in a discussion about addressing DV in a pandemic environment (N=14). Between April and September 2020, the Alliance convened five focus groups (N=37) to engage survivors of violence, church leaders, community members identifying themselves as LGBTQ, business and ethnic community leaders, and young adults averaging age 23. These groups discussed DV perpetrator accountability and in the process provided information regarding how DV is addressed in the community, who has the authority to hold a perpetrator accountable, and opportunities for intervention.

| **Resource** | **Stakeholder Engagement** **Table 2** |
|---|---|
| Focus Groups | 'Effective interventions should not single out the perpetrator or victim but rather approach them as members of a family, community and culture.'<br>'To prevent violence and help victims establish healthy, safe live, practitioners recommend placing these social issues with a cultural context.'<br>'Participants suggest that there is a difference between 'family' violence and 'domestic' violence' and one is more culturally acceptable/generational (family) than the other (domestic) prompting the need for a clear definition and visual description of what violence is in all its forms, how it impacts victims and the community, and how all violence should be prevented.' |

| | |
|---|---|
| | 'There is limited communication about violence and so it is hidden.'<br>'Violence is when home is not safe.'<br>'Victims are anyone with weaknesses, but mostly children and women; perpetrators are mostly men.'<br>Recommendation 1: support church leaders with tools and training to build their capacity to identify perpetrators, address violence early to minimize impact, and build their confidence to discuss violence in their congregations.<br>Recommendation 2: design interventions to support the family to help the victim.<br>Recommendation 3: use protective factors/cultural resources to develop effective interventions with and for men.<br>Recommendation 4: first responders and service providers must reflect on their cultural filters to avoid labeling and judgement (victim-blaming). |
| Virtual Meeting: Service Providers and First Responders | The providers agreed that violence and assault have increased during the last nine months since COVID started, specifically drug-related violence.<br>School and social activity closures have isolated youth and impacted their 'drive towards drug dealers and gang related interactions as substitutes for normal communication and to fill the need for social belonging.'<br>'importance of involving safe practices with children for COVID as well as family safety by teaching children to recognize unsafe situations and raising awareness in the school.'<br>'need to engage the older youth and adults in the community to make them aware of DV, be able to identify the signs, and talk about the issues – partnership with the schools is key' |

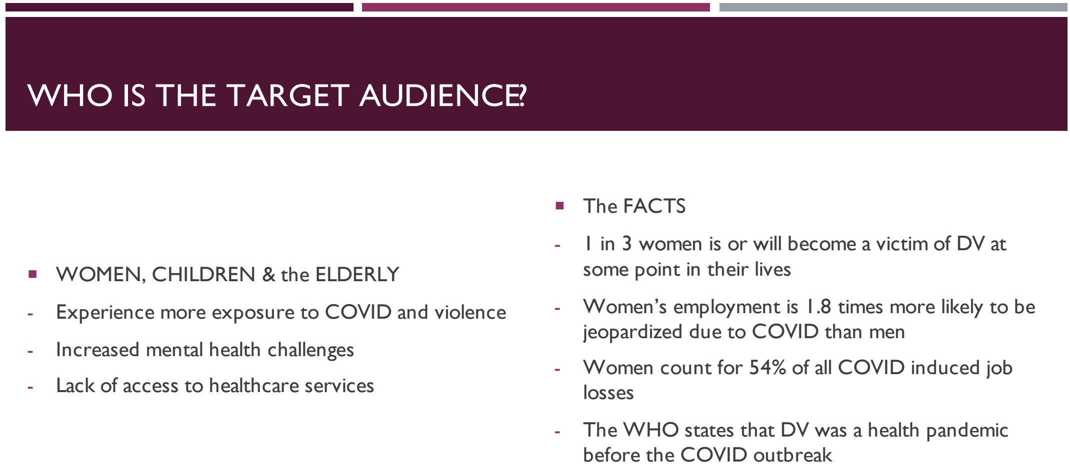
The following is a **recap of the Stakeholder Engagement Findings**:

