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Methodological and Ethical Considerations in Research With Immigrant and Refugee Survivors of Intimate Partner Violence

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Abstract

To promote safe and positive health outcomes by utilizing culturally relevant evidence-based interventions for immigrant and refugee women survivors of intimate partner violence, their active participation in research is critical. With 43.6 million immigrants and refugees living in the United States, there is a need for research studies to eliminate health disparities in these populations. However, barriers to recruiting and retaining these populations in research prevent the provision of quality and culturally informed services to meet their needs. The aim of this article is to discuss the recruitment and retention strategies employed and analyze the methodological and ethical challenges in the context of the weWomen Study. The use of a multifaceted approach informed by best practices maximized recruitment efforts and active participation that generated high numbers of immigrant and refugee women participants. The study also substantiated the need for more community-based participatory approaches to engage community members in the development of culturally appropriate approaches that instill a sense of ownership over the research process. Active research participation of immigrant and refugee survivors will help investigators understand their unique needs and facilitate the implementation of targeted evidence-based interventions.

Keywords

African; Asian; evidence based; Latin American; recruitment; women

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Introduction

Immigrants and Refugees in the United States

In 2014, the number of immigrants in the United States was estimated to be 43.6 million, a rise of 30% since 2000, and a number that included more than 11 million undocumented immigrants (Pew Research Center, 2017). Besides, there have been three million refugees in the United States since the Refugee Act of 1980 and the Resettlement Program was established (Pew Research Center, 2017). The number of refugees admitted to the United States has also risen (53,691 admitted in 2017), with 80% of new refugees coming from the Asian and African countries (Mossaad, 2019). Given the increasing numbers of refugees, and in particular, those from Asian and African countries, there is a critical need to address the research challenges and implications in the recruitment and retention of immigrants and refugees (Shedlin, Decena, Mangadu, & Martinez, 2011; Wang et al., 2014). Addressing these challenges would maximize their active research participation to inform evidence-based interventions.

Multiple reasons spur the migration of people into the United States, including political anarchy, instability from civil wars, atrocities, human rights abuses, and economic need. These negative consequences require holistic approaches to address the unique needs of immigrants and refugees (Katigbak, Foley, Robert, & Hutchinson, 2016; Mose & Gillum, 2016). To address these needs, it is important to recruit immigrants and refugees in research to inform the development of culturally appropriate evidence-based interventions to promote positive health and health-related outcomes.

Risks, Vulnerabilities, and the Need for Culturally Relevant Evidence-Based Interventions

Poor health and related outcomes for immigrants and refugees lead to the disproportionate burden of diseases and an increase in health disparities, which result in undue U.S. health care costs. The costs have been estimated at more than US\$4 billion, although, overall, immigrants and refugees tend to use medical care less frequently than American-born citizens (Flavin, Zallman, McCormick, & Wesley Boyd, 2018; Heiniger, Sherman, Shaw, & Costa, 2015; Zallman et al., 2013). As immigrant and refugee women acculturate into the United States, their experiences differ, thus negatively influencing their ability to adapt to multiple stressors. Specifically, these could include acculturative stress, economic challenges, discrimination, social isolation, linguistic barriers, limited knowledge of available health resources, as well as limited access to health care compounded by undocumented status (Gomez et al., 2010; Levels, Dronkers, & Jencks, 2017; Panchang, Dowdy, Kimbro, & Gorman, 2016). Undocumented status in the United States, social isolation, and linguistic barriers, and low economic status put immigrant and refugee women at heightened risk for intimate partner violence (IPV) (Sabri et al., 2018). Sabri and colleagues (2018) in their formative research work also substantiated these multifaceted and interrelated vulnerabilities that put immigrants and refugees at risk for IPV. Similarly, acculturative stress and social isolation, having limited social connections with people in their home country, can increase conflict between intimate partners, increasing women's risks for IPV (Uehling, Bouroncle, Roeber, Tashima, & Crain, 2011). The stressors experienced by immigrants and refugees compounded by the IPV experiences substantiate

the importance of addressing their needs using evidence-based interventions (Katigbak et al., 2016; Mose & Gillum, 2016), which can be achieved through their participation in research studies.

