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Impacts of Culture on Perceptions of Intimate Partner Violence among Fijian Indian Women

By

SHAYAL S PRASAD
THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

Nursing Science and Health-Care Leadership

in the

UNIVERSITY OF CALIFORNIA

DAVIS

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2021

Acknowledgements

I wrote this thesis with the purpose of it being a voice for the countless number of women who have suffered in silence due to Intimate Partner Violence (IPV). My goal is to encourage women to talk about IPV; to convey how liberating it can be to share their experiences with other women. I want to dedicate this to my aaji's and nani's (grandmother's), my mother, fua's and mausi's (aunts), and all the women who have raised me. Their lived experiences and their willingness to share their experiences of IPV amongst each other was a motivating factor in initiating this study. Additionally, I want to take this opportunity to thank the Fijian Indian women who participated in this study. Without you and your contribution, this would not have been possible. I am grateful that you recognized the need for a conversation about IPV within the Fijian Indian community. You are all so bold and brave for doing so because I understand how traumatic such discussions can be for some. Especially when there is someone we know who is a victim of IPV. Thank you for having this conversation with me.

I want to take this opportunity to thank my professors at Betty Irene Moore School of Nursing, who guided me through this emotional path. Dr. Fawn Cothran, Dr. Jessica Draughon Moret, and Dr. Julie Bidwell appreciate your endless guidance and support. Lastly, I want to thank Dr. Jann Murray-Garcia, without whom this thesis and study would not exist. Thank you for embarking on this journey with me. Your belief in me made this thesis possible. It was a privilege and an honor to work on this study under your guidance.

The impact of IPV and its lasting effects on women's life is very close to my heart. I have seen women suffer and what hurts more is when you cannot do much about it except be angry. This thesis highlights my journey of that anger turning into a call for action. I hope that my work can help someone out there looking to gain an insight into this community.

Abstract

The purpose of this phenomenological study is to determine how cultural views impact Fijian Indian women's perception of IPV. The first objective of this study identifies themes in Fijian Indian women's perspectives regarding IPV. The second objective of this study determines the impact these themes have on Fijian Indian women. The lifetime economic cost for Intimate Partner Violence (IPV) in the United States (U.S.) is 3.6 trillion dollars. Studies show that South Asian women are at a higher risk for experiencing IPV in the U.S. Fijian Indian women are part of the diverse South Asian diaspora; however, there is no published data on the experience Fijian Indian women have had with IPV. Ten Fijian Indian women, 18 years of age and older, who reside in California, were recruited through social media platforms. Data were collected through a semi-structured interview which took place either face-to-face or via zoom call. Results reveal that within the Fijian Indian community, women report a silencing and normalizing of the IPV experience. Contributing factors to this silencing and normalizing include familism/collectivism, shame and judgment, patriarchy/traditional gender roles, generational gap/learned behavior, and Hinduism's gender hierarchy. When it comes to seeking help for IPV, women are more inclined to seek help within the family than from outside the family. According to these interviewees, health care providers and law enforcement end up being their last choice. Health care providers must understand the cultural nuances of the Fijian Indian community to provide holistic, patient-centered care, especially when it comes to providing care to a victim of IPV.

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Introduction

The Centers for Disease Control and Prevention (CDC) defines Intimate Partner Violence (IPV) as abuse or aggression that occurs in a close relationship with a current or former spouse or dating partner (CDC, 2018). There are five types of behaviors that can be classified as IPV: physical violence, sexual violence, economic violence, stalking, and psychological aggression (CDC, 2018). Physical violence is when a person attempts to hit, kick, or use physical force to hurt their partner. Sexual violence is when forcing a partner to take part in a sex act, sexual touching, or a non-physical sexual event (sexting), without consent (CDC, 2018). Economic violence involves controlling access to money (Domestic Violence, 2020). Stalking is a pattern of repeated, unwanted attention and contact by a partner to the extent that it provokes fear for one's safety or the safety of one's loved ones. Psychological aggression is verbal or non-verbal communication used to inflict mental and emotional harm or to exert control over someone (CDC, 2018).

Intimate Partner Violence (IPV) varies in severity and frequency. It impacts individuals in every community, at every income level, and at all levels of education (NCADV: National Coalition Against Domestic Violence, 2020). Although both males and females experience IPV, women are at a higher risk for experiencing it. One in four women and one in 10 men report experiencing sexual violence, physical violence, or stalking from their partners; 43 million women and 38 million men reported experiencing psychological aggression (CDC, 2018). The CDC reported that 41% of female IPV survivors experience some form of physical injury; nearly

half of female homicide victims are killed by current or former intimate partners (CDC, 2018). IPV negatively impacts women's physical and mental health, and it puts them at risk for engaging in health risk behaviors (CDC, 2018). The lifetime economic cost of IPV, for all victims, due to expenses related to medical services for injuries, lost productivity from paid work, criminal justice, and other costs, is $3.6 trillion in the United States (CDC, 2018). The cost of IPV over a victim's lifetime is estimated to be $103,767 for women and $23,414 for men (CDC, 2018).

This thesis begins with an in-depth consideration of the history of how people from India came to be in Fiji and how that colonial indentured servitude under British influence structured their gender and sexual relations and ethnic minority status in Fiji. These cultural perspectives and ways of being followed by Fijian Indian immigrants to the United States are important to understanding the complexity of responses to IPV among Fijian Indian American women today.

Background

Indians in the Fiji Islands

The Fijian Indian community is a unique group of South Asians displaced from India during the British occupation. After the abolishment of African slavery in 1833, the British started the Indian indentured system in 1838 for a cheap source of labor to work on a sugarcane plantation in the South Pacific (Sharma et al., n.d.). Between 1838 to 1916, approximately 1.2 million Indians were displaced from India and taken to other countries, including Trinidad/Tobago, Guyana, Fiji, Tanzania, and Kenya (SAALT, 2020; Sharma et al., n.d.). Of

those 1.2 million laborers, 60,537 Indians were transported to Fiji over 37 years (Ali, 1979). Although laborers were promised a wage, the Indian Indentured system was a “global substitute for African slavery” as laborers were constantly reminded that the plantation owners owned them for the duration of their agreement. In some ways, their treatment of Indians was characteristically similar to slavery (Lally, 2018, pg. 71).

Recruiters were brought into India to persuade Indians to migrate to Fiji, and other countries, for labor. Some Indians were kidnapped and forced to migrate using false documents; others went willingly to earn a living, as most of India was impacted by poverty (Ali, 1979). Recruiters would describe Fiji as a paradise where people could go and work to earn money, and then they could bring that wealth back home to help themselves and their families (Ali, 1979). Indentured servants who migrated to Fiji would later become known as “Girmitya" or “Girmit.” “Girmit” is also known as “Agreement,” referring to the agreement that these indentured laborers signed when they were being recruited to come to Fiji. Laborers signed these agreements by stamping their thumb on a piece of paper that stated that they would have to work in these plantations for a specific length of time (i.e., five years), and then they would be able to return to India at their own expense. Unfortunately, laborers were prevented from leaving by the government of Fiji and the Colonial Sugar Refining Company (CSR) of Australia. This way, they could ensure a continued supply of laborers for Fiji’s sugarcane industry. Laborers were paid in shillings for their labor, barely enough to go back. In addition, laborers got time added to their contract as punishment, which kept them in Fiji longer. Ultimately, workers who kept in

touch with their family members in India went back. Others stayed in Fiji and started a new family. The Indentured laborer system was eventually abolished in 1920.

Life in Colonial Fiji

During their years of servitude, Indians were bound to this contract to the extent that the estate managers could criminally prosecute them for attempting to leave (D'Souza, 2000). Living conditions for laborers were terrible; they were housed in sheds that were "partitioned into ten by seven ft cubicles" (D'Souza, 2000). Additionally, there was a lot of corruption among estate managers and law officials in Fiji. If a laborer was accused of a crime, they were likely punished, regardless of whether they had committed the crime. The punishment was having the years of servitude extended, resulting in a continuous source of labor for the plantations. The British practiced the system of indentured labor the same way they practiced the system of slavery.

Among all the countries that were part of the indentured servitude program, Fiji had the highest rates of suicide among Indian laborers (D'Souza, 2000). Suicide rates among Fiji Indians were 0.780 per thousand and later climbed to 0.831 per thousand, while suicide rates back in India were 0.046 (Lal,1985). Factors that contributed to high incidents of suicide included depression due to homesickness, feelings of being bound to an agreement, poor living conditions, and "domestic unhappiness" (D'Souza, 2000; Lal, 1985). Indian men committed suicides at high rates in Fiji, and Indian women experienced high rates of homicide until 1920.

