Intimate partner violence and alcohol use among the Ngöbe and Buglé indigenous population of Panama, Central America

Violencia intrafamiliar y el uso de alcohol en la población indígena Ngöbe y Buglé de Panamá, América Central

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ABSTRACT

Indigenous communities of the Ngöbe and Buglé peoples in the Chiriquí province of Panamá, Central America, identified a growing problem with alcohol use and intimate partner violence (IPV). The researchers were invited to determine the extent of the problem. A descriptive correlational study adapting an interview-style survey from the 2005 World Health Organization "*Multi-country study on women's health and domestic violence against women: Summary report of initial results on prevalence, health outcomes and women's responses*" was conducted to provide initial data that identified the extent, qualities and risk factors of IPV (1). Results illustrated a correlation between alcohol and intimate partner violence among the population; significant correlations between alcohol abuse, IPV, education level, number of pregnancies, and number of living children were identified. Increasing the awareness of this issue can affect future development of community-based interventions for this unique population.

Key words: intimate partner violence, alcohol use, indigenous populations

RESUMEN

Las comunidades indígenas Ngöbe y Buglé, habitantes de la Provincia de Chiriquí, Panamá, América Central, identificaron un problema creciente con el uso de alcohol y violencia intrafamiliar. Los investigadores fueron invitados a determinar la gravedad del problema. Para obtener información inicial sobre la gravedad, características y factores de riesgo en la violencia intrafamiliar se llevó a cabo un estudio correlativo y descriptivo, adoptando el estilo de entrevista de la Organización Mundial de la Salud, "*Estudio multinacional sobre la salud de las mujeres y violencia doméstica contra las mujeres: resumen del reporte de los hallazgos iniciales sobre prevalencia, resultados de la salud y respuestas de las mujeres, 2005*". Los resultados demostraron una correlación entre el alcohol y violencia intrafamiliar entre la población. Se identificaron correlaciones significativas entre el uso de alcohol, violencia intrafamiliar, nivel educativo, número de embarazos, y número de niños vivos. Ser conocedores y conscientes de estos factores puede tener un impacto en el futuro desarrollo para intervenciones comunitarias en esta población.

Palabras clave: violencia intrafamiliar; alcoholismo; poblaciones indígenas

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INTRODUCTION

Intimate partner violence (IPV) is a complex issue. It encompasses physical, emotional, sexual, and economical aspects of human lives. Heise and Garcia-Moreno and Jewkes, Sen & Garcia-Moreno, define intimate partner violence, as "behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, and psychological abuse and controlling behaviors" (2). One study conducted in Latin America revealed 4% to 15% of women reported experiencing violence from a partner (3).

Intimate partner violence (IPV), once commonly referred to as domestic violence, is a global tragedy. The World Health Organization (WHO) performed an in-depth study in 2005 of different populations across the globe to determine the ways in which they were affected by the violence, listing individual risk factors related to IPV including age, low educational level, intra-parental violence, harmful use of alcohol, acculturation practices that enhance alcohol consumption, and acceptance of violence. The international study listed the need for primary prevention by creating a "climate of non-tolerance" by criminalizing IPV and by promoting equality between men and women through legislation and ultimately within the culture (2). Despite similarities, all populations suffering from intimate partner violence problems are unique.

Two Panamanian indigenous peoples, the Ngöbe and Buglé, living in the reservation (Comarca), selected over 50 community leaders to participate in focus groups in attempts to identify community concerns. Many of these leaders explicitly voiced concerns with possible increases in alcohol use and intimate partner violence throughout the Comarcha (4). The purpose of this qualitative descriptive study, utilizing individual, one-on-one interviews, was to provide baseline data that identifies the current incidence of intimate partner violence and the correlation of IPV with alcohol use and contributing factors in the select indigenous populations of Panamá.

Literature review

Substance abuse has been commonly found to have a significant correlation with rates of intimate partner violence. Alcohol was most often the substance of choice. In Chile, Mexico, Nicaragua and Haiti, evidence showed that alcohol abuse, use or the state of being drunk increases the risk of violence by a male toward a female partner (3). A study of the Brazilian population showed that men reported drinking during incidences of IPV four times more than their women counterparts (5). Fals-Stewart (6) confirmed the link between alcohol and domestic violence, revealing that male physical aggression toward females was eight times higher on days when men drank alcohol when compared to days of abstinence from alcohol.