The Inclusion of Immigrant and Refugees in Research Studies to Inform Evidence-Based Interventions

The risks and vulnerabilities of the women survivors of IPV lead to enormous costs on the U.S. health care system because of the needs for support, services, and care from IPV consequences such as HIV infection, and poor mental and physical health (Black et al., 2011; Campbell, 2002). Abused immigrant women have similar vulnerabilities to American-born women survivors. The major difference is that for foreign-born survivors, these experiences are compounded by multiple unique challenges such as fear of deportation and/or losing custody of their children further preventing their willingness to report the abuser (Sabri et al., 2018; West, 2005). Also, immigrant and refugee women might have a higher rate of IPV because women come from cultures that normalize violence with limited to no response from enforcement and legal services in their home country (Sabri et al., 2018).

The inclusion of immigrant and refugees in research studies is critical because active participation would inform the implementation of evidence-based interventions to address their unique needs. It is important that researchers first understand IPV survivors' realities to design effective and sustainable health interventions for positive outcomes (Ibrahim & Sidani, 2014). In doing so, investigators encounter many difficulties when accessing IPV survivors for research because of survivors' mistrust of researchers and service providers (Ibrahim & Sidani, 2014). This has led to a broad array of terms, often used interchangeably to describe the difficulty in accessing survivors: "hard to reach," "hidden," "underrepresented," or "underserved" are some of the common terms. It is important to note that investigators use these terms to describe other groups such as gangs, injection drug users, and men who have sex with men (MSM)(Burt, Hagan, Sabin, & Thiede, 2010; Muhib et al., 2001; Petersen & Valdez, 2005). In this article, we use "hidden population" specifically to refer to immigrant and refugee survivors of IPV. In addition, "hidden population" denotes a general inclination among immigrant and refugee groups to keep health-related affairs private or hidden. Hidden is more appropriate now given immigrants' need to hide from Immigration and Customs Enforcement (ICE) officers in the current political environment. Hidden populations often hide from authorities and may, therefore, be afraid to access health care and other related services (Mervosh, 2019; Mose & Gillum, 2016; Shedlin et al., 2011). Immigrant and refugee women survivors of violence may consider researchers as outsiders and prefer not to share their personal experiences. Their voices and experiences remain "hidden" unless targeted and tailored strategies are employed. To increase active participation in the weWomen study, investigators employed multiple strategies to recruit immigrant and refugee women, which are discussed in this article.

The weWomen Study

The weWomen Study (1 R01 HD081179 01A1; <https://wewomen.nursing.jhu.edu/home>) is a multisite, multiphase study for immigrant and refugee women who have experienced IPV.

The aim of the weWomen Study is to develop and test the adaptation of a culturally tailored risk assessment tool for immigrant and refugee women to empower women to increase their safety, promote healthy relationships, and reduce negative mental health outcomes. Furthermore, the study aims to evaluate the impact of the culturally adapted safety planning decision aid on safety, mental health, and empowerment for women from diverse geographic regions including Africa (Ethiopia, Nigeria, Democratic Republic of Congo, Angola, Uganda, Rwanda, and Burundi), Asia (India, Philippines, Laos, and Thailand), and Latin America (South and Central America). There are two phases of the weWomen study: Phase 1 was a qualitative study in which we conducted in-depth interviews with 84 women from the stated regions and conducted focus groups with their service providers (Sabri et al., 2018). We used the data generated from Phase 1 to inform the weWomen intervention for immigrant and refugee women, which is an adaptation of the myPlan App (<https://www.myplanapp.org/home>) developed by Glass and colleagues. Phase 2 is an ongoing randomized control trial (RCT) to test the effectiveness of the adapted safety decision aid (that includes the culturally relevant Danger Assessment Instrument [<https://www.ncjrs.gov/pdffiles1/jr000250e.pdf>], safety and resource priority setting, and tailored safety action plan). We published findings from Phase 1 and the study protocol for Phase 2 in two articles (Sabri et al., 2018; Sabri et al., 2019).

The objective of this article is to discuss the recruitment and retention strategies employed with immigrant and refugee women survivors of violence and analyze the methodological and ethical challenges in the context of the weWomen study. We anticipate that the strategies and experiences shared will inform and optimize recruitment efforts by other investigators and service providers with similar interests in improving the health and safety of immigrant and refugee women.