Implications of Being a Minority

The encyclopedia of critical psychology defines a minority group as a "subgroup of the population, whose religious, ethnic and racial or other characteristics differ from the majority group" (Perkins & Wiley, 2014). Indian women in Fiji were quite literally a minority group as the number of adult Indian females to 100 Indian men in Fiji was only 43.17 (Lal, 1985). Indentured Indian men were "eager to put down their roots in their new home" in Fiji; however, there were not enough women available (Lal, 1985). This led to high rates of suicide among men on the plantation, which was attributed to "domestic unhappiness" (Lal, 1985). Inversely, women were being murdered by men on the plantation due to "alleged infidelity," which was "punishable by death" in an Indian society. (Lal, 1985). Among the crimes that were reported and recorded among the 60,965 Indians, "between 1885-1920, 96 indentured servants were murdered, 68 of which were women and 28 men" (Lal, 1985). Incidentally, there was a high rate of homicides against indentured Indian women in Fiji. In this situation, women were victims of homicide because of cultural factors, specifically traditional gender roles, which set expectations of how men and women should act within the Indian society. Unfortunately, this contributed to the increase in crime against women and the loss of their lives.

Sexual harassment, sexual exploitation of women, and unfair working conditions were other crimes against women. Women were sexually exploited because the "shortage of women led to sharing of women" (D'Souza, 2000, pg. 1073). Stories of two indentured laborers in 1912, Kunti and Naraini (2021), grabbed national attention and shed light on the conditions of Indian

women in Fiji. Kunti was a laborer, who had emigrated to Fiji with her husband. During her fifth year working in the plantation, the overseer attempted to sexually molest her in an isolated area of the farm. Kunti fought him off and ultimately had to jump into a river to escape; she was saved by a bystander (Kumar, 2021). Naraini was among other women who were mistreated in the plantations. She was a mother who had given birth to a stillborn baby and was expected to return to work three to four days postpartum (Kumar, 2021). She refused to return to work and consequently was physically abused by the overseer, to the extent where she had to be carried to a hospital for care (Kumar, 2021). Justice was never served in either of the cases. Kunti was later accused of lying, and the perpetrator in her case was never held accountable. Naraini's abuser was arrested, found not guilty, and freed. As minorities in Fiji, Indians had poor life outcomes. When mixed with colonialism, women's life outcomes were worse than the rest of Fiji's population, with none worse than the life outcomes of Fijian Indian women.

Colonialism's Impact on Race Relations

In order to understand the unique complexities of the lives of Fijian Indians, specifically Fijian Indian women, it is essential to understand how colonialism impacted not only gender and sexual relations but race relations in Fiji. Since the arrival of Indians in Fiji as indentured servants, the relationship between native Fijians and Indians has been poor. The Fiji Islands was one of many convenient locations to introduce the indentured laborer system because it was a British Colony. Indians were brought to Fiji by the British to work on the Australian Colonial

Sugar Refineries (CSR). This allowed the British to profit off sugar exports without damaging their relationship with the Native Fijian population.

The Fijian government and its power structure have been made to favor Native Fijians regarding land ownership and control (Nanda, 1992, p. 566). As the indentured laborers completed their agreement terms, some went back to India, and some decided to stay in Fiji. In response, the Fijian government started to regulate Indians and the use of their land, which marginalized them. Between 1905 to 1915, the government passed the Native land ordinance of 1905 and the regulation of the Native land of 1915 (Lally, 2018, p. 73). The Native land ordinance stated that 83% of the land in Fiji belonged to the Native Fijians, which prevented Indians from owning land (D'Souza, 2000). Later the British colonial office passed the Agriculture Landlord and Tenant Ordinance (ALTO), which allowed Indians and the British to lease Native Fijian land to farming and agriculture, much like the sharecropping arrangements characteristic of the American South (Lally, 2018). These land leases could go from five to ten years, all the way up to 99 years, and they allowed native Fijians to keep their land while ensuring productivity for the British (Lally, 2018). The laws and regulations passed by the British colonial office and the Fijian government only served to protect the interests of the Crown and the Fijian Natives at the expense of Fijian Indian laborers.

Racism in Fiji

Fiji received its independence from Britain in October of 1970. Indo-Fijians made up the largest ethnic group in Fiji by 1986, which consisted of 48.6% of the population, while the

Native Fijians made up 46.2 % (D'Souza, 2000). Approximately 80% of all Indo-Fijians were sugarcane farmers and at the turn of the 21st century, as the 99 year-long leases began to expire, landlords refused to renew them. People began to lose their farmland and means of livelihood. The laws and regulations that were passed were temporary solutions to a much larger issue that was being ignored -- racism. The CDC defines racism as a structure that consists of policies, norms, practices, and structure that "assigns values and determines opportunity" based on a person's look or skin color. It ultimately harms people's mental and physical health and prevents them from attaining their highest levels of health (CDC, 2021). Fijians Indians have lived in Fiji as minorities for 144 years and have endured racism from the Fijian government and the British colonial offices, through the laws and regulations that have continuously marginalized this community.

Despite making up more than half of the country's population, Fijian Indians have struggled to gain representation in the Fijian government. Every time Fijian Indians gained representation or a voice in the Fijian parliament, it was quickly revoked through coups that Fijian leaders carried out. The first coup in Fiji occurred on May 14th, 1987, after native Fijian Dr. Timoci Bavadra was elected as a prime minister (Nanda, 1992, p. 567). Dr. Bavadra's cabinet consisted of six Native Fijians, seven Indians, and one part-European (Nanda, 1992, p. 567). This election prompted a protest by the Taukei Movement, who wished for a political system exclusively for Native Fijians. Following this protest, the third-ranking military officer, Sitiveni Rabuka, led a coup where Dr. Bavadra was arrested, and the constitution was revoked.

(Nanda, 1992, p. 568). Following the first coup, promises were made to create a more "bipartisan government" however, this promise was not upheld as Rabuka led Fiji into a second coup on September 26th, 1987 (Nanda, 1992, p. 568). This new military government passed the "Fundamental Freedoms Decree of 1987" which stated: "freedom of life, liberty, security of the person and protection of the law may be restricted by decree in the interests of public order and morality" (Nanda,1992, p. 569).

After the second coup, Rabuka placed governor-general Ganilau, also known as Ratu Sir Mara, as the new prime minister of Fiji. This new regime asserted "strict Methodist Sabbatarianism" upon non-Christian Fijians and "increased harassment of Fijian Indians" (Nanda, 1992, p. 569). As a result, 30,000 and 40,000 Indians fled Fiji after the second coup, which left Fiji's "multiracial society evenly divided between indigenous Fijians and ethnic Indians" (Nanda, 1992, p. 571). Following the second coup, the Fijian Parliament had to make changes to its Constitution because of its affiliation with the "Internal Convention of the Elimination of All Forms of Discrimination" (Nanda, 1992, pg. 575).

Fijian Indians slowly started getting rights in Fiji's governance and being protected under law. In 1999, Fiji elected its first Indo-Fijian Prime Minister, Mahendra Chaudry. This election led Fiji into its third coup, which forcefully removed Chaudry as Prime Minister. Laisenia Qarase became prime minister of Fiji following this coup and ultimately was removed from power in 2006 following Fiji's fourth coup. As minorities, when Fijian Indians experience "social stressors rooted in systems of inequality," created by the Fijian Government, it has direct

and indirect impacts on health and wellbeing (Perry et al., 2013). Consequently, many Fijian Indians migrated to North America and Australasia (Lal, 2003).

Intimate Partner Violence: Potential Elevated Risk for Fijian Indian Women Living in the United States

In migrating to the US, Fijian Indian women carry generations of trauma and abuse that they experienced in Fiji into a country where they are at risk for further marginalization. This places them at a higher risk for poor health outcomes in the United States. First, being a Fijian Indian makes them a minority and more susceptible to racism. Second, being a woman places them at a higher risk for harm due to increased gender discrimination. And third, being an immigrant in the United States increases their risks for abuse further.

IPV is a serious preventable public health problem in the United States that disproportionately impacts ethnic minority women (Stockman et al., 2015). There are 32,304 Fijians living in the United States, and 75% resides in California (United States Census Bureau, 2010). This places Fijian Indian women at triple minority status because they carry generations of trauma and abuse into a country where they are at risk for further marginalization. Despite all the research that has been done around IPV, there is no published research exploring how IPV impacts Fijian Indian women.

Impoverished persons from India came to Fiji through the false promises of colonial indentured servitude under British influence. The Europeans created this crooked system of indentured servitude in the late 1800s to replace the Atlantic Slave Trade, which exploited and

brutalized Africans, in meeting the cruel and inhumane labor demands of economic avarice. The indentured servitude of Indians in Fiji structured the gender and sexual relations and ethnic minority status that followed Fijian Indian immigrants to the United States. Cultural perspectives and traditions influenced by these traditional gender and sexual relations, ethnic minority status, and now immigrant status in the United States is important to understanding the complexity of responses to IPV among Fijian Indian American women today.