Easton, Mandel, Hunkele, Nich, Rounsaville, & Carroll (7) stated that based upon the proximal effects model, "substance use typically precedes episodes of IPV, and episodes of violence often occur closely in time to the consumption of alcohol". Although studies have been conducted in socioculturally and economically diverse countries where health care access exists, there is limited research of IPV among indigenous populations, posing unique obstacles to any investigation. The population may reside in remote and difficult to access communities, differ in culture and norms from the mainstream population, and hold significant discrepancies in the occurrence of social problems. A study of domestic violence screening in New Zealand, including both European and women native to New Zealand, confirmed the importance of cultural considerations during screening and development of interventions (8).

Specific to the Ngöbe and Buglé populations, several cultural considerations were taken into account. The culture itself is modest and reserved. Women focused on care of the family and children and on the creation and selling of artisanal objects and items as their form of income. Intimate relationships are often not considered specifically a marriage, but were instead a union of life partners.

When conducting assessments and planning interventions for any form of interpersonal violence, culture is a vital factor that must be considered. Culture is central to how people organize their experiences, identify a problem, view abuse, and seek assistance (9). This is particularly important

when an investigator studies an unfamiliar culture, requiring an important level of cultural competency. Cultural ideals may have a substantial impact on reporting an incidence of violence. The WHO (1) stated that, "often traditional social and cultural gender norms make women vulnerable to violence from intimate partners, place women and girls at increased risk of sexual violence, and condone or support the acceptability of violence".

Brabeck and Guzman described values of Hispanic cultures, specifically Mexican-Americans in the study, to include '*machismo*', '*marianismo*', and '*familismo*'. Machismo was compared to traditional values of patriarchy, *marianismo* to the afflictions of women, and *familismo* to considering the needs of the family unit before considering the needs of each individual member (10). There were mixed findings in review of available literature, but concluded that maintenance of traditional patriarchal gender roles did not correlate to decreased likelihood that women seek help for violence or flee the relationship. Levels of perceived *machismo* were similar between women who had fled an abusive relationship and those who had not; perceived *machismo* was also not related to help-seeking behavior (10).

The Panamanian Comarcha

The Comarcha in western Panamá is home to over 160,000 Ngöbe and Buglé indigenous people. This mountainous, isolated area spans across the country from the Pacific to the Atlantic Oceans. The Comarcha is divided into nine districts; each district has more than 100 small, isolated villages. It is not unusual for 200 to 400 people living in one identified community that requires the inhabitants to walk over 4 hours to access one health outpost and an elementary school. All of the villages are of great distances from each other with mud roads, no electricity, clean water, sanitation or other infrastructure to support health, communication or community support. This isolation, according to the community leaders, enhances the sociology of the indigenous communities and may affect the frequency of experienced and reported violence. Before arriving in Panamá, it was known to the researchers that the area was substantially isolated and remote with limited resources. One must travel by private bus from the Comarcha to the nearest town, David, over 80 miles away. The police stations, hospitals and all other resources are located outside of the Comarcha itself. Schafer & Giblin (11) have considered that physical isolation, the rural view that issues of the home should 'remain in the home' and the scarcity of transportation and resources endemic among impoverished communities contribute to unspecified levels of IPV.

METHODOLOGY

A convenience sample of 70 Ngöbe and Buglé women in selected communities of Panama were assessed for intimate partner violence and alcohol use. Data included in the results and analysis section is only from the one indigenous community of *Soloy*, located in the southwestern region of the native reservation (Comarca). Surveys were translated into Spanish, reviewed for cultural sensitivity for the population, and utilized to collect data, serving as a blueprint for the interview process.

Face-to-face interviews were deemed to be the most culturally appropriate method of data collection. In the 2010 study, the WHO reported that levels of intimate partner violence are most accurately represented through survey and self-reports, rather than through incidents reported to authorities. According to Sorenson, Stein, Siegel, Golding and Burnham (12), women are more likely to share experiences about sexual violence with female interviewers. Interviewers, as a result, were required to be female. The use of trained, certified translators, fluent in Spanish, English and Ngöbe, was vital as some participants were more fluent in the native language, Ngöbe. Selection of trilingual translators by the Ministry of Health was based upon availability, expertise and overall knowledge of the community.

Translators were required to sign agreements that all information they relay, see, and hear remained in the strictest of confidence to maintain the privacy of the women and the legitimacy of the research. If participants were able to read Spanish, they were given the option of filling out the survey privately. A recent study of disclosure rates comparing self-report, medical staff interview, and physician interview illustrates statistically relevant and

comparable rates of disclosure (13). Therefore, the investigator assumed the responses of the women to be reliable and accurate.