Method

Study Design, Sample, and Data Collection Procedures

We completed the qualitative phase of the study in 2017 utilizing the interview data to inform a culturally relevant and replicable weWomen safety decision aid. The weWomen study is currently in the RCT phase. We refer readers to the publication by Sabri and colleagues (2018) for details of the demographic characteristics of the sample and data collection procedures. We obtained institutional review board approval for all study-related activities and from all participating home institutions.

Recruitment, Retention Challenges, and Strategies

To maximize recruitment efforts, we leveraged diverse and multiple recruitment methods, including phone calls, flyers, online platforms (social media, newsletters, and media outlets), in-person recruitment (personal invitations, snowball technique, referrals, and formal and informal networks), and through community partner collaborators (resettlement organizations, women's refugee health clinics, and faith-based social service organizations). Also, multiple sites were used for data collection with a primary focus on the communities where immigrant and refugee women congregated or sought help (health centers, churches, immigration offices, English as second language classes, and social centers where cultural

activities are held). We also recruited at grocery stores, hair salons, libraries, and schools frequented by the target population.

One of the primary challenges encountered in recruitment and retention was the language barrier. An important component of recruitment and data collection processes was translating or interpreting study-related materials in participants' preferred language while ensuring semantic equivalency. Also important was involving language-concordant research team members—bilingual or bicultural recruiters, and research assistants. To address the cultural and linguistic differences of the participants, investigators trained the research assistants, and community partners who were fluent in the languages represented by the women. Onsite interviews conducted with the use of interpreters took twice as long because relying on the expertise of the interpreters was essential to maintain context and details as immigrant and refugee women told their stories. In Phase 2, study materials were translated into six different languages (Spanish, Arabic, Hmong, French, Swahili, and Somali). Nevertheless, language barriers persisted, as some women could not read in their native language causing a major challenge. Women utilized their mobile devices and did not have immediate access to bilingual staff to assist in navigating the weWomen online platform.

In addition to the need for cultural and linguistic considerations, investigators accounted for the multilevel influences unique to immigrant and refugee women survivors. To this end, the research team remained informed of the evolving national immigration policies, transportation, low literacy, and education needs of the women. For example, regarding transportation needs, we interviewed participants at their location of choice they deemed safe and convenient. We also had to consider high dollar amounts for participant incentives as appropriate, and provision of fare for transportation, and meals. We combined the costs with the participation incentives to increase their interest and participation.

We also utilized the help of community and religious leaders to facilitate participant recruitment. We collaborated with community organizations, facilitated meetings, and presented the study to staff and stakeholders to gain trust and support for the study. Extra costs also entailed compensating our recruiters for successful participant enrollment. Having collaborators and team members who were intimately knowledgeable about immigrant and refugee communities provided the weWomen study increased visibility and credibility as a safe intervention for the women to use. The increased visibility and credibility also allowed the women to feel comfortable in sharing information about the weWomen study with their social networks, with some women referring their mothers, daughters, and friends. One of the sites in the southwest region of the United States collaborated with service program members to collect data. Our research and community collaborators trained and assigned community volunteers to assist with recruitment and data collection processes as well as strengthened relationships with community members. Their sustained presence in the agencies ensured prolonged engagement in the community. These programs have access to mobile devices onsite to ensure that women participants had safe access to enroll in the study and during follow-up time points to complete study-related activities, which further enhanced retention.

Developing and nurturing trusting relationships with women participants and community partners were essential retention strategies for our longitudinal RCT weWomen study. In our efforts to maintain long-term contact with our partners, we conducted weekly phone calls and sent email messages in-between data collection times to stay connected and keep our partners and participants motivated and engaged. It was also important to demonstrate our interest in the community and potential participants' well-being by referring them for needed services as appropriate. Similarly, the methods that assisted with study recruitment also aided with retention for Phase 2. Many of the women felt comfortable reaching out to the research team by email to discuss problems while navigating the online study platform, receiving incentives, and referring friends. In addition, women contacted their referring organizations to contact the weWomen staff, particularly if the participant was a nonnative English speaker.

Although we utilized a multi-prong approach to participant recruitment and retention that were evidence based and found to be effective, enrollment and retention of immigrant and refugee participants were extremely challenging.