Literature Review

The intended focus of this literature review was to explore the prevalence and perceptions of IPV among Fijian Indian women. A literature search was conducted on PubMed, CINHAL, and Google Scholar using the search terms domestic violence, intimate partner violence, spous* violence, and partner violence, combined with OR. To capture the population and location, the search terms Fijian Indian, Indo Fijian, Fiji Island were used, also combined with OR. The results showed that there is no published literature that explores the perceptions of intimate partner violence within the Fijian Indian community. The populations and locations were then broadened to South Asia, Southeast Asian, India, Southeast Asian, and South Asian, combined with OR. The results showed eight published articles exploring the perceptions of violence among South Asian women living in North America. Thus, this literature review will explore how South Asian (SA) women perceive IPV.

The literature search indicated that few studies explored South Asian women's perceptions of IPV in North America. While sparse, the existing literature suggests that SA women experience IPV at a higher rate than women in other ethnic minority groups, and they are more likely to seek help for IPV (Raj & Silverman, 2002a; Raj & Silverman, 2003b; Maker &

Deroon-Cassini, 2007; Thapa-Oli et al., 2009). The studies included in this literature review were conducted in the United States and Canada. Despite the differences in countries, these articles identified some common trends among SA women and the problem of IPV: familism/collectivism, patriarchy/traditional gender roles, and victim-blaming were all identified as barriers that prevented SA women from seeking help for IPV.

Familism/Collectivism

Several of the articles identified the concept of familism and collectivism as a barrier to South Asian (SA) women seeking help for IPV. According to Merriam-Webster, familism is a social pattern in which the family assumes ascendance over individual interest (2020). Ahmad et al. (2015) state that familism emphasizes family relationships; for example, matters concerning a family are considered private. Collectivism is the notion of prioritizing the needs and goals of a family/community over an individual. Abuse is considered a private family matter, and this often leads to the minimization of women's experience of IPV (Ahmad et al., 2015). The concept of collectivism was further defined by Ahmad et al (2015), as either horizontal or vertical collectivism, with an emphasis on vertical collectivism that impacts most SA women. Vertical collectivism is when a hierarchy is defined by the family/community and they show a willingness to sacrifice self for collective good (Ahmad et al., 2015).

Studies reported that women chose to sacrifice their happiness and tolerated partner abuse for a long time. This was to preserve family unity and achieve a perceived collective good for their significant others, especially their children (Ahmad et al., 2009; Pajak et al, 2014). SA women did not seek help or talk to others about IPV (Raj et al., 2002). Familism led women to maintain secrecy and denial about violence, minimize disclosure about battering, identify with victimization, and even elect to protect their abusive partner, particularly if they were socially

and culturally isolated (Maker & Deroon-Cassini, 2007). Ultimately, SA women's experiences of domestic violence were minimized due to the cultural notion of familism and collectivism, which enforces the idea that IPV is a private family matter.

Patriarchy/Traditional Gender Roles

Multiple studies identified the concept of patriarchy as a barrier to seeking help for IPV among SA women. Patriarchy is an ideology that refers to ideas and beliefs that justify male domination over women in society (Ahmad et al., 2004; Ahmad et al., 2009). Traditional gender roles place men as dominant and women as submissive (Maker & Deroon-Cassini, 2007). Studies found that women who agreed with patriarchal norms were less likely to see spousal abuse as abuse ultimately placing them at a greater risk for continued abuse. Women in these groups often delayed seeking help and discouraged other women from seeking help (Ahmad et al., 2004; Thapa-Oli et al, 2009). When women are identified as submissive and subordinate, it promotes violence to maintain family structure and honor, minimizing their experience of IPV (Ahmad et al., 2004; Maker & Deroon-Cassini, 2007).

Studies reported that SA women felt that their family and community expected a 'real' woman to remain silent about abuse (Ahmad et al., 2004). This is so they can maintain the marital bond as an obligation of good wives, daughters, and sisters whom they perceived to have a subordinate role to men (Ahmad et al., 2009). The same study reported that women had "three obedience's" in life, meaning they were expected to be obedient to their father, brother, and husband (Ahmad et al, 2009). Studies also found that SA women do not perceive sexual violence as abuse. This phenomenon stems from patriarchy and traditional gender roles that require further investigation on perceptions of sexual violence among SA women (Ahmad et al., 2015; Thapa-Oli et al., 2009).

Victim Blaming and Shaming

The Canadian Resource Centre for victims of crime states that victim-blaming is when victims are wrongfully portrayed as individuals who "seek out and submit to violence" and thus are held accountable for the crime they experienced (2009). Several studies identified victim-blaming as a reason why they often choose not to seek help. Women reported that cultural expectations of silence, subordination, and obligation from women increased their feelings of shame and guilt, which lead them to believe that disclosing or seeking help was never an option for them (Ahmad et al., 2009; Pajak et al., 2014). Studies also found that SA women believed female victims lie or exaggerate claims of domestic violence; they agreed that women sometimes deserve abuse and that they deserved the abuse (Raj & Silverman, 2002; Madden et al., 2015).

Women who sought help, despite the barriers they faced, experienced victim-blaming attitudes from providers (Pajak et al., 2014). They reported that providers' blaming attitudes often generated support for abusive partners and prevented women's access to resources. Part of the victim-blaming attitude came from women seeking help after years of abuse and not earlier in the course of abuse (Pajak et al., 2014). As mentioned before, SA women often do not seek help or delay seeking help for IPV due to familism and patriarchy. Placing blame on women for the violence they endure for years highlights the lack of knowledge and understanding that society has of victims of abuse. This can potentially delay help-seeking even more, placing SA women at a greater risk of harm.

Limitations

One limitation that was prominent in all studies was that the measuring tools researchers used were not designed for the SA community. Most of the scales that were used had to be translated into English and were not culturally centered. This makes it harder to understand how

SA women, and ultimately Fijian Indian women, perceive IPV. However, the qualitative design used in studies with SA women helps eliminate some disparities in the results. The small sample sizes for the quantitative studies limit the generalizability of the results to all SA women. Seeing certain themes reappear in different studies suggests that despite these studies' sample sizes and locations, women report similar concepts surrounding IPV and help-seeking. Given the results from the search strategy and the fact that one author did three of the nine studies (Ahmad et al., 2004; Ahmad et al., 2009; Ahmad et al., 2015), it is evident that there is not enough research being done on this specific topic. Another limitation was the fact that half of these studies were conducted in Canada, limiting generalizability to South Asian immigrant women living in the United States. However, the recurring themes across all studies suggest that despite the location, SA Women share similar cultural perceptions of IPV.

Purpose

The purpose of this study is to determine how cultural views impact Fijian Indian women's perception of Intimate Partner Violence (IPV). The first objective of this study is to identify themes in Fijian Indian women's perspectives about IPV. Fijian Indians are similar to South Asians because they are part of the diaspora population of South Asia. However, because they live in Fiji, cultural practices and values may have changed due to a different political environment. Unlike South Asia, Fijian Indians are a minority in Fiji, impacting women's perception of violence. The literature synthesis suggests that familism/collectivism, patriarchy/traditional gender roles, and victim blaming shape SA women perceptions of IPV. The second objective of this study is to determine how these concepts impact Fijian Indian women.

Methodology

Design

This qualitative study utilized a phenomenological approach to explore the perceptions of Fijian Indian women towards Intimate Partner Violence (IPV). The advantage of using a qualitative approach is that it is "flexible and elastic"; it is holistic, as it requires researchers to become involved and allows for ongoing data analysis (Polit & Beck, 2018, p. 266). Phenomenology provides the knowledge of a lived human experience, which gives each person's perception meaning (Polit & Beck, 2018).

This design was selected based on the objectives of this study to determine if, which, and how cultural views impact Fijian Indian women's perceptions of Intimate Partner Violence (IPV). The first objective of this study is to identify themes in Fijian Indian women's perspectives about IPV. The second objective of this study is to determine how these themes impact Fijian Indian Women. No published research exists that explores the Fijian Indian population about this public health issue. Due to this gap in the literature regarding the perceptions of Fijian Indian women and IPV, a qualitative phenomenological approach offers the opportunity to document how Fijian Indian women make sense of this phenomenon.

Study Approval and IRB

This study went through a two-step approval process before data collection. The first step included creating material that was appropriate for this study and its participants. Peer debriefing was utilized for this process. All the material used for this study, for example, the recruitment flyer, the interview questions, the consent form, and the resource page, were

reviewed by the co-investigator and two professors at the Betty Irene Moore School of Nursing (See Appendix A-D). The second step consisted of an Institutional Review Board (IRB) application, which was submitted to the University of California Institutional Review Board and the University of California, Davis Social and Behavioral Committee. This study was exempted by the IRB.

Study Sample and Sampling Technique

Informant triangulation and purposive sampling were used to recruit a diverse group of Fijian Indian women with lived experiences and understanding of the Fijian Indian culture. Women from various ages, sexual orientations, educational and financial backgrounds, and immigration status were included. The inclusion criteria for this study were English-speaking Fijian Indian women over the age of 18, living in California, who were either born in Fiji or had parents born in Fiji. It was not necessary for women to have any personal experience with IPV in order to participate in this study.