Participants

In order to participate in the survey, subjects were required to be women with a stated age of at least 16 who had once been in a relationship with a man. Within this culture, birthdates have not always been perceived as important. On several occasions women were unsure of their true age, so participants were asked to identify an age bracket, from 16-25, 26-35, 36-45, 46-55, and 56 or older.

Instruments

The survey used by the World Health Organization to collect data for their 2005 study of domestic violence against women in 20 countries was adapted to fit the needs of the Ngöbe and Buglé indigenous populations (1). Written authorization was granted by the WHO Department of Permissions for use of an adapted and abridged version. The interview questions were reviewed and revised, utilizing the expertise of a Panamanian professor who had worked for several years in the Comarca, incorporating a heightened level of cultural sensitivity. The survey initially included 168 questions, all with multiple-choice style or yes/no answers. Culturally sensitive alterations to the survey were made, including the omission of ten questions, addition of nine questions, and adjustment of two questions.

An English version and Spanish translation with a reverse translation by Panamanian native speakers were utilized. Researchers explained to each interviewed woman that their truthful responses to the survey would provide an initial understanding of intimate partner violence and cultural dynamics. They were told that the information would be used to understand what elements place them at risk of IPV, the data would be kept confidential, all data would be presented in aggregate form only and responses would assist in the design of helpful and appropriate interventions in the future.

Questions within the survey focused on specific themes and assessed many factors including: a) perception of health, b) alcohol use among women and their partners, c) different types of intimate partner violence, and d) a number of cultural norms. These adapted questions were used during the interview process because of their previously proven effectiveness. Using the World Health Organization's scale determined for their 2005 *Multi-country Study on Women's Health and Domestic Violence against Women*, physical violence was classified as moderate or severe based on likelihood and extent of physical injuries. Subsequent questions regarded the frequency and type of intimate partner violence. Factors that seem to aggravate violence were also assessed in the questionnaire. At the completion of the survey, each woman expressing experience with intimate partner violence was given the name of the one Comarcha mental health nurse and her cell phone number. The woman was also encouraged to contact the community leaders who supported the investigation as well as self-identified family support.

Informed consent and confidentiality

Participants were given a form to review written in Spanish explaining the parameters of the project and all of the different definitions of intimate partner violence, as violence may not necessarily be physical. If individuals expressed illiteracy, they received a verbal explanation based on the previously mentioned document. Individuals willing to be interviewed were invited to participate. Instead of recording names, all surveys were misidentified. They were explained the terms of the interview and provided verbal consent to partake in the study after all of their questions and concerns were addressed.

Anonymity was maintained for all interviews by: a) not requiring the women to sign any papers; b) politely insisting upon the isolation of the participant and interviewer, or during interviews which occurred in the health clinic interviewers and participants relocated to a room which allowed a closed door, so that discussion could not be overheard by people of the household, neighbors, or others in the clinic; and c) all interviewers and translators signing a form of confidentiality. Men who were present at any time during the interview process were informed that the topic of the interview was women's health and for privacy reasons they were asked to leave the immediate area.

Institutional approval

Approval for this study was granted by the Institutional Review Board of the University of South Florida, the Ministry of Health of Panamá, and the University of Panamá and by verbal assent of the local community leaders.

PROCEDURE

Researchers walked through the villages to recruit willing participants. Women were often within their homes, but were also found walking in their community. Researchers introduced themselves to the women and explained the purposes of the study, verbal consent was obtained and the interview commenced. Researchers were often invited into the homes of the women for the duration of the interview. Interview lengths ranged from 45 minutes to two hours. Many of the women provided elaboration of their responses, contributing to the richness of the data.

RESULTS

Violence and factors of age, literacy and employment

The results of the surveys were summarized in this section. Because not all participants answered every question, the sample size was reported for each finding. Unless otherwise specified, the sample size (n) was 36. The following results will often present the participants in two groups: one included women reported experiencing violence, and the other contained women who did not confirm the presence of violence. Table 1 shows the reported age brackets of all of the women surveyed and the reported age of their partner.

Age	16-25	26-35	36-45	46-55	56 or older
Women	19%	31%	17%	14%	14%
Men	11%	28%	25%	14%	17%

Table 1. Ages of men and women in Soloy, Panamá

Note. Totals were rounded for men and women and do not total 100% - some women were unsure of their age and/or the age of their partner

The majority of women were between ages 26-35, and the majority of women who had experienced intimate partner violence (IPV) were between these ages (36% of women), however there was no significant correlation between violence and men or women's ages. Figure 1 depicts the education of the men and women of *Soloy*. Reported attendance of school and literacy rates is both higher in columns depicting male status when compared to women.