Figure 2

## Evidence Assessment: To Whom and in What Context

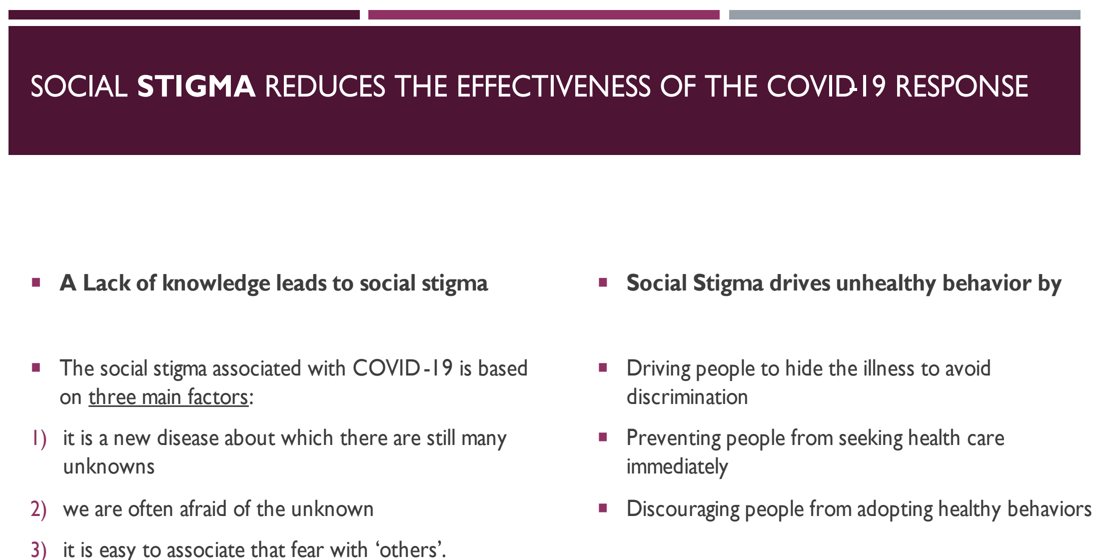
**Identifying the Targeted Audiences**

Figure 3




The empirical evidence points to women, children and elderly as the most vulnerable to violence with or without a pandemic. The **victims are *'anyone with weaknesses',*** which describes the impact of cultural power dynamics, and interdependence. This points to two important groups who should be targeted in the context of the local environment: individuals in political and cultural power (decision makers and leaders), and those who can advocate on behalf of those at risk i.e. peer leaders, sports coaches, church groups, healthcare providers, social services advocates, et cetera..

Figure 4




Stigma is what the victim feels, and what the accuser projects. It comes from a **lack of knowledge** and a **lack of empathy**. Stigma comes from our mindset of labeling danger and socially unacceptable conditions with specific people.

In the same way that stigma reduces the effectiveness of the COVID-19 response, stigma also reduces the effectiveness of services created to help those victimized by violence. **Stakeholders state that confidentiality is a critical concern in the local community.** Stigma perpetuated through the common practice of 'faitatala' or gossiping can be a barrier to community engagement and effective communication. **Dissemination efforts must protect victim and service user safety**. 'Cultural Safety' is a strengths-based construct which aims to subvert unequal power relations by building trust[16].

## Evidence Assessment: What (context: audience needs/values/motivations and expectations)

**Table 3**

| Target Group | Specifics | Target Groups' Needs, Values, Motivations, Expectations | | | |
|---|---|---|---|---|---|
| | | Needs | Values | Motivations | Expectations |
| Community | general public focus - all ethnicities | multi-lingual, visual presentation of info, easy to follow instructions for violence prevention and safety planning; service contact info is valid and services presented are available as advertised | info provided from two perspectives: Victims & Bystanders focusing on a collective approach i.e. 'our problem', 'we hurt'; empathy, safety, social connectedness | to be strong and healthy, protect community, family and culture | info disseminated in multi-lingual formats, easily accessible, visual, clear messages and instructions on how to access services; services are available as promoted and they experience an appropriate response PRODUCTS: social & mass media, Podcast, newsletter, Summit |
| Adults age 18+ | general adult population age 18+ w/emphasis on women | multi-lingual info that clearly illustrates what services are available, how to access services, how to protect self and family from violence in a pandemic environment | promote empathy, resilience and self-reliance, family; trust in providers and first responders | achieving wellbeing, resilience, safety and protection of their children | info disseminated in multi-lingual formats, easily accessible, visual, clear messages and services are available as promoted; focus on sheltering, safety and health PRODUCTS: same as community |
| Youth | general youth population age 12+ w/emphasis on teens & young adults | info on how to communicate with adults/parents; alternatives to unhealthy social activities esp during lockdown; info on how to deal with depression, isolation; how to protect oneself from violence | promote empathy, resilience, family, creativity, connectedness | achieving a sense of wellbeing and self-reliance, feelings of achievement | approaches to youth that focus on their voice - adults listening instead of talking; respect; opportunities for learning, engagement, leadership PRODUCTS: social media, youth workshops, Summit |