Ten participants were recruited through convenience sampling and snowball sampling (See Appendix A). The convenience sample was obtained using a recruitment flyer that was posted on the PI's social media outlets (Facebook and Instagram page), which were viewed and presumably forwarded to others by women who had access to social media and were on the Principal Investigator's (PI) friends list. Snowballing was also used as a recruitment technique as participants encouraged other Fijian Indian women to participate in this study. The flyer included information such as the description of the study, inclusion criteria, contact information, and where the study would take place. Recruitment took place between August 2020 to December 2020.

Data Collection Procedures

Although participants were not required to have any experience of IPV, some women were victims of abuse who participated in this study. The PI conducted one-on-one interviews to protect participants' identities and provide the women with a safe, secure environment to speak freely. This would not have been possible to do in a focus group. Video call interviews were preferred over face-to-face interviews to ensure participants' safety due to COVID. Once individuals expressed interest in participating in this study and met the inclusion criteria, the PI established a location for the interview. A consent form was sent to participants before the interview and was read and reviewed with each participant immediately preceding the interview. Each participant was notified that their voices were being recorded and that the researcher was also taking notes as they spoke. Participants were given time to ask questions regarding the consent and the interview process prior to starting the interview. They were asked not to disclose their name or any other personally identifying information.

Interviews were conducted in-person or via any form of video call that participants preferred. Open-ended, semi-structured questionnaires guided this interview. The PI sought participants until data saturation was achieved or, in other words, when the participants were sharing no new information. All interviews were recorded and transcribed verbatim for accuracy. If participants felt uncomfortable being recorded, the PI was prepared (and offered) to record the responses only in writing. All participants felt comfortable being recorded. During the interviews, the PI took field notes to document non-verbal communication, body language, tone, and emotional responses. Data and all information related to this study were stored in the PI's password-protected computer.

Interview Process

The interview questions were created by the PI and reviewed by the PI's thesis committee at the Betty Irene Moore School of Nursing. Participants were asked demographic questions such as age, sex, sexual orientation, education, relationship status, employment status, and immigration status. The open-ended portion of the interview inquired participants' individual understanding of IPV, and how men, women, and the community view it. In addition to that, participants were asked where Fijian Indian women should reach out to for help for IPV (See Appendix A). This interview aimed to determine how Fijian Indian women perceive IPV and whether these perceptions impact women seeking help for IPV. The interview was designed to give healthcare providers a cultural lens of how they could most effectively and respectfully provide care to victims of IPV in the Fijian Indian community.

Data Analysis

After concluding each interview, the recordings were transcribed verbatim by a HIPAA-compliant transcription service. After each interview was transcribed, the PI reviewed each interview to ensure that the interviews were transcribed correctly. The next step was to identify unique themes through the process of coding. Coding, in qualitative research, is used to assign meaning to the responses that are received in an interview (Basit, 2003). This process gave the PI the opportunity to code-recode the data. In qualitative research, coding allows researchers to identify recurring words, themes, or concepts and it turns them into standardized data that can be analyzed (Polit & Beck, 2018). Recoding is when this process is repeated after a specified amount of time has passed. As a final step, each of the interview transcripts were read by the

thesis chair/co-investigator, reviewing the field notes relayed by the PI. These discussions resulted in consensus in themes gleaned from the data. This step was taken to ensure the accuracy of the findings and to reduce any bias.

Trustworthiness

The primary researcher for this study is a Fijian Indian immigrant to the United States who has resided in California for 20 years. She is also a registered nurse. Being part of the Fijian Indian community gave her special access to the Fijian Indian population. As a member of this very small and specific cultural community, the PI possessed cultural insight into the Fijian Indian community, having attended numerous religious gatherings and having an established relationship with members of the community. The strength of the study was the participants' familiarity with the PI's background. This allowed them to openly speak regarding the thoughts, feelings and beliefs about IPV within the community.

Strengths and Limitations

Due to the researchers' connection with the Fijian Indian community, the process of bracketing was used to minimize bias. Bracketing is the process of identifying and holding in suspended judgment preconceived beliefs and opinions about the phenomenon under study (Polit & Beck, 2018). Bracketing was done by the PI keeping a reflective journal. The PI documented her thoughts and feelings about how the recruitment process went, the communication process and nature of the collected data, and the analysis of the findings. To further minimize bias, collected data was coded by the PI but analyzed by both the PI and the thesis chair/co-investigator. Peer debriefing was used at each step of this study as well, as part of the structured

classroom experience of the Masters-Leadership program for which this thesis project is required.

A limitation to this study was that the PI's connections with the Fijian Indian community extended only to the community that practiced Hinduism. Therefore, findings are limited to how Fijian Indian Americans of the Hindu community view IPV. Fijian Indian women who practice Islam, Sikhism, Christianity, Buddhism, or any other religion were not a part of this study. The significance of religion in the perceptions of IPV, specifically the Hindu religion, will be further explored in the results sections. However, it is essential to note that religion plays a role in shaping perceptions. Therefore, future studies in the Fijian Indian community will need to be more representative of all faiths.

Ethical Considerations

Participant Protection

It is important to note that women who had experienced IPV also participated in this study and shared their personal experiences. In this situation, the PI was a mandatory reporter. All participants were informed that the PI is a mandatory reporter prior to the interview. Additionally, if participants disclosed their personal experience with IPV, as the interviewer, the PI had resources for every participant, so that they could seek help. Resources included information for getting health insurance so medical help could be obtained, along with local shelters that women could access in their area (See Appendix D). All ten interviews were analyzed and stored in a password protected computer where information could be reassessed to keep an audit trail. Information collected from each interviewee was shared only with that

respective interviewee who wanted it. The participants' interviews and field notes were discarded in four months (December 2021) using the IRB guidelines.

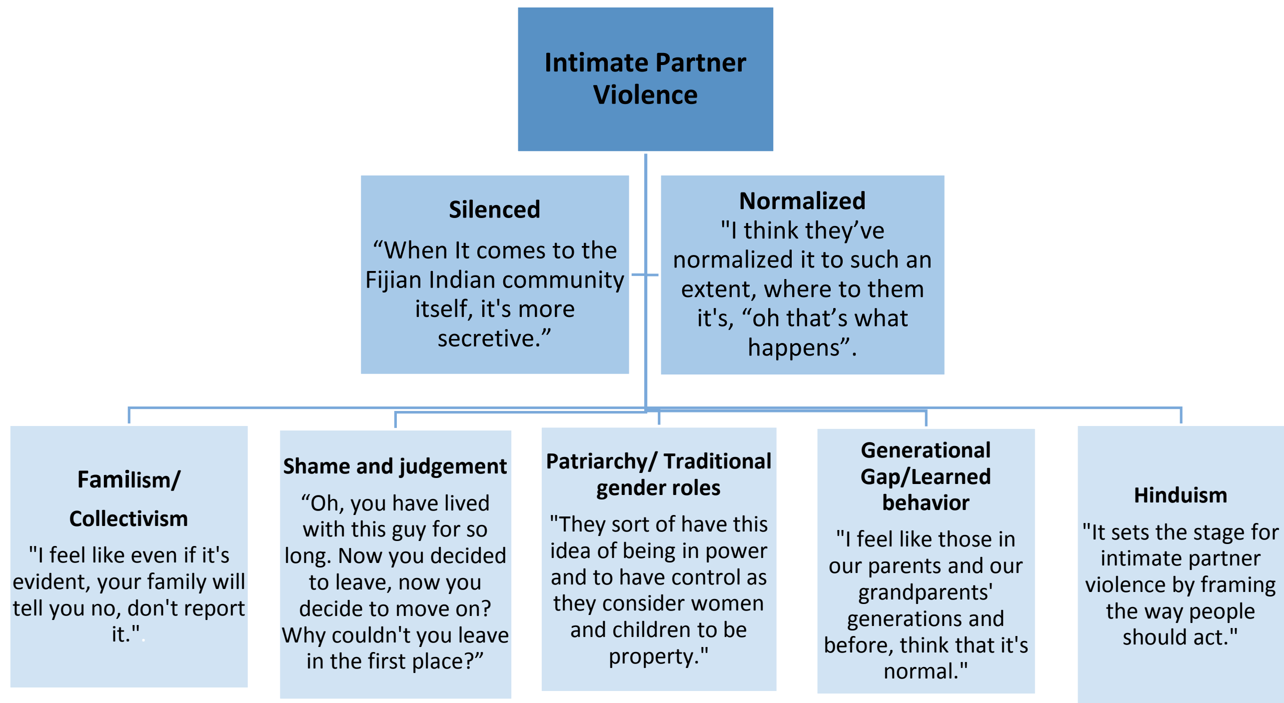
Results

Through semi-structured interview, ten Fijian Indian women shared their perceptions of IPV as members of the Fijian Indian community in California. Interviews took place either face-to-face or via zoom call. The interview questions were designed to assess cultural perceptions of IPV and examine what effective help looks like within the community (see Appendix B for interview questions). Each interview lasted between 20 – 40 minutes, with the average being 30 minutes. Overall, study results indicated that Fijian Indian women recognize IPV, and they know that abuse comes in different shapes and forms, whether that is physical, emotional, or mental abuse.