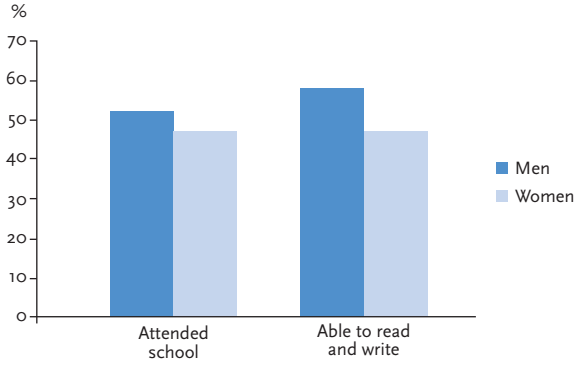

Figure 1. Demographics of men and women in Soloy, Panama

Note. Totals for men do not total 100%; some women were unsure of their partner's literacy and/or educational status

In addition to literacy rates, questions were posed to the women regarding the employment status of their partners. The majority of male partners in this study (47%) were currently working (n = 33). Thirty-three percent were seeking work, six percent were retired, and three percent of the men were currently studying (n = 33). When asked about marriage, 50% of women reported that they are currently married or with a male partner, 33% reported single status, and one woman reported that she was not sure of her status (n = 31).

Violence and abuse histories

When asked about the proximity of family members, half of the women reported being able to easily visit family members with no significant differences between groups. Eleven of the 25 women who denied abuse stated that they could regularly depend on their family for support compared to two of the eleven women who experienced abuse, however, this was not found to be statistically significant. On average, 36% of women reported being aware as children that their mothers were being hit by their

father or mother's partner, with no significant difference between the two subsets of women. When asked about the childhood homes of their partners, 29% of women stated that the mother of their male partner was beaten (n = 34) and 21% that their male partners were beaten regularly by someone in his family (n = 34); neither of these questions held statistical differences between the two groups.

Violence and health perception

There was no significant difference in the perception of health, levels of pain and discomfort, or difficulty in carrying out activities of daily living between women who reported physical or sexual abuse and those who did not. When questioned about their level of pain, one-third of the women most commonly reported moderate levels of pain or discomfort. Overall, only 33% of women considered their health to be good and 3% of women reported an excellent state of health. The responses of women displayed in Table 2.

Very poor	Poor	Fair	Good	Excellent
11%	33%	19%	33%	3%

Table 2. Women's perception of overall health status

Note: Percentages may not add to 100% due to rounding

Women were interviewed regarding their perception of both their physical and mental health. They were asked if they had experienced any of several common complaints within the previous month. It was found by Pearson Chi-Square analysis that women who reported experiencing physical or sexual abuse were more likely to also report uncomfortable feelings in their stomach during the last month ($\chi^2 = 4.134$, df = 1, p = 0.52). Responses to questions regarding other types of physical ailments were not significantly different between the two groups, listed in Table 3.

In order to assess mental health status, women were presented with several questions. Thirty-one percent of women surveyed confirmed that they had difficulty thinking clearly, with no significant differences noted between the two groups. Feelings of unhappiness were prevalent among the women, with nearly two-thirds (64%) of women reporting such feelings; there were no significant differences between the two groups. The majority of women who reported having experienced violence at some point reported crying more than usual, compared to slightly less than half of the rest of the population who also reported crying more than usual, 82% and 48% respectively; however, the differences between the two groups were not found to be statistically significant.

Physical ailment	Percentage of women reporting (%)
Easily tired	75
Always tired	69
Frequent headaches	67
Easily frightened	58
Nervous/worried	53

Table 3. Most common physical ailments reported

Note: Women were able to choose more than one response; totals will not equal 100%

Violence and culture

Questions regarding cultural norms related to violence were asked as a part of this assessment. No significant difference was noted between the groups of women in respect to their views of instances in which it is considered acceptable to experience violence. Table 4 depicts the cultural statements and responses.

The women were provided with hypothetical situations, and were asked if the given situation was a good reason for a male to strike his partner. Again, the answers among the women were not statistically different but worth noting (Table 5).

Cultural statement	Women confirmed violence (n = 11)		Women denied violence (n = 25)		Total (n)
	Agree	Disagree	Agree	Disagree	
A good wife obeys her husband even if she disagrees	5	6	11	12	34
Family problems should be discussed with people in the family	7	4	14	11	36
A woman should be able to choose her own friends even if her partner disagrees	8	3	17	6	34
It is important for a man to show his partner who is boss	2	9	7	14	32
It is a wife's obligation to have sex with her partner even if she doesn't feel like it	3	8	7	17	35
If a man mistreats his partner, others outside the family should intervene	8	3	20	4	35

Table 4. Assessment of cultural viewpoints regarding violence

Note: Some women chose not to answer the question, and as a result, the sample size does not always equal 36.