**Table 3 continued**

| Target Group | Specifics | Target Groups' Needs, Values, Motivations, Expectations | | | |
|---|---|---|---|---|---|
| | | **Needs** | **Values** | **Motivations** | **Expectations** |
| service providers | DHSS, CSS, DOH, DOE, TAOA, NGOs | practical technical info to support their services, training, referrals to their services, media products they can adapt and promote | promote empathy, cultural respect, family, social connectedness | achieve org goals, keep clients and general public safe, prevent violence | relevant technical info provided in a timely, accessible way to help them achieve their goals PRODUCTS: newsletter, mass media, participate in Podcast, Toolkit |
| first responders | EMS, DPS, CPS, LBJ | technical support and training to develop appropriate polices and protocol to address DV in pandemic environment; facilitating collaboration with service providers and decision makers | promote empathy, cultural respect, family, social service, victim-focused response | ability to resolve each incident successfully, prevent violence | relevant technical info provided in a timely, accessible way to help them achieve their goals PRODUCTS: training workshops, media explaining their services, participate in Webinar |
| decision makers, leaders | Faife'au, faipule, pulenu'u (OSA), youth sport coaches, church youth leaders, Intersections' peer leaders, DWYA program facilitators, DOE NHS | relevant prevention strategies presented in action-based terms, brief interventions adapted for their use with their target audiences to promote safety and violence prevention | strengthening and protecting community, women and youth | to be able to implement interventions that improve the lives of those they serve (community, family, youth, women) | relevant, low/no cost interventions and training info; culturally appropriate strategies PRODUCTS: policy briefs, youth workshops, community talanoa with pulenu'u, faipule |

## Dissemination Plan: With Whom

**Stakeholder Engagement in Planning and Execution**

Meaningful stakeholder participation drives and sustains any effort to change the status quo. The following illustrates the various levels of stakeholder engagement and the prospective number of participants to achieve meaningful stakeholder impact:

**Table 4a: Stakeholder Engagement Defined**[13]

| **Level of engagement:** | **I** Stakeholder given info (passive) | **II** Stakeholders are consulted (listening) | **III** Stakeholders engage in dialogue with the Alliance (two-way process) | **IV** Alliance activities are driven by stakeholder (proactive) |
|---|---|---|---|---|
| **Engagement approach:** | Inform via public media, published reports, newsletters | ***Listen to stakeholders*** through formal meetings; ***hear their view*** through surveys, interviews | Hold focus groups and provide feedback; ***use stakeholder driven performance measures and reports*** | Set up a stakeholder council to allow representatives in management access; ask for stakeholder verification of reports |
| **# Stakeholder participants:** | **Community-wide** | **Purposively selected stakeholders** | **Limited # of key stakeholders** | **Very limited # of key stakeholders (top decision makers)** |

Based on the descriptions in Table 4a, the Alliance's stakeholder engagement extends through all four levels. **Table 4b: Examples** of **CURRENT** engagement levels include the following:

| **Level of engagement:** | **I** Stakeholder given info (passive) | **II** Stakeholders are consulted (listening) | **III** Stakeholders engage in dialogue with the Alliance (two-way process) | **IV** Alliance activities are driven by stakeholder (proactive) |
|---|---|---|---|---|
| **Stakeholder Groups** | General community; 1st responders DPS, EMS, LBJ, DOH | DV Victims, LGBTQ, Church & Youth leaders, Service Providers (AG, DHSS,), Faipule | TAOA Admin., ASCC Admin., AG's Victim Advocates, CSS, Intersections, Faife'au, Youth Summit Committee | Alliance Board, SOFIAS, Community Advocates |