The first objective of this study identified themes in Fijian Indian women's perspectives regarding IPV. According to interviewees, in the Fijian Indian community, culturally speaking, IPV is a topic that is met with Silencing and Normalizing (Refer to Figure 1). Factors contributing to the silencing and normalizing of IPV within the Fijian Indian community include familism and collectivism, shame and judgment, patriarchy and traditional gender roles, generational gap and resultant learned behavior, and gender-related teachings of Hinduism. The second objective of this study determines the impact these themes have on Fijian Indian women. Interviewees also indicated that cultural factors play a significant role in deciding whether women in the community seek IPV help.

Figure 1

Themes and Contributing Factors



Note: The terms Domestic Violence and Intimate Partner Violence were used interchangeably by participants at times, and in the quotes that follow, whichever term each woman used is what appears in the specific quote.

Demographics

Participants' ages ranged between 21 to 45 years of age, with an average age of 24.5 years old. The majority of women were heterosexual/straight. Of the remaining 30% one participant identified herself as lesbian, one participant identified herself as bisexual, and one participant preferred not to answer. The majority of the women in this study were single, while two women were currently in a relationship, and one was divorced. All participants were educated beyond high school, with the majority possessing a bachelor's degree. Twenty percent had some college education, and the other ten percent had their associate's degree. Most women were employed,

and most of the participants were born in Fiji, with the median age of immigration being five years of age (Table 1).

Table 1

Demographic Chart

	Participants	Total
Age Range		
21-25	6	60%
26-30	1	10%
31-35	2	20%
41-45	1	10%
Sexual Preference		
Heterosexual/ Straight	7	70%
Gay/Lesbian	1	10%
Bisexual	1	10%
Prefer not to answer	1	10%
Relationship Status		
Single	7	70%
In-a-relationship	2	20%
Separated/Divorce	1	10%
Education		
Some College	2	20%
Associates	2	20%
Bachelor's	6	60%
Employment		
Yes	7	70%
No	3	30%
Country of Birth		
Fiji	8	80%
USA	2	20%

Silencing and Normalizing

Interviewees indicated that IPV in the Fijian Indian community is normalized. Women are expected to tolerate abusive partners because maintaining a marital bond is very important within the culture. One participant stated that when she was in an abusive relationship, her mother-in-law told her:

> *"that women go through this and sometimes you have to compromise. Our community has made it, has made it like an okay thing for our, for girl or woman to go through it."* (Participant 9)

Another participant shared how she felt after a conversation with her grandmother, who experienced violence from her spouse.

> *"My grandma, when she came, um she was talking about a situation in which she was, you know, hit by her husband and it was such a, it was such a weird experience to hear her talk about it and kind of, she was almost kind of numb to it because she kind of just said it so matter-of-factly. Like 'oh this just happens'*. (Participant 3)

In reference to silencing, IPV is seldom discussed within the community because it is seen as a personal relationship matter that couples can resolve amongst themselves rather than the crime that it is. During the interview, women stated of IPV in the Fijian Indian community.

> *"It's not talked about, it's almost like taboo. It stays within the family. So, then it continues to happen. Over and over again. Or if people do find out like Indian people, they don't do anything to help*." (Participant 10).

Normalizing and silencing resulted from the enacted concepts of familism and collectivism, patriarchy and traditional gender roles, shame and judgement, and Hinduism. Each concept plays a significant role in how IPV is perceived and responded to within the community.

Familism and Collectivism

The concept of familism/collectivism refers to the idea that one's family comes first. Women are expected to place their family and family unit first; they are expected to prioritize family honor and respect. The Fijian Indian community gives a lot of importance to the concept of family and collectivism, and this concept serves as a barrier when it comes to seeking help for IPV. Data indicate that when seeking help for IPV, women search for help within the family, or someone trusted outside the family. In-laws or even biological family members will tell women to stay in the relationship to make it work. This is partly because a broken relationship will tarnish the family's reputation in the community. Ultimately, women are discouraged from talking about IPV with others and seeking help because it places their families at risk for defamation or social stigma. One participant shared her experiences with her own family and talked about how they discouraged women from getting help.

> *"It's the image of family that needs to be defended. And so, if you need help, and your family is like, you know what, you don't love your family, clearly, you don't support your family, you would have kept this under wraps, you would have dealt with this quietly and by yourself. And now that you've involved everybody else in your business, you will now face the wrath of the community" (Participant 8).*

Another participant described what she has witnessed with situations where women did not leave abusive partners because of their families.

> *"Well, I think the help should always come from the family. Um, you know, the family should be able to help you, but I do know, because our...of our culture, a family sweeps it under the rug, um, they don't want to get involved, you know, in another family's marriage. Um, and I feel like if it's not, if your family's not the one supporting you, then*

of course, you know, if you have the capability, you should go and seek help outside. But I think a lot of times because of the fear that women have, they don't do that. They just put up the, with the abuse." (Participant 7).

Fijian Indian women are expected to shape their lives around the concepts of familism and collectivism, where their priorities are to serve and protect their families. This serves as a barrier to seeking help for IPV, to the extent that help is delayed or in some cases never received.

Patriarchy and Traditional Gender Roles

Participants emphatically and consistently expressed that IPV within the community is silenced and normalized because of patriarchy and traditional gender roles. Patriarchy is the social system that gives men authority and power, whether in a political role or within the household. It strongly influences how a Fijian Indian family unit is structured. Within this community, men are the head of the home, and women are homemakers. Fijian Indians grow up learning these traditional gender roles, which in turn reinforces patriarchy intergenerationally. One participant opened up about what she had witnessed growing up regarding children's upbringing within the community, saying that:

> *"I feel like just growing up within the community, and kind of seeing how parents raise their daughters, it's very different from how they raise their sons. We are taught to basically be a grown woman when we're still young, our childhood I feel like it disappears. In a sense, we don't have a childhood, you know, we don't get to do what our brothers do. We were the ones who have to stay home and were basically taught how to be a wife"* (Participant 4).

One participant stated that IPV is normalized as it was suggested that patriarchy assumes violence at the hands of men is something women must deserve.

"I think that there is a heavy amount of people that think that it's okay. As long as it's the man hitting a woman…because there is a strong patriarchal structure and if a man hits a woman, then she probably deserved it, is what some people think" (Participant 2).

Enough people, men and women, believe and behave in ways that keep patriarchy as a social structure in place, creating an environment where abuse is normalized and not discussed. This means that women may not ever seek help for IPV because it is normalized to such an extent that she does not perceive abusive behaviors as abuse.

Shame and Judgement

Interviewees indicated that there is substantial shame and judgment when it comes to IPV in the Fijian Indian community. As mentioned earlier, women are expected to tolerate abuse to maintain their family unit. As a result, they are ashamed to talk about their experiences of IPV because they do not want to be perceived as weak. Study participants revealed that women were subjected to victim-blaming when they did talk about abuse. They frequently ran into situations where abuse from men was justified. One woman stated that:

"When they do talk about it, it's usually in regard to the woman being looked at negatively. Like not, not um, basically not holding up her end of whatever bargain marriage is supposed to be. I think there is a lot of um, shame about violence, domestic violence and intimate partner violence. I feel like there is shame on um, there is shame on both sides. For men who perpetuate violence, they um, the idea that they, there is the idea that they can't do anything wrong almost...I feel like for women it's the burden to take that accountability" (Participant 3).

Women who have attempted to seek help were looked down upon by family and members of the community. A participant stated that women were accused of breaking a family apart when they sought help.

> *"It's like, something like, as a whole culture, like, it's, if you don't do that, or if you're like, talking about in public, you're seen as like someone, especially as like a woman, or that's like, going against your culture or like, you know, trying to, like break up your family"* (Participant 5).

As a survivor of IPV, another participant shared her experiences of shame and judgment she faced after leaving her husband due to abuse.

> *"When I was going through it, people were, people who knew, not many people knew, but the people who knew they knew that it was happening to me, they were totally fine. But I think for the part that I actually stood up for myself, I became the bad person. Because I feel like I'm, I feel like, people considered me wrong to be standing up for myself. People considered me a bad person to be, to be leaving your husband and moving on with your life 'Oh, you have lived with this guy for so long. Now you decided to leave now?' You decide to move on? Why couldn't you leave in the first place? So, so things like that were actually questioned about my character, about my behavior"* (Participant 9).

Shame and judgment are barriers that prevent women from seeking help for IPV. It often delays one's intentions for seeking help in the first place. After leaving one form of abuse, they have to face emotional and mental abuse from the community. This further places' them at risk for harm.