Methodological and Ethical Challenges and Strategies

Having to respond to funder's requests for outstanding and progress reports placed an enormous burden on investigators. At a time when immigrants and refugees fear being accosted by the U.S. ICE Officers, our recruitment efforts were even more challenging. Specific examples include women who were afraid to provide email addresses or any contact information fearing that ICE would find them. It was a difficult situation for us even though we obtained a Certificate of Confidentiality (CoC) for the study. A CoC is a document issued by the National Institutes of Health and other Federal agencies to prevent forced disclosure of identifiable participant information. It offers a second level of protection in addition to the institutional review board approval.

Another challenge was the fear, misconceptions, and limited understanding of the U.S. laws and their responsibilities in research, which some might perceive as coercive, but construed as mandatory by immigrants and refugees. The notion of perceived coercion is important for immigrants and refugees given that some might have experienced human rights abuses in their countries of origin. Clear and simple explanations are important to ensure that potential participants fully understand the concept of voluntary participation. In addition, the engagement of community leaders was helpful in these situations. Nonetheless, if not implemented carefully, engaging leaders could lead to coercion. For example, if community leaders request participation directly, participants might be uncomfortable refusing someone in a position of power, particularly in communities where the women receive support.

Some participants preferred verbal instructions to complete study-related forms. Given participants' low literacy level, providing study information in audio albeit expensive is a viable option that we discussed during our weekly team debriefing meetings. It is an enhancement that would have potentially increased participant enrollment; nonetheless, it was not implemented because of budgetary constraints. Instead, we relied on research staff and collaborating organizations to assist.

We also encountered challenges administering the Amazon electronic gift cards as participant incentives. Our community partners reported that participants had a preference for physical visa gift cards or Walmart gift cards, which were easier for them to use and more accessible. For example, participants could not access the electronic gift cards online even with written instructions and some did not have email addresses to receive the link for the gift card. Some women reported to our partners and communication with the research team that they feared opening an email account because of ICE.

Another important challenge was the Internet connectivity with Wi-Fi at the data collection sites, further limiting recruitment efforts. Additional challenges included the two-factor authentication process that we implemented to limit online scammers. The validation process consisted of a combination of email and text messaging. Women had to provide a valid phone number to receive a validation code allowing them to proceed with the registration and enrollment process. Approximately three months following the implementation of the validation process, we recognized that some participants failed to return to complete the registration process. Furthermore, because often the women used Voice over Internet Protocol, the decision was to validate them manually, which also required additional wait time for participants to be enrolled in the study. Unfortunately, this resulted in losing momentum for participants to proceed with the enrollment process, particularly during the onsite recruitment, thus limiting the total number of participants we would have accrued.

In the community-based resettlement settings, we experienced barriers with screening and disclosure of IPV due to lack of trust, stigma, and religious barriers among newly arriving immigrants and refugees. Community partners from the resettlement organizations reported a strong negative connotation related to partner violence because many women preferred not to disclose abuse to service or health providers. In many instances, women told the providers that it was “*Haram*” (bad) to discuss marital problems and their “*Hadith*” (religious beliefs) prohibited such disclosures. Therefore, our community partners found it challenging to ask the women screening questions about their intimate partners.

In addition, we encountered difficulties related to agencies’ lack of capacity to implement the weWomen study to their incoming clients due to logistical difficulties and the lack of resources. Our partners explained that the lack of sustainable culturally appropriate and viable alternatives for survivors beyond the limited temporary services also presented barriers to IPV screening and disclosure of IPV experiences.

Discussion

In this article, we reported the recruitment and retention strategies utilized in the weWomen study as context to analyze the methodological and ethical challenges related to involving hidden populations in research studies. The strategies we used were best practices supported by a substantive body of evidence. Our team of investigators has been creative in maximizing recruitment and retention strategies given the critical need for immigrant and refugee women experiencing IPV to be represented in research studies. Despite our best

efforts and commitment to complete the study successfully, we continue to encounter insurmountable challenges that have extended our recruitment period.

Weekly team debriefing meetings provided a forum to share challenges the research team encountered and brainstormed strategies to counter the multiple, sometimes, overwhelming obstacles, which we addressed in this article. In spite of the multi-prong recruitment and retention strategies to engage immigrant and refugee women, the process was difficult and arduous. Recruitment challenges were further compounded with national conversations around documented and undocumented immigrants, and the evolving federal policies.