This dissemination plan incorporates feedback from stakeholders at engagement levels I and II. The Key Performance Indicators are driven by their information needs, resource use capacity and accessibility. **Table 3** lists the six Target **Groups** of the plan: **Current** engagement level (as a Group):

| Target Group | Current engagement level | Goal |
|---|---|---|
| 1. General, multi-ethnic, community | Level I | |
| 2. Adults age 18+ w/emphasis on women | Level I & Level II | |
| 3. Youth | Level I & Level II | |
| 4. Service providers | Level I & Level II | (goal: Level III) |
| 5. First responders | Level I & Level II | (goal: Level III & IV) |
| 6. Decision makers and Leaders | Level I & Level II | (goal: Level III & IV) |

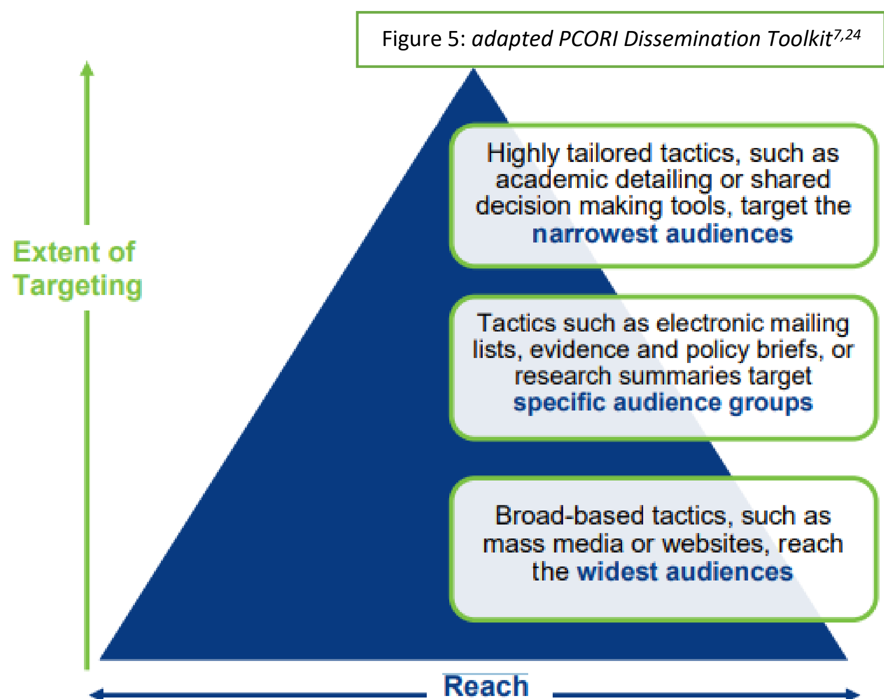
Maintaining existing partnerships with stakeholders is important but building new partnerships with the Target Groups 'First Responders' and 'Decision Makers, Leaders' is critical to implementing the Plan. Through the Alliance's various events and partnership activities individual actors in each of these groups have been identified and engaged however top-level decision makers in these organizations have not actively participated in recent violence prevention and awareness efforts. The Alliance will **promote 'meaningful' participation** by implementing the following[20,23].

- **Shift approach to integration** of stakeholder groups and their roles instead of individuals and their work
- **Shift emphasis on relationships** with stakeholder groups instead of programs, projects, and objectives
- **Shift actions towards process** rather than structures and organizations (how do the Alliance's priorities and work align with those of the stakeholder, how is the Alliance a part of the stakeholder's processes?)

## Dissemination Plan: How & When

Dissemination strategies will be defined by 'reach' and extent of the targeting. Levels I and II in Table 4b represent the widest level of reach (bottom of triangle, Figure 5), while Levels III and IV represent the middle and top areas of the triangle.

Figure 5: *adapted PCORI Dissemination Toolkit*[7,24]




Keeping in mind context, and target groups' need for accessibility to the Toolkit, capacity to use the Toolkit, and safety/confidentality when accessing and using the Toolkit, dissemination strategies will be presented to representatives from each of the six target groups via **Talanoa Tables**. In each Talanoa, the Toolkit will be presented and participants asked to respond to **two questions**: (1) what information will help them decide to use the Toolkit resources; (2) in what ways can that information be provided? Their assessment of the strategies and tools will be incorporated into the final delivery of the Toolkit.