Generation Gap and Learned Behavior

Interviewees reported a generation gap in the perception of IPV between younger and older generations of Fijian Indians. The older generation still believes that IPV is normal and

something that should be kept private. This belief is fueled by the concept of patriarchy and traditional gender roles, along with the concept of familism and collectivism. One participant stated that she feels that older men in the community feel that IPV is normal, and this is reflected in how they undermine women's experiences of violence.

> *"Um I think definitely older men have this belief and they have justified it and had it for such a long time where it's so ingrained in like the way they operate in every sense you know, with women. Um you know, even underscoring women experiencing violence in like a multitude of ways. I would like to think that younger men don't share that feeling, but I can't say that for sure."* (Participant 3).

Another participant stated the women from the older generation consider IPV normal. She stated that women would not leave abusive relationships; rather, they will dismiss the abuse and continue with life.

> *"Um definitely the older generation is a little bit different, because they are so used to like, old, old times. Whereas if you do something negative or harmful, the woman will just stay or act like nothing happened or forgive you"* (Participant 4).

Participants stated that men were more likely to be abusive in households where they are taught these values, stating that IPV is a learned behavior. Men in the younger generation who have grown up in an abusive environment were more likely to think that IPV is normal and act on it. Women said that men in these specific situations would have to do a lot of unlearning and relearning if they wanted to break this cycle of IPV. For example, a participant stated that:

> *"Oh man, like, older ones, are clinging on to it as their, you know, as they're getting older, and having more health issues, losing control of their lives and the situations, especially if the women are healthier. And then they decide to pass that ugliness on to*

their kids. And so, unless you are not a part of the Fijian Indian community, you have to like actively, like you, I feel like you have to intentionally undo that for yourself. That idea that you are a privilege, you are you" (Participant 8).

Women talked about how both men and women teach the younger generation that IPV is normal, by never holding them accountable for their actions. Without accountability, the older generation reinforces the fact IPV is normal, that it is okay to hurt one's spouse. One participant stated that they had witnessed mothers who have normalized IPV by justifying their son's abusive behavior. She stated that:

"I feel like we see that in their partners, you see in that in the mothers, and you know, they are kind of like always covering for the men and justifying and uh, I feel like that goes back to a lot of internal, internalized sexism and misogyny" (Participant 3).

Ultimately, the normalizing and silencing of IPV has been passed down from one generation of Fijian Indians to another because the elders believed it, practiced it, and passed down that learned behavior to the next generation. Although the younger generations are beginning to move away from the teachings their elders passed on to them, at least according to these interviewees, the normalizing and silencing still happens, again according to the interviewees, serving and reinforcing barriers victims have to navigate through. This indicates two things, 1) that if a Fijian Indian woman seeks help for IPV from someone older, they will most likely not get the help they need. Instead, she will be advised to stay and maintain her household because that is expected from her. 2) Fijian Indian women might not recognize abuse and abusive behavior patterns because they may be taught that these behaviors are normal and expected. Interviewees suggested this means that she may not seek help for IPV at all.

Hinduism

Following colonization, when Indians came to Fiji, many brought the religion of Hinduism, which was widely practiced throughout India. Hinduism has different shapes and forms, not only in India but in other areas where it was introduced. Despite the location, the basic foundations of Hinduism are patriarchal in nature. Participants talked about how people in the community gravitate more towards spirituality in times of need; therefore, if women do seek help for IPV, it is spiritual in nature. One woman stated:

> *"I feel like whenever sometimes Indian people are struggling with these situations, they don't really know what to do and instead of seeking like, things like mental health and domestic violence, instead of going to, you know, like a therapist or doctor, or a group, they will go to a pundit [Hindu priest]. I feel like that's a very, I mean, I think, Indian folks in general have a tendency to, you know, move towards spirituality when they are trying to cope or deal with or navigate something and I feel like it's something definitely something also present in the Fijian Indian community"* (Participant 3).

An unexpected finding in this study was that Hinduism plays a role in the normalizing and silencing of IPV within the Fijian Indian Community. Women stated that Hinduism, from their experience, determines people's life structure. One participant shared her experiences with religion and how it was interpreted and portrayed in her household.

> *"I guess like, with for me, it goes back to the to like me, and my like, how do I feel religious. It's based on like, learning and hearing about it from the movies. And that was representation to me …. what you should aspire to be. That was on screen. And then in real life, it would be kind of different. So, to me, it was like, Okay, so that's the movie version. And in the real-life version, it's, you know, Dad sits down at the table, and mom*

and wife, bring him the plate (laughs) and they bring the chai, and they bring the cup, and all these things. So, it's subservience. And so, here's religion, defining what healthy and good relationships look like, or, you know, portraying, you know, values. And then you see your parents who are, like having you watch this, and then playing out, you know, it kind of fit" (Participant 8).

Another participant talked about how, in their own lives, religion has been used to normalize violence against women. For example, she explained that:

> *"Parts of the community that people don't understand like focus on pooja (prayer), and like, religion. And how big a part it plays, and the stories that come with our religion. Like Hinduism, at least Hinduism is what I experienced as a Fijian Indian is that there is a large influence of stories on how a person should live. And if you are outside of the community then you don't know that much about Hinduism. That way you can't model your behaviors the way that someone else might have. It sets the stage for intimate partner violence by framing the way people should act. Like there's one story where someone transforms so that they look like a woman's husband and have intercourse with her. The woman in question gets turned to stone for 'cheating' when she was basically raped. Like, stories like this frame women as the default-to-blame-party which gets into people's heads"* (Participant 2).

The Fijian Indian community seeks spiritual and religious help during times of trouble and distress. This is a barrier for those who seek help for IPV because, within this religion, IPV is normalized, abusers are not held accountable, and women are the ones who are blamed for their experiences of abuse. To these interviewees, this indicates that pundits [priests], poojas [prayer events], and mandir [place of worship], are not places women can go when seeking help for IPV.

In addition to perceptions, this study sought to determine what help looks like in the Fijian Indian community. Participants were asked 1) Where Fijian Indian women think help should come from for IPV; 2) What they think is important for healthcare workers to understand about IPV within the community; and 3) What they think is important for other Fijian Indian women to know about IPV. The goal for these questions is to create resources for women that are culturally sensitive to the needs of this specific community.

Where Should Help Come From?

The last part of the interview inquired specifically about ways to help IPV victims in the Fijian Indian community. This study asked participants about where they think help should come from for women within the community who experience IPV. The PI asked participants "where do you think help should come from? Should help come from within the family, outside the family, from a healthcare provider, or from law enforcement?" (See Appendix D). The responses to this question created a hierarchy, where the majority of participants said that help should first come from within the family, then from someone outside the family who can be trusted. Healthcare providers were the third option, and law enforcement was the last resort for help if situations were very bad.

Participants stated that help should ideally come from within the victim's family. Ideally, family members should step in and prevent abusive situations from continuing. However, family involvement and advocacy depend on learned behavior and how much cultural beliefs influence them. Family members could potentially help if they recognize abuse and understand the harms of it. In a household where abuse is normalized and silenced, a woman will continue to suffer until she recognizes the need for help. In this situation, participants stated that women should seek help from someone outside the family, such as a friend, co-worker, or someone they can

trust. Trust is an important factor here because getting help from outside the family can make situations worse within the victim's family if they find out. When helping victims within the Fijian Indian community, one must respect victim's privacy because of the shame and judgment they can face from the family and the community.

The finding that healthcare workers and law enforcement were not the first places where women would get help may shed light on how abuse is perceived within the community and whether IPV is seen as a health risk or a serious crime enough to require law enforcement. Although participants stated that healthcare providers might be a good place to get help for IPV, this was not their first choice but rather a last option. When asked about law enforcement, participants expressed a lack of trust towards law enforcement. Some women stated that they would never seek help from law enforcement. To her, they make the situations worse because they lack an understanding of cultural norms in the community. Other participants stated that they would call the police if situations got too severe.

What is Important for Healthcare Workers to Understand?

Intimate Partner Violence has very serious health implications; therefore, it is important for healthcare workers to understand what cultural norms surround the Fijian Indian community. Data revealed that to provide care for IPV victims, healthcare providers should establish trust, determine patients' needs and ensure that their privacy is protected. The following section integrates participants' advice to providers (Results) with a tone usually reserved for a traditional Discussion section. Their suggestions were specific and poignant enough to be an unnecessary repetition of their advice in a traditional Discussion section separated from their quotes.

Establish Trust

As a healthcare provider, caring for IPV victims can be challenging, especially if we do not understand how their culture impacts their health decisions. Participants emphasized the fact that Fijian Indian women will not talk about IPV with their healthcare providers. It is important to establish trust with patients prior to assessing and inquiring about their experiences with IPV. As one participant put it:

> *"I'd advise them [healthcare providers] to be patient because sometimes it takes a while for people to talk about, talk about things that are really hurting them. Especially in this community we are taught 'oh don't say that don't say that don't say that"* (Participant 2).