To increase participant recruitment, researchers expanded their enrollment criteria when they encountered challenges that interfered with recruitment targets. For example, Blanchet and colleagues (2017) added Anglophone mothers to their study at the midway mark to bolster enrollment, although they had originally sought to recruit participants of African and Caribbean descent. In our study, we increased the time during which prospective participants could have experienced IPV to allow for an expanded reach in enrolling participants. Although we did not conduct a comparison analysis to determine the number of participants before and after this was implemented, more women were eligible to join, which resulted in increased enrollment numbers. Online venues also provided opportunities to connect with a network of people in cultures that participants can identify (Carlini, Safioti, Rue, & Miles, 2015). Perceived as a “safe” platform, online venues allow immigrants and refugees to connect with others and extend their networks; find valuable information related to jobs, legal counsel, and other relevant information; and remain “hidden” behind mobile devices and computers. Hidden in the online platform provides anonymity for participants and increases the chances for their active participation because the pressure of being watched or seen is limited or nonexistent. In addition, the online platform offers participants the flexibility to access the intervention at their convenience making it easier for them. Almost half (41%) of the participants in one study were recruited from online or social media platforms (Carlini et al., 2015), and in others, investigators recruited up to 70% of participants through online methods (Carlini et al., 2015; Ibrahim & Sidani, 2014). Unfortunately, when we posted information about the weWomen study online, study materials were accessed by scammers, which caused illegitimate study registrants that had to be manually removed by our team. Technology-based strategies and venues are an important recruitment tool, but caution must be used with multiple validation processes in place (Carlini et al., 2015; Dewitt et al., 2018).

The use of the automatic translation of messages into other languages that are integrated into social media and other communication software also makes the online platform a versatile medium to attract hidden populations. The challenge, however, is the potential absence of semantic equivalency in the misinterpretation of statements and the resultant poor-quality data.

In addition to online recruitment strategies, our team used the personal contact strategy to strengthen trusting relationships with community collaborators and potential participants—viewed in the literature as an important step in successfully recruiting and retaining hidden populations (Blanchet et al., 2017; Martinez, McClure, Eddy, Ruth, & Hyers, 2012).

Community engagement through events and presentations demonstrated high participation rates in some studies (Chan & So, 2016; Martinez et al., 2012). In the weWomen study, we reimbursed our collaborators to conduct intensive recruitment efforts and engaged the community through snowball sampling techniques. Researchers found the importance of engaging community members to develop social connections and cultivate trust (Burnette & Sanders, 2014; Buseh et al., 2017; Hernandez et al., 2019; Javier et al., 2019; Reiss et al., 2014). Community advisory boards have also been found to be highly effective in establishing the engagement of the community to not only maximize recruitment efforts but also build long-term relationships (Javier et al., 2019; Njie-Carr, Jones-Parker, Massey, Baker, & Nganga-Good, 2018).

The length of the study questionnaires was a barrier, so the team spent ample time iteratively reviewing and determining sections on the questionnaires that needed to be eliminated to mitigate participant burden. Chan and So (2016) reported that the number one reason women declined to participate in their study was the length of the questionnaire (24.3%, $n = 115$). Researchers should be cognizant of the importance of optimizing measurement items to reduce participant burden, particularly given the need to investigate multiple intersecting factors to increase understanding of the needs of hidden populations such as immigrant and refugee survivors of IPV. Investigators must tailor the questionnaires to capture relevant concepts central to the research questions to mitigate burden and for successful recruitment and retention of study participants.

Periodic phone calls in-between data collection time points, as a means to motivate and to stay in contact with study participants, is an important retention strategy. Given its importance, investigators should inform regulatory agencies and institutional review boards of the need for “check-in” calls, its role in facilitating project timelines, and ensuring that the health needs of hidden populations are better understood through their long-term participation in research studies.

Cultural and linguistic considerations are important in the recruitment and retention of immigrant and refugee populations in research. The weWomen study, among many other studies (De La Rosa et al., 2012; Giarelli et al., 2011), reported translating study-related materials in participants’ preferred language or utilizing trained interpreters. This strategy was not surprising due to the extensive language barriers and because typically the first step to tailoring study-related materials for cultural relevance is the translation of materials. Achieving semantic equivalence is essential in the cross-cultural translation of study materials (Gabriel, Kaczorowski, & Berry, 2017; Kyriakakis, Waller, Kagotho, & Edmond, 2015; Njie-Carr, Adeyeye, Zhu, Sanneh, & Ludeman, 2018). However, we found varying degrees in the level of detail provided by investigators when reporting the cultural adaptation of their study materials. For example, the study by De La Rosa and colleagues (2012) was very detailed and provided substantive information related to these efforts. Carlini and colleagues (2015) discussed the use of surface structure adaptation through the inclusion of the Brazilian flag and translating to spoken language. While variation in the reporting is diverse, ensuring semantic equivalence is critical to obtain quality data.