Does a man have a good reason to hit his wife if:	Women confirmed violence	Women denied violence
She does not complete household work to his satisfaction	2	2
She disobeys him	3	5
She refuses to have sexual relations with him	3	2
She asks him whether he has other girlfriends	2	7
He suspects that she is unfaithful*	2	9
He finds out that she has been unfaithful	4	9

Table 5. Acceptable reasons for women to experience violence

Note: * n=34

Women were interviewed regarding questions of economic and emotional abuse, specifically isolation. Nearly half of the women who reported violence also told interviewers that their partner tried to keep them from seeing friends (46%), compared to 17% of women who denied experiencing violence; however, this finding was not statistically significant (n = 35). Findings were similar regarding male partners restricting contact of women with their families (n = 35). Regarding economic abuse, overall, 39% of the women related having been refused money for household expenses even when their partner had money for other things, with no statistically significant differences between the two groups (n = 33). Of the values listed in Table 6, one of the comparisons was found to be statistically significant; there was a positive correlation between women being treated indifferently or ignored by their partner and having experienced violence at some point.

(n = 35, χ^2 = 4.443, df = 1, p= .035).

	Woman confirmed violence	Woman denied violence
Isolates woman from friends	46%	17%
Isolates woman from family	46%	21%
Must always know woman's location*	64%	39%
Ignores woman or treats indifferently	64%	25%
Angry woman speaks to other man	64%	38%
Often suspicious that woman is unfaithful	73%	38%
Woman must seek permission to pursue healthcare	64%	38%

Table 6. Isolation tactics of emotional abuse (n = 35)

Note: *n = 34

Violence and alcohol consumption

Eleven of the 36 women surveyed confirmed that at some point they had experienced physical or sexual violence (31%). Physical or sexual violence and intimate partner drinking, particularly the male partner, was found to be related and statistically significant (n=35, χ^2 = 7.098, df = 1, p = .008).

Of the women that had experienced IPV, 30% reported that their partner consumed alcohol nearly every day, 30% said once or twice a week, 30% said occasionally, and only one woman said never. Women who denied IPV reported that their husbands did not drink on a daily basis, and nearly half (47%) reported that their partner never consumes alcohol. The difference between these groups of women was significant (n=27, χ^2 = 7.797, df = 3, p = .050). Figure 2 shows the prevalence of male partner alcohol consumption as reported by women who had and those who had not experienced IPV.

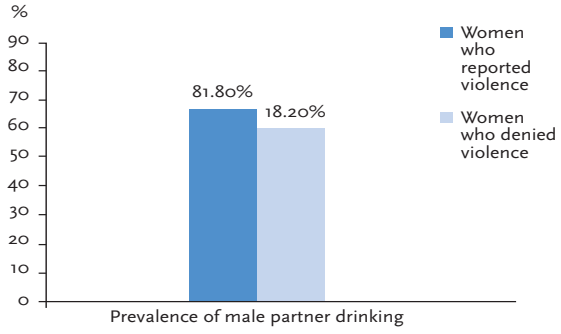

Figure 2. Comparison of reported alcohol consumption of male partners

Interestingly, the reports of the women's alcohol consumption were not significant. Eight out of the eleven women who experienced IPV stated that they never drank, and 20 out of 24 women who were not abused stated that they never drank (n = 35). Overall, 80% of women denied any alcohol use. In order to assess interpersonal violence beyond the home, women were asked if, to their knowledge, their partner had ever been involved in a physical fight. Just less than half (44%) of the participants reported knowledge of their partner being in a fight with another man, and overall, there was no significant difference between the two groups of women.

Ramifications of violence

Women were asked if they had ever sustained injuries from IPV and, if so, were asked to identify them. More than half of the eleven women (55%) who reported abuse stated that they suffered scratches or bruises. Of these eleven women, three reported having their teeth broken because of violence. Injuries reported by the sample of women are listed in Table 7.

Type of injury	Percentage of women (%) (n=11)
Cuts, puncture, or bite	9
Scratch or bruise	55
Sprain or dislocation	0
Burn	9
Penetrating injury, deep cut or gash	9

Type of injury	Percentage of women (%) (n=11)
Broken eardrum or eye injury	18
Fracture	9
Broken teeth	27

Table 7. Type of injury experienced as a result of violence

Physical violence was categorized by the WHO in 2005 as moderate or severe (1). Moderate violence includes slapping, pushing, and shoving. Severe violence was defined as kicking, dragging, and using any form of weapon. The most common form of abuse was a slap (82%). See Table 8 for an itemization of responses.