Establishing trust can be challenging for those providers who work in fast-paced areas, such as urgent care clinics or hospitals. Although certain hospitals and clinics do an abuse screen on every patient admitted, Fijian Indian Women are not likely to share their experiences of violence. Primary Care Providers (PCP) are best positioned to establish trust with their patients because they can see their patients more frequently. In comparison to an acute care hospital or an urgent care clinic, when a patient comes into their doctor's office, they are not rushed through their visit. Doctors have the opportunity to ask questions and understand their patients, allowing them to build trust over time.

Provide Privacy

The silencing of IPV within the Fijian Indian community has resulted in women not speaking about abuse with anyone they cannot trust. When a trusting relationship has formed between care provider and patient, according to participants, providing privacy is the next crucial step in accurately screening IPV victims. When assessing a patient for IPV, they suggested that providers ensure that they are in a safe, secure, and private environment, where she can speak

away from her partner and other family members. Participants talked about how important privacy is to get a genuine dialog going regarding victims' experiences of abuse, for example,

> *"I think, I think they should know that it is not something people will readily talk about. It's not something that um uh, yea, I think it's not something people will readily talk about, and I think it's something that um if say someone is brought in with some injuries or something like that and uh, if they were with a family member, I don't think they would expose those sorts of things. I think they would have to be alone and in a safe setting to really um share that kind of information"* (Participant 3).

At this time, help is available for women who have left their abusive partners. Unfortunately, there is little help for women still living in abusive relationships and who cannot speak up. Providing privacy for victims, especially if they present with their abusive partners, is important to the patient's safety. If the perpetrator or his family members find out that the victim is talking about her experiences of abuse to outsiders, it could place her at a higher risk for experiencing abuse.

Determine Needs

Seeking help for IPV in the Fijian Indian culture is a significant decision. It often means that, despite everyone around her normalizing a specific behavior and silencing her, a woman still wants to get help. So, when women do seek help for IPV through healthcare providers, determining their needs is essential. To truly help victims, as healthcare providers, we must determine what women need. Participants talked about helping women where they need help, and one participant stated that:

> *"In order for that, for someone to come out and ask for help, they need to feel like they're not being pushed into it, and that they're like, it's like an outsider forcing it out of them.*

And it's like, okay, so you're an abusive relationship. And it's like, you're talking about my life. And, okay, are you doing, like, let me give you a list of shelters to go to, and it's like, I am financially dependent on this man… So, offering like, you know, if you are able to find out about this pair, this person and what kind of life they're living, yeah, then you are better able to serve her and her needs, maybe what she wants to do is try and talk to him, because that's where she's at. Maybe she wants one on one time with him. And she can't do that if the kids are always there, and she doesn't want them seeing her, like being in this abusive situation. So, she needs childcare. Whatever it is, and maybe that's going above and beyond" (Participant 8).

Women should feel understood and supported when seeking help for IPV. If assistance is not helpful for them, you risk discouraging them from seeking more help. This pushes them back into living in an abusive environment without any help, leading to worse health outcomes.

Ideally, "help" for IPV for any woman should be multidimensional and multifaceted. It is not to say that the current system we have in place is inadequate or ineffective, rather it only helps those women who are ready to leave abusive relationships. We know that often women are not able to leave abusive relationships because they face many barriers. In situations like these, help should still be available and accessible to them. As healthcare providers, we should seek to provide care and ensure optimum health outcomes for all women, no matter where they are. Ultimately, providing a list of shelters and giving women numbers to hotlines that help victims of abuse may help some women, however, we can leave many women behind. Especially if women do not have access to transportation, face language barriers, or their citizenship depends on their spouses. This list could go on; however, it should not be a barrier to living a healthy life. Currently, there are no evidence-based resources available to guide healthcare professionals to

provide person-centered IPV care to Fijian Indian women; the goal is to create such resources for them.

Discussion

One would assume that because South Asian women and Fijian Indian women share similar cultural experiences, they would have similar experiences with IPV. All the studies used for the literature review focused on the experiences of South Asian women and physical abuse. They identified three major themes that impact South Asian women: patriarchy, familism and collectivism, and victim-blaming. Data shows that Fijian Indian women's experience of IPV is a bit more complex or at least specific and nuanced to Fijian Indian immigrants to the United States, versus experiences generalized to all women of the South Asian diaspora. Both groups of women are impacted by patriarchy, familism/collectivism, and victim-blaming. This study identified the two major themes of IPV and five sub-themes that impact how IPV is perceived and how these perceptions then influence behavior, including several areas of distinctiveness in the experience of Fijian Indian women in the United States.

Fijian Indian women are aware of IPV and its different shapes and forms. Unfortunately, cultural factors play a significant role in determining whether they seek help for IPV. Most often, according to these interviewees, women within the Fijian Indian Community do not seek help for IPV. This is because IPV is normalized, and at the same time, met with silence in their communities and family relations. The experiences of IPV are not made public because it is seen as a personal matter that can be resolved within a relationship or within the family. Women are expected to tolerate abuse and stay in abusive relationships due to strong emotions towards Familism and Collectivism. They prioritize family honor over their well-being. In a situation where experiences of abuse are made public, the abused individual faces shame and judgment

from the community. Women are blamed for the abuse and viewed as weak for not being strong enough for tolerating abuse, especially if they leave their partners. The Fijian Indian culture is patriarchal which is shown in how the family unit is constructed. Families often have traditional gender roles in a place where men are the head of the household, and women are the caretakers and homemakers. Men go out to earn, and women stay home and care for the home and children.

The older generations have maintained this patriarchal structure in place by teaching younger generations these traditional gender roles. These teachings are reinforced during Pooja's (Prayers), where pundits (priests) interpret the religious texts of Hinduism, such as the Ramayana or Bhagwat Gita, to maintain the social structure. Hinduism is patriarchal in nature and plays an important role in interpreting traditional gender roles for men and women. Within the religious texts of Hinduism, one can find examples of how abuse against women is repeatedly justified, and women who are abused and tolerate it are glorified and seen as strong and brave. According to this study's participants, these religious and cultural factors play a significant role in the silencing and normalizing of IPV and most often, and why women within the Fijian Indian community do not seek help for IPV. This can lead to poor health outcomes, as IPV impacts ones' physically, mentally, emotionally, sexually, and socially.

As healthcare providers, it is imperative to understand that Fijian Indian women will not freely talk about their abuse. Therefore, it is critical to establish trust before having a conversation about IPV. When assessing IPV, providing privacy is crucial because women will not talk about abuse in front of anyone. Take the partner or any family member out of the room before initiating any conversation about abuse. Lastly, to help women in the Fijian Indian community, we must first determine what they identify as needing. In other words, help women

where *they* say they need and will accept help. All three of these factors influence each other symbiotically.

To completely understand these factors, we must know that they each have significant barriers. Establishing a trusting relationship with a PCP means that women must have access to healthcare. This poses the question, how can we, as healthcare providers, care for Fijian Indian women who do not have access to healthcare in the United States? Lack of access to healthcare and/or health insurance is a barrier for women. It is especially challenging for women who are not employed or are dependent on their spouses for financial support. They do not get the opportunity to have a proper screening due to the lack of a PCP. We also know that hospitals and urgent care clinics may not be the best place for a proper IPV screening. Unfortunately, providing care to this specific subset of women is still a challenge in the United States due to the lack of universally available, accessible, affordable, and culturally responsive healthcare.

Privacy is vital to Fijian Indian women, not only in terms of HIPAA concerns but in those desires for privacy that reflect safety concerns for women. This poses another question, as mandatory reporters, how can healthcare providers report incidents of IPV without compromising patient safety? When a care provider informs patients that they are mandatory reporters of abuse, that may deter women from speaking up about abuse. This is primarily because women may not understand the laws and regulations after IPV is reported. She may be concerned about her perpetrator finding out that he was reported. She may be worried about having her husband arrested, the safety and provisions for her children, or even the social stigma outlined by this study's participants. This is problematic because it takes away her autonomy to decide if, when, and how she wants to leave the abusive situation. We must explain what it means to be a mandated reporter, what happens when a case is reported, and what protection

measures the victim has access to. This is to encourage women to speak up. Further research is required to determine how mandatory reporting impacts caring for IPV victims.

Strengths and Limitations

One limitation of this study was that the median age for participants was 24.5 years, with ages ranging from 21- 41 years. This study suggests that younger women are more likely to talk about IPV with others than middle to older age women. This is consistent with study data where participants talked about generational gaps and learned behavior. When participants were being recruited for this study, younger women were more agreeable to the interview. In contrast, older women were more reluctant to participate when told the topic was about IPV. This made it difficult for the PI to gather data on how middle and older women think and feel about IPV. Fortunately, all the participants for this study came from diverse backgrounds, whether that diversity reflected dimensions of sexual orientation, partnered status, education, employment, or immigration status. Despite having a diverse range of participants, the retrieved data was consistent and similar across all interviews. All participants stated that IPV within the Fijian Indian community is silenced and normalized.