The Toolkit will be presented to the public via a multifaceted media campaign. It will be the first of its kind in American Samoa. The Alliance's Media Coordinator will work with identified 'champions' from each target group to produce appropriate media products to demonstrate the usefulness and accessibility of the Toolkit to target group members. Professionals who collaborate with the Alliance on development of the Toolkit resources will be highlighted spokespeople as prior local research found that having information delivered by experts is more likely to be viewed as trustworthy and valueable.

First, dissemination will prioritize audiences targeted for the widest reach e.g., community, adults age 18+ over a period of six months. The evaluator will monitor the key performance indicators reported by the Media Coordinator. In month seven, or as determined by 6-month performance measures, the Alliance will target

specific audience groups with the proposed podcast, webinar, and quarterly workshops. Table 5 provides an overview of proposed goals, objectives and strategies to make the Toolkit accessible, useable, and a catalyst for improving victim safety and service provision during a pandemic.

**Table 5: Dissemination Goals, Objectives, Strategies**

| Goals | Objectives | Evidence-Based Strategies |
|---|---|---|
| 1. Make the Toolkit of resources **accessible** to the six target groups | Objective 1a: Produce the English and Samoan language Toolkit in print and digital formats<br>Objective 1b: Incorporate Toolkit resources into the Alliance's existing media plan and community engagement activities | Frame and target messaging to audience groups.<br><br>Use 'culturally appropriate communication and dissemination strategies' to mitigate the impact of disinformation, misinformation and divisive rhetoric. |
| 2. **Motivate target groups' use** of Toolkit to reduce fear and stigma, and increase safey, in the context of a pandemic environment | Objective 2a: Create awareness of the Toolkit within target groups<br><br>Objective 2b: Increase target groups' motivation to use and apply Toolkit contents<br><br>Objective 2c: Create inclusive concepts to communicate a collective 'call to action' | Create multi-lingual, culturally appropriate, plain language media messaging in multiple formats.<br>Identify 'champions' in each stakeholder group who can advocate use of Toolkit using 'narratives' and storytelling to illustrate relevance and useability.<br>Use plain language, informal education in media to build target audience capacity to use and apply Toolkit.<br>Avoid victim narratives focusing only on negative experiences - focus on positive outcomes (e.g., safe family, happy life) instead of problems. |
| 3. **Increase** target groups' level of **stakeholder engagement** with the Alliance to sustain Toolkit use. | Objective 3a: Create opportunities for Alliance to engage stakeholders in productive activities using the Toolkit<br><br>Objective 3b: Provide accurate informal education and recommendations in plain language to assist service providers, policy makers, and community leaders in planning of polices, protocols and services | Utilize diverse, culturally responsive presentation formats to increase reach.<br>Promote strengths-based interventions utilizing Toolkit resources.<br><br>Reframe pandemic-related terms like 'lockdown' and 'social' distancing to those aligned with cultural positivity i.e. 'stay safe', 'physical' distancing with social closeness. |

**Table 6** outlines the theorized **short and long-term outcomes for each goal**. Short term outcomes are relevant to change experienced by individual members of target groups such as changes in knowledge, attitudes, beliefs, and behaviors. This includes having an awareness and acceptability of the Toolkit resources, an understanding of the information, and the intent to incorporate the Toolkit into their decision-making processes. Short term changes are also evident in the use of the Toolkit to guide policies addressing DV, changes to service provider protocols, and the extent to which the Toolkit becomes an institutionalized resource. Long-term outcomes represent a shift in social norms – a

recognition of DV as a community problem and concerted efforts to access help; and overall reduction in incidence and prevalence of DV as a result.

**Table 6: Dissemination Outcomes**

| Goals | Short-Term Outcomes | Long-Term Outcomes |
|---|---|---|
| Make the Toolkit of resources **accessible** to the six target groups | Implementation of dissemination strategies puts audience in touch with Toolkit in print and/or online | Toolkit is a primary resource for DV prevention in the Territory |
| **Motivate target groups' use** of Toolkit to reduce fear and stigma, and increase safey, in the context of a pandemic environment | Individuals understand the Toolkit information<br>Individuals accept the Toolkit resources as valid means to reduce fear, stigma and increase safety | Individuals use the Toolkit to create personal safety plans<br>Reduction in DV incidence<br>Reduction in revictimization |
| **Increase** target groups' level of **stakeholder engagement** with the Alliance to sustain Toolkit use. | Individuals find the Toolkit resources to be useful, relevant, safe to engage in the topics with the Alliance and other stakeholders<br>Uptake in Toolkit inspired policies and protocols for service providers | Service providers experience an increase in number of individuals seeking their assistance<br>The Alliance receives consistent attendance and participation by target groups in its outreach |