Type of violence	Women who experienced IPV	Women who denied IPV	Total
Slapped or object thrown at	9	3	12
Pushed or shoved	8	4	12
Hit with fist or other object	8	3	11
Kicked, dragged, or beaten	6	4	10
Choked or burned	4	0	4
Threatened with weapon or weapon used against	2	1	3

Table 8. Forms of physical violence

Note: For each type of violence, sample size is noted in the total column

In an effort to understand the cycle of violence, women were asked about situations that led to violent episodes. Responses to this inquiry are listed in Table 9.

Situation precipitating violence	Women who agree and also reported violence (n=11)	Women who agree and did not report violence (n=25)	Total
No particular reason	0	0	0
When the man is drunk	9	10	19
Money problems	6	6	12
Difficulties at his work	3	3	6
When he is unemployed	4	3	7
There is no food at home	6	7	13
There are problems with his or her family	2	3	5
She is pregnant	2	3	5
He is jealous of her	4	8	12
She refuses sex	4	6	10
She is disobedient	5	5	10
Other: The man wants another woman	1	0	1

Table 9. Situations that lead to violence

Note: Women responded only if they confirmed a precipitating factor, as a result, sample sizes are not equivalent to n-values

Violence and sex

When asked if a woman can refuse to have sex if she does not want to, only 42% of women agreed. More than half of the women surveyed (53%) reported that they do not have the right to refuse sex with their partner when he is drunk. Importantly, nine out of eleven, or 82% of women who had experienced abuse reported that the man being drunk was a situation precipitating violence. In fact, it was found by Pearson Chi-Square analysis that there was a positive and significant correlation

between the frequency of which the man drank alcohol and the presence of violence in the relationship (n = 27, χ^2 = 7.759, df = 3, p = .051).

In assessing for the different types of violence, women were asked questions regarding sexual experiences, sexual violence, and the sexual rights of women. There was no statistical difference between abused and non-abused women in consent of their first sexual experience. The mean age of the first sexual experience was fifteen years old; ages ranged from 10 to 19 years (n = 31). Although not significant, more than half of women who had experienced violence, in all instances, stated that they could not refuse sex as seen in Table 10.

A woman can refuse to have sex with her husband if:	Woman confirmed violence	Woman denied violence
She doesn't want to*	5	10
He is drunk	3	13
She is sick	3	10
He mistreats her*	2	9

Table 10. Acceptable reasons to refuse sex (n = 35)

Note: *n = 34

To assess for sexual violence, women were asked if they had ever been forced to have sex, if they had sex out of fear, or if they had ever been forced to participate in something they considered a degrading or humiliating sexual act. Of women who had experienced violence, 73% replied that after an incidence of violence, the male partner had forced her to have sex with him (Figure 3).

Women were also questioned specifically regarding abuse from persons other than their partner after the age of fifteen. Of women who had not reported IPV, four out of 25 reported having experienced abuse from their father, while only one of the eleven women who had experienced IPV reported this. Of the 25 women who did not report experiencing physical or sexual violence, one woman reported that they had experienced abuse from a stepfather, and two women had experienced violence from another male in the family.

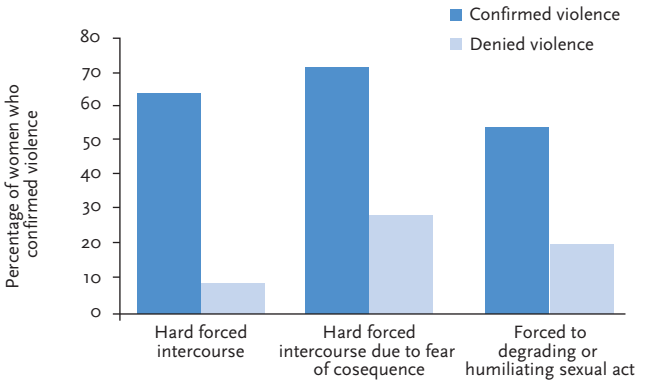

Figure 3. Comparison of sexual violence between two groups of women (n=35)

Two out of the eleven women who confirmed IPV reported abuse from a male friend of the family. Three women reported having been forced by a male family member, other than her father, to perform a sexual act after the age of fifteen, two of the three women mentioned above confirmed violence and one denied experiencing violence.