While written study recruitment materials in the languages of participants were found to propagate enrollment, this strategy failed to address mistrust of researchers, which was an important barrier in studies with hidden populations (Ibrahim & Sidani, 2014). Therefore, community partnerships and collaborations are important to develop trust, including the engagement of key stakeholders and leaders from the community (Choi, Heo, Song, & Han, 2016; Gabriel et al., 2017; Hernandez et al., 2019; Javier et al., 2019; Katigbak et al., 2016; Njie-Carr, Jones-Parker et al., 2018; Sheehan et al., 2016; Wang, 2014). In addition, we trained bicultural and bilingual team members to support recruitment efforts, which is consistent with other studies (Blanchet et al., 2017; Choi et al., 2016; Lara-Cinisomo, Plott, Grewen, & Meltzer-Brody, 2016; Reiss et al., 2014). Data collectors from the same cultural and linguistic background helped increase recruitment efforts. It was also important to demonstrate an interest in participants' overall well-being (e.g., the need for health care and immigration support) beyond the interests of the research study. Maintaining connection throughout the research process and providing referrals for resources were important considerations for the recruitment and retention of abused immigrant and refugee women.

Furthermore, it was important to address some ethical challenges in working with immigrant and refugee survivors of IPV. These include considerations of factors beyond the usual protections to confidentiality such as deportations and impact on children. Other strategies may include a waiver to the signed consent form, limiting personal information that would link participants to signed consent forms, providing cash incentives, and obtaining a CoC.

The time commitment in research studies is an important barrier for immigrants and refugees. To mitigate this barrier, other researchers (Gabriel et al., 2017; Hanza et al., 2016; Lara-Cinisomo et al., 2016) budgeted for extra expenses such as hiring more recruiters or research assistants, higher incentives, and providing meals, child care, and transportation costs as we did in the weWomen study. In addition, with a better understanding of the needs and concerns of immigrants and refugees through their participation in research, health care providers will be better prepared to tailor clinical practice and services that are culturally relevant and sustainable.

Our study also substantiates the need for more community-based participatory approaches by engaging community members (e.g., ambassadors, mobilizers, cultural navigators) to develop culturally appropriate approaches to intervene with communities in a way that instills a sense of ownership over the intervention process. Although, in our study, community-based participatory research (CBPR) was not part of the study protocol, we engaged coinvestigators and research assistants who were of similar cultural backgrounds as study participants. In addition, the research team actively engaged community organizations and staff as partners. Nonetheless, a better approach would have been to engage community partners in the development stage of the study (Buseh et al., 2017; Njie-Carr, Jones-Parker, et al., 2018). Also important is community education around U.S. family laws and raising awareness to empower immigrant and refugee women to make informed decisions about safety planning and risk assessment.

Conclusion

We discussed recruitment and retention strategies used in the weWomen study substantiated by best practices. Our strategies connecting with our partners, using word-of-mouth and direct contact with participants consistently generated adequate enrollment in Phase 1 or formative stage of our study. Ensuring that study materials were in participants' language of preference and the recruiters were of similar cultural background further propagated enrollment. In addition, routinely using multiple methods to optimize participation was critical. We identified a multifaceted approach to optimize recruitment and retention efforts for hidden populations. In spite of the creative strategies we used, the current evolving immigration policies make recruitment of immigrant women even more challenging.

Recruiting and retaining immigrant and refugee survivors of violence is difficult because of multiple risks and vulnerabilities that place them at a disadvantage. The challenge has gotten worse, thus limiting investigators' chances of implementing interventions to support the women with the tools and services they need. Unfortunately, these challenges could translate to limited research participation and less evidence-based interventions to inform our work with immigrant and refugee women. However, we remain optimistic because it is only through the active participation of immigrant and refugee survivors that investigators will understand their experiences and unique needs to implement targeted evidence-based interventions.