## Evaluation

The purpose of the Evaluation is to assess the effectiveness of the dissemination strategies, and whether the objectives were properly implemented, and goals achieved. Each objective is a step stone towards realizing the goal. Each strategy is the means or approach with which each objective is implemented. **Table 7** outlines the Key Performance Indicators that represent quantitative change.

**Table 7: KPIs and Dissemination Performance Goals**

<table>
<tr><th>Dissemination Tool</th><th>Key Performance Indicators</th><th>ANNUAL OBJECTIVES</th><th>PERFORMANCE GOALS (what/how/who)</th></tr>
<tr><td>Website</td><td>Yearly visits</td><td>5000 views</td><td rowspan="6">Goal: Increase Adoption/Use and Reach of the Toolkit using the Alliance's website - a key resource for DV information made relevant for the local community during a pandemic<br>What, How: Maintain current output - monthly newsletter (ED); monthly Podcasts and Webinars (Judy); social media posts (Marilyn and Eleanor) - and Increase Reach by growing email list, and identifying ways to get partners involved with content...their awareness months, activities, etc.<br>Target Groups: Online users, adults and youth, service providers</td></tr>
<tr><td>Podcast</td><td rowspan="3">Monthly views and Monthly downloads</td><td rowspan="2">1 COVID Podcast, 1 Webinar</td></tr>
<tr><td>Webinar</td></tr>
<tr><td>Newsletter</td><td>500 views</td></tr>
<tr><td>Piloted Toolkit</td><td>Completed</td><td>1</td></tr>
<tr><td>Manuscript</td><td>Completed</td><td>1</td></tr>
<tr><td>Facebook</td><td>Yearly 'Likes'</td><td>5,000</td><td rowspan="4">Goal: double # likes & followers between Apr-Dec 2021<br>What, How: Post consistent weekly stories, with pics, informing followers of COVID actions – use story sharing<br>Target Groups: Adults age 18+, specifically women</td></tr>
<tr><td></td><td># followers</td><td>5,000</td></tr>
<tr><td></td><td></td><td>1x week COVID post</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

| Mass Media<br>Samoa News<br>KHJ/Talanei | # of releases | 12 | Goal: 12 press releases published by each of the 3 media outlets (4 pieces per outlet) What, How: narratives, education, etc. Target Groups: Adults 18+ |
|---|---|---|---|
| Policy briefs<br><br>Events | # written | 1 | Goal: Publish 1 policy briefs What, How: pandemic related policies pertaining to CPOs, sheltering, first responder protocols etc. Target Groups: first responders, leaders |
| Summit | Annual | 1 | Goal: Include Pandemic issues in annual Alliance summit What, How: Present pandemic stats, policy, etc. Target Groups: Summit attendees; online users if done virtual |
| Workshops | Quarterly | 2 | Goal: Conduct community workshops on pandemic related issues such as safety planning during lockdown, resources available, etc. using Toolkit. What, How: Using stakeholder meeting data create 1-hour workshops to educate attendees on relevant subjects and collect feedback data. Target Groups: community stakeholders |

***"Some of the most important social indicators require qualitative rather than quantitative information and these can be verified and evaluated by stakeholders"***[13]

To evaluate the Dissemination Plan, the right data must be collected for analysis**.** To understand how the desired changes materialize, the evaluator will also collect qualitative data that conveys the context, extenuating circumstances, and confounding factors. While KPIs above capture the frequency with which dissemination tools are produced this data does not reflect the acceptability and appropriateness of products and strategies across target audiences – without qualitative information the evaluator could only *assume* KPIs were met, or unmet, because of these and other attributes. **Table 8** presents the means with which Dissemination performance data will be collected to ensure quantitative data is understood in the appropriate context.