Based on our findings, sexual abuse before the age of fifteen did not put women at a higher risk of experiencing IPV later in life. Incidences of sexual abuse within the family were noted within the population. Nine women reported having unwanted sexual experiences before the age of fifteen (age range = 5 - 14; X = 12 years of age).

Violence and support networks

In an effort to plan future interventions, it was deemed highly important to discover with whom women were sharing their experiences with IPV. Women were given the option to choose multiple responses for all of the following assessments. While two of the eleven women who reported experiencing physical or sexual violence stated that they had not told anyone about the violence, eight (73%) had disclosed physical violence to their parents. The nine women who disclosed violence to others were equally likely to divulge this information to their aunts/uncles, their partner's family, and their neighbors, at a rate of 27%. They were least likely to reveal episodes of violence to police, healthcare providers or physicians, priests, counselors, women's groups, and local leaders, with equal rates of disclosure at 9%. When including

both women who had encountered violence and those who had not experienced violence but had possibly seen or heard it, 33% of total women told their parents. Only 6% of total women reported to a healthcare provider, and 3% to the police.

when asked where they had previously sought help; three of the eleven women who reported violence also reported that they were most likely to go to the hospital or healthcare clinic for help with violence. Other places the women reported to have gone were the police, shelter, and women's groups. Of this same group, women were allowed to choose more than one answer regarding why they sought assistance. The largest percentage sought help equally, 18% for each listed reason, because a) she was encouraged by friends, b) she could not endure any more, or c) she was badly injured or afraid her partner would kill her. Women sought help less often (9%) for each of the following: her partner threatened or tried to kill her, or she was thrown out of the home.

Of the women who reported experiencing physical or sexual violence and did not seek help, most (36%) reported they did not know why they had not sought help, followed by 27% for each of the following responses; the violence was normal or not serious, or the woman was afraid seeking assistance would end the relationship. Less commonly, 18% reported for each of the following: a) women reported that they were afraid of more violence as a result of seeking help, b) that they were embarrassed or afraid that they would be blamed or not believed, c) they thought that it would not help or had known other women who had not been helped, d) they were afraid to lose their children, or e) they were afraid to bring a bad name to the family.

Ninety-four percent of women reported that they would like to receive more assistance (n=18). Women were permitted to choose more than one response to this question. The majority, ten of the eighteen women, reported that they would like to receive more assistance from the health center. Other responses women mentioned that they would like to receive help from where, in order of prevalence: their families, their mothers particularly, the police, the mother of their partner, and religious leaders. Seventeen women reported that they wanted help, yet not all women answered these questions, and many women who had not experienced violence did not answer these questions (Table 11).

	Reported IPV	Did not report IPV	Total
From whom would you like more help?	7	10	17
Family	5	3	8
Mother	4	3	7
Partner's Mother	3	0	3
Health Center	6	4	10
Police	4	4	8
Priest	2	0	2

Table 11. Women's wishes about receiving more help regarding

Note: IPV (n = 17)

Of the eleven women who reported abuse, more than half, 55%, reported having left the home, even if only for one night, because of the violence. Of these women, reasons reported for leaving included most commonly that either she could not endure any more or that she had been thrown out of the home, at a rate of 27% each. Participants stated to have left because (18% for each of the following responses): a) she was encouraged to leave by friends or family, b) her partner had threatened or tried to kill her, c) her partner threatened to hit the children, or d) that the children appeared to be suffering. Rationale for women returning to the relationship was most commonly (55%) that she did not want to leave her children.

Nearly three quarters (70%) of women who had experienced abuse also had a sister or sisters that were in an abusive relationship, compared to a quarter of the women who were not experiencing violence; this difference was not statistically significant (n = 26). However, women who had experienced IPV were statistically more likely to have known friends who were also experiencing violence. The majority of women, 82%, who had experienced IPV knew friends who were also experiencing, or had experienced, abuse, compared to

44% of women not in abusive relationships (n = 34, χ^2 = 4.437, df = 1, p = .035).

DISCUSSION AND RECOMMENDATIONS

The primary goal of this study was to assess the presence and extent of violence and alcohol use in a population and to determine factors aggravating violence, in an effort to plan future interventions. Violence and alcohol abuse have long been recognized as cohabiting issues among studied areas, and we have shown, even in such a unique indigenous population as the Ngöbe and Buglé people, that this is prevalent. Women were categorized into two groups for comparison: a) those who reported experiencing physical or sexual violence and, b) those who denied such experiences. Eight women left this question blank and they denied violence in previous questions; as a result, they were treated in this research study as denying violence.