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Biography

Veronica P. S. Njie-Carr, PhD, RN, ACNS-BC, FWACN, is an associate professor in the School of Nursing at the University of Maryland, Baltimore. Her research interests and scholarly activities are in the areas of global health, HIV-related disparities, and intimate partner violence. She is committed to finding solutions to contribute to eliminating health disparities and propagating health equity. Her work focuses on systematic cross-cultural, psychosocial, and behavioral interventions for people of African descent living with HIV infection and women who experience intimate partner violence.

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Jill T. Messing, MSW, PhD, is an associate professor in the School of Social Work at Arizona State University. She specializes in the development and validation of intimate partner violence risk assessment instruments. She is particularly interested in the use of risk assessment in evidence-based practice, and focuses on the development and testing of risk-informed interventions for survivors of intimate partner violence.

Allison Ward-Lasher, MSW, is a doctoral candidate in the School of Social Work at Arizona State University. Her research interests include intimate partner violence, polyvictimization, victim advocacy, social service and criminal justice intervention, and the role of empowerment and victim-centered advocacy in improving client outcomes. Her research has examined housing interventions for victim-survivors of IPV, the impact of risk on victim-survivor and offender outcomes, risk assessment with immigrant and refugee victim-survivors, strangulation, and other victim and offender characteristics on criminal justice outcomes in cases of intimate partner violence.

Crista E. Johnson-Agbakwu, MD, MSc, FACOG, IF, is an obstetrician/gynecologist at Maricopa Integrated Health System. She is the founding director of the Refugee Women's Health Clinic and director of the Office of Refugee Health, in the Southwest Interdisciplinary Center at Arizona State University. Her research investigates strategies to improve sexual and reproductive health outcomes for newly arrived refugee women, particularly those who have undergone female genital cutting (FGC) as well as gender-based violence (GBV). She currently leads a federally funded effort through the Office on Women's Health to improve the provision of health care services, community engagement, and provider cultural competency on FGC across the state of Arizona.

Catherine McKinley (Formerly Burnette), PhD, LMSW, began working with Indigenous tribes of the Southeast over 10 years ago related to violence against women and children, mental health, substance abuse, and health. She has worked in collaboration with tribes to develop the ecological "Framework of Historical Oppression, Resilience, and Transcendence," which identifies and organizes culturally relevant risk and protective factors across community, family, and individual levels. Since coming to Tulane in 2013, she has published more than 40 peer-reviewed journal articles and has been involved in federally funded research. Her work addresses violence and health disparities using culturally relevant intervention approaches.

Nicole Campion, BA, is a student in the dual-degree MD/MPH program at University of Maryland School of Medicine. Her scholarly interests include trauma, community violence, and health system strengthening in low-resource settings. She aspires to be a clinician who helps bridge the gap between primary care and mental health care.

Saltanat Childress, MSW, PhD, is an assistant professor at the University of Texas Arlington School of Social Work. Her work is focused on promoting women's wellbeing and prevention of GBV globally. She is dedicated to improving long-term health and social outcomes and empowering survivors of GBV through economic empowerment, asset

building, and improving responses of criminal justice, public health, and social service systems. She has coordinated a variety of development programs in Central Asia with organizations, including USAID (United States Agency for International Development), The World Bank Group, Asian Development, and the European Union.

Joyell Arscott, PhD, RN, ACRN, is a trauma and violence research postdoctoral fellow at Johns Hopkins School of Nursing (T32HD094687). She graduated from Duke University with a PhD in nursing and University of Maryland, Baltimore, with her BSN. She is also an AIDS Certified Registered Nurse (ACRN). Her research examines the historical impact of social, structural, and institutional factors that contribute to the health inequities in marginalized populations, particularly adolescents and young adults. She aims to understand the impact cumulative trauma has on the sexual decision-making and reproductive outcomes for minority adolescents.

Jacquelyn Campbell, PhD, RN, FAAN, is professor and Anna D. Wolf chair at Johns Hopkins University School of Nursing. Her major area of research is violence against women and associated physical and mental health outcomes, including intimate partner homicide. She has also developed and tested interventions for women exposed to violence in the health care, advocacy, and judicial systems in the United States and globally, including the danger assessment risk of domestic violence lethality instrument and interventions based on it.

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