**Table 8: Data Collection Plan**

| Dissemination Tool | Data Collection Tool | Data Collection Method |
|---|---|---|
| Website | Web analytics | On the last day of each month, the Media Coordinator will download and report the web analytics for the website, including the newsletter, the podcast and webinar. Specifically, number of views, downloads, shares for each product posted. |
| Podcast<br>Webinar<br>Newsletter<br>Toolkit<br>Manuscript | Quarterly Talanoa with representatives of each Target Audience Group | The evaluator and Program Specialist will conduct quarterly Talanoa with individuals who represent each Target Group (1 group/month with up to 12 participants or 2 per Group). Group discussions will be guided by 2 primary questions: 1) what information helped them decide to use the Toolkit resources and which resources were most helpful; (2) in what ways can the Toolkit be improved? After the first 6 months, the Talanoa questions can be modified to discover user outcomes. |
| Facebook | Social Media Analytics | Review month-end social media analytics reporting; examine feedback and comments on social media posts and analyze to identify what info is resonating with audiences, what are the info needs and gaps, what audiences are not being engaged |

| Mass Media | | |
|---|---|---|
| Samoa News KHJ/Talanei | Web Media Analytics | Reader responses to online posts of the articles submitted to Samoa News, KHJ/Talanei will be reviewed at month end by the evaluator. Frequencies for PSAs and other products for radio will be counted by Media Coordinator. Messages will be presented to Talanoa groups and feedback collected on whether they heard/read the products, reflection and impact of message on their personal decisions/actions. |
| Policy briefs | User feedback – KI interview | The evaluator will assess distribution and impact of policy brief through feedback from target group representatives using 'quest-erviews' in person, virtual or via email. Follow up on actual policy changes will be documented. |
| Events | | |
| Summit Workshops | Participant feedback - survey | Evaluator and Program Specialist will develop brief post-event surveys to collect immediate feedback, and follow up with key informants six months later to identify impact on participant as a result of attendance and info retainment. |

**Data Assessment and Reporting**

Data assessment activities will merge with the existing Alliance program evaluation plan. The Alliance's Media Coordinator and Program Specialist are responsible for data collection with support from the evaluator. The evaluator is responsible for data assessment and reporting. Dissemination and implementation plan evaluation will be reported with the annual Alliance program evaluation.

In addition to identifying successes, the data assessment will also identify which issues and which at-risk populations are not participating in online conversations, the Summit and Workshops, which groups are not being exposed to mass media and therefore missing opportunities for education and connectedness with service providers. The Talanoa discussions will be key data gathering tools, representative of the Target Groups. Gender gaps, age gaps, and information needed but missing on social media will be identified and all data will inform the iterative process of improving the information disseminated and the processes by which it is shared.

## Summary

Six Target Groups are identified through the literature review and the Alliance's program assessment activities. The **Dissemination Plan aims to communicate the following**:

- Why Target Groups should use the Toolkit – advantages, disadvantages, risks, costs, benefits associated with content and applicability to their decision making;
- What sections/tools/info should be marketed to which specific end user groups.

How will the **audiences receive information** about the Toolkit?

- Through **tailored strategies targeting the audience** environment
- **Multifaceted strategies** to increase accessibility and exposure to dissemination messaging
- **Meet end users in their environments** and providing tools that translate well to the user's context and make it easier to use
- Use practices that are relevant to users in the American Samoan setting.

What will be **the message**?

- Messages to address factors that may help or prevent adoption and use of Toolkit
- Messages that motivate decision makers/leaders to adopt Toolkit (i.e., integrate toolkit into everyday work protocols etc.)
- Messages that explain why the Toolkit is important, how does it affect providers' work, community, and individual lives.

### Recommendation for Stakeholder Discussion

- The Alliance's Board of Directors comprises a diverse group of community perspectives, social and cultural connections, and professional skills. These are assets which should be utilized more fully in the Alliance's efforts to reach the target audience groups. '**Utilizing the Board of Directors'** is the primary recommendation for effective dissemination and implementation of the Toolkit.
- **Use evidence-based marketing strategies adapted for culturally responsive communication to American Samoans** in general using mass media, and at-risk groups (women, youth, LGBTQ, minorities, etc.) using personalized methods featuring 'champions' they can identify with and relate to.
- The WHO and UN predict that COVID-19 is not the last pandemic. The Alliance can **leverage the current high-profile media coverage and extenuating social circumstances** to draw attention to domestic violence incidence and prevention.

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