Women were surveyed regarding several variables in addition to obvious inquiries related to alcohol and violence. It was deemed important to assess the mental and physical health of the women along with opinion-based cultural assessment questions. The overall status of mental health in the population surveyed was not significantly different in the two categories of women. About two-thirds of the women reported feelings of unhappiness, but again there was no significant factor identifying mental health concerns in either group. The only significant aspect of health complaints related to victims of IPV was stomach pain. This vague yet important complaint may be a culturally sensitive question utilized by the health professionals attending all women in the Comarcha. It is possible that overall living conditions and the typical role of the Ngöbe woman could be the cause of pervasive unhappiness among the population. There were also no significant differences in the abilities of the women to perform usual activities, levels of pain, or problems with memory or concentration between women who reported abuse and those who did not.

The study suggested that violence stemmed from the alcohol use of the man, but not the woman, as eight out of the eleven women who experienced IPV stated that they never drank. Sixty percent of these eleven women stated that their partner drank at least on a weekly if not daily basis, and 30% reported him drinking less than four times in a month. In the Comarca, people make their own alcohol from plants, called "chicha". Because it is homemade, alcohol content may vary. Also important is the concept that alcohol consumption in this population was not measured based on the number of drinks, but instead on the frequency with which the women and their partners drank. Alcohol consumption was measured this way not only because of the varying alcohol content in every drink, but also because drinking cups and dishware were made from any materials available including dried gourds and other plant material, and as a result were different sizes. Consequently, it is very difficult to quantify the actual amount other than simply by frequency of consumption.

Interestingly, the only set of answers regarding emotional abuse with significantly different values between the two groups of women regarded the man ignoring or treating his partner indifferently. It appears that although the overall confirming responses to questions of emotional abuse or control ranged from more than a quarter of the women to half in some cases, the propensity of violence was only increased if women answered that they had been ignored or treated indifferently.

None of the cultural questions listed in Tables 4, 5, and 10 were found to be significantly different when comparing the violence and non-violence groups. Based on the results in Table 5, it seems apparent that from a cultural perspective, women never agree that there is an acceptable reason to experience violence. On the contrary, women seem to have the perspective that they have limited sexual rights; at least half of women who had been abused felt that they did not have the right to refuse sex with their partner. Knowledge of these cultural viewpoints is essential when considering further action to aid this community.

This research involved the indigenous people, Hispanic or Afro-Panamanians, and non-Hispanic healthcare providers from the United States. This may have influenced disclosure rates, as women may have felt safer discussing the topic with either a

foreigner or fellow Panamanian. Women were asked two specific questions in an attempt to identify willingness to discuss IPV issues with their family and, by extension, people beyond their family. Of women who had experienced IPV, 36% disagreed that family problems should be discussed with family members. Eight of the eleven women (73%) responded that individuals outside of the family should intervene if a man mistreats his partner. Women either may have decided to speak with both interviewers, or could have chosen not to converse with the non-favored party at all. Kozoil-McLain et al, studied the process of domestic violence screening. Regardless of ethnic matching, the majority of women screened for violence were affected positively, declaring that they either learned something from the screening process regarding their experiences, IPV, their community, or that they were not at fault for the violence they had been enduring (6). It is impossible to tell the effects of ethnic matching, or the lack thereof, on the disclosure; however, it was apparent that our effect on the women was positive, with 63% of women reporting feeling better after the survey, 34% feeling no different, and only one (3%) feeling worse. This implies the need for interventions and the importance to strengthen the available support system and resources.

Recommendations included adjustments to the survey instrument as previously discussed, that would be helpful for future studies. The survey would also be shortened to desirably fewer than one hundred questions, as there was concern about fatigue towards the end of the interview.

A method for quantifying alcohol consumption would be devised. It would be particularly beneficial to devise an additional survey for men; this would identify male cultural issues and engage men as participants in the community endorsed studies. Increasing the number of participants with a focus on random selection rather than dependent upon availability may add to variability of responses and participants. Finally, the small sample size of 36 women from 3 different communities should be increased to accurately represent more of the over 160,000 residents of the Comarcha.

One goal in this study was to identify the presence and any possible correlations between intimate partner violence and alcohol abuse in the Comarca of Panamá. It was found to be significant that women whose partners consumed alcohol were at a higher risk of intimate partner violence; hence, abstinence from alcohol use is a protective factor. There is a significant correlation between the frequency of alcohol consumption and violence, but further research is needed to determine the exact causes of violence. Continued work with the community leaders and the Ministry of Health is critical in the identification, development and implementation of community-based interventions.

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