Another potential limitation for this study was that the PI was a member of the Fijian Indian community. Intimate Partner Violence is not something women within the community talk about freely; therefore, there was a preconceived expectation that women would not openly talk about the abuse. Additionally, being a member of the community could potentially be a source of bias for this study. Ultimately, this potential source of bias proved to be a strength because participants seemed more willing to talk about IPV. Participants felt comfortable sharing personal information with the PI, which they would usually keep private. This demonstrates a level of trust that participants had in the PI, which comes through familiarity. For example, some

participants were willing to share their sexual preferences as "Bisexual or Gay/Lesbian," with the PI despite it being something very personal that not everyone is willing to share. Growing up with cultural and religious traditions of the target population gave the PI an insider's appreciation of the nuance, beauty, and historical and cultural experiences of this population. Those outside the community perhaps could not enter and gather this valuable data.

Implications for Future Studies

An unexpected finding of this study was that Hinduism plays a role in silencing and normalizing IPV within the Fijian Indian community. This study was not designed to examine the impacts of religion on IPV among Fijian Indian women. Therefore, future studies should explore the influence of religion on life and health outcomes. Additionally, cultural effects on perceptions of IPV among Fijian Indian men have not been explored. This could provide insight on where interventions should be targeted from a community and healthcare standpoint. Lastly, to help victims of IPV, it is important to understand what help looks like to them. This study sheds light on how healthcare providers can help their patients, though there is a gap in knowledge regarding how women can get help if they do not go to a healthcare provider. This is crucial for those victims who lack access to healthcare, are unemployed, are socially isolated, or have recently migrated to the U.S.

Finally, this thesis reflects the importance of researchers not homogenizing populations ("South Asian women") and disregarding or not being curious about the nuances and needs of specific cultural groups. This study explored the perspectives of Fijian Indian immigrants to the United States, specific perspectives of women from 21 and 41 years. This was not a study of native Fijian women, Hindu women, Pakistani women, Sri Lankan women, or all women of the South Asian diaspora (South Asian women), or even Fijian Indian women still living in Fiji.

Each cultural group will have its own nuances that need to be explored and understood. Furthermore, many South Asian women do not share the experience of being “minorities” in their native land.

Fijian Indian women are minorities because of the history of their ancestors’ indentured servanthood, stolen dreams, stolen futures, and stolen familial relations back in India, from where they were cruelly coerced to leave (Ali, 1979; D’Souza, 2000). These intersectionalities mean more detailed research, but their experiences and identifying culturally respectful, effective approaches to helping them deserve this extra attention (Crenshaw, 1990). Their histories, cultures, and thousands-year old religious traditions live in these women. This includes this largely unknown history (to U.S. health care workers) of an indentured servitude created by the British to replace the exploited labor force diminished by the termination of the Atlantic Slave Trade of Black Africans.

Fijian Indian women in the United States carry these histories, cultures, and religious traditions into the clinical encounter. It is disrespectful to ignore these lovely textural nuances because it risks us missing ways we as health care providers can be most effective and respectful. We as Americans, especially as a relatively non-diverse health care workforce, need to know and continuously seek to better understand and appreciate one another in much more detailed, historically contextualized ways. This study contributes to this imperative.

Conclusion

The World Health Organization (WHO) defines health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 2020). According to the CDC, IPV impacts victims physically, mentally, emotionally, and financially (CDC, 2018). Results from this study reveal that cultural views

within the Fijian Indian community serve as a barrier to women seeking help for IPV. IPV is silenced and normalized due to familism and collectivism, shame and judgment, patriarchy and traditional gender roles, generational gap and resultant learned behavior, and the gender-related teachings of Hinduism. When caring for IPV victims in the Fijian Indian community, healthcare providers should establish trust, determine their needs, and protect their privacy. As healthcare providers, understanding cultural barriers can better address poor health outcomes in high-risk communities impacted by IPV. Study results indicate a need for a more culturally sensitive approach when it comes to assessing IPV within the Fijian Indian community for healthcare providers. This can help us save lives, enhance health outcomes, and potentially reduce healthcare costs related to IPV.

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Appendix A: Exploring Perceptions of IPV in the Fijian Community

Exploring the perceptions of Intimate Partner Violence among The Fijian Indian Community

Would you like to be part of a research study?

Studies show that South Asian women are at a higher risk from experiencing Domestic Violence (DV)/Intimate Partner Violence (IPV). However, there is no research available on the experiences of Fijian Indian women. This study will explore how women in our community are impacted by DV/IPV.

Who: This study is looking for Fijian Indian women living in California, who are willing to share their views and understanding of Intimate Partner Violence (IPV). All information will be kept confidential. Findings from this study will be used to assess the needs for the Fijian Indian community and shape future research on Intimate Partner Violence.

Participants must meet the following criteria?

→Fijian Indian (born in Fiji or have at least one parent who is Fijian Indian)
→Female
→18 + years old
→Speak English

What: Participants will be asked to take part in an hour-long interview, which will consist some demographic questions and open-ended question asking how the Fijian Indian culture impacts their perception towards IPV. Everyone who participates will be given a $5 gift card, as a token of appreciation.

Where: Interviews will take place at a location where participants feel comfortable or you can choose to have face-to-face in person interviews or zoom video call.

Please feel free to contact the primary researcher, Shayal Prasad via phone (925) 642-9268
Or email shyprasad@ucdavis.edu

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Appendix B: Interview Questions

Hello, my name is Shayal Prasad and I am a student at UC Davis, Betty Irene Moore School of Nursing. I work at the UC Davis Medical Center as a Float nurse on the Patient Care Resources department.

I want to thank you for taking out time to participate in this study. Among all the studies that have been published regarding Intimate Partner Violence, Fijian Indian Women are not represented in any of them. My goal is to collect data, in order to determine specific needs for the Fijian Indian Community, in regard to Intimate Partner Violence. Today, we will be talking about how Domestic Violence/ Intimate Partner Violence is perceived in our community.

Before we begin our interview, I want to go over information that is important for you to know. Under the California Penal Code 11160a, I am a mandated reporter for domestic violence. This means that if you disclose any incident of abuse during the interview, I have to report it. The interviews will be audio-recorded with your permission, so that I can transcribe them. All information collected will be stored in a password-protected computer. I will be the only person who will have access to the interview recordings. I will not ask for any personal information and I request that you do not share any personal information about yourself. To protect your identity, any personal information that is shared, will be deleted or removed prior to the transcription process.

Do you have any questions before we begin?

Demographic Questions:

Age:

Sexual Preference:

- Heterosexual or straight
- Gay/Lesbian
- Bisexual
- Transgender
- Prefer not to answer

Relationship status:

- Single
- In-a-relationship
- Married

- Separated/Divorced
- Widow

Highest level of Education:

- Some Education, but did not complete high school
- High School Diploma/GED
- Some college
- Associates degree (2-year community college degree)
- Bachelor's
- Master's degree or higher

Do you work: Yes No Other:

Where were you born:

- USA
- Fiji
    - How old were you when you came from Fiji?
    - Do you have both or at least one parent who is Fijian Indian?

Open Ended Questions:

1. **When you hear the terms Domestic Violence or Intimate Partner Violence what comes to mind?**
    a. Can you describe that to me, give me an example?
2. **What does it look like in your community after someone has experienced DV/IPV?**
3. **What are YOUR beliefs about Domestic violence and whether women should get help for this?**
    a. What is your thought on whether that help should come from inside the family? outside the family? From a Healthcare provider? From law enforcement?

4. **How do you think other people in the Fijian Indian culture think or feel about DV/IPV?** *(NOTE for Question 4: These will be used as clarifying or follow-up questions as needed. It may be the case that the interviewee has covered these issues in previous questions, or in other parts of Question #4).*
    a. How do you think men in your culture think or feel about DV/ IPV? How do men's beliefs and thoughts vary by age or generation? What are men's responses to IPV/DV and whether or not women should seek help outside the family? Inside the family? From Healthcare provider? From law enforcement?
    b. How do you think women in your culture think or feel about DV/ IPV? How do women's beliefs and thoughts vary by age or generation? What are women's responses to IPV/DV and whether or not they should seek help outside the family? Inside the family? From Healthcare provider? From law enforcement? What do you think, women think about the men getting help if are committing DV/IPV? And where do you think that help come from: Help inside the family? outside the family? From Healthcare provider? From law enforcement?
5. **What do you think your Fijian Indian friends would advise as a solution if you had been a victim of DV/IPV? What would you advise to a friend if she disclosed to you that she was/is a victim of DV/IPV?**
6. **Is there anything you think is important for me to know?**
7. **What is important for Fijian Indian community to know about DV/IPV? What do you think is important for other people to know about DV/IPV within the Fijian Indian Community (in particular healthcare provider and law enforcement)**

Appendix C: Consent Form

Title of research study: Impacts of culture on perceptions of Intimate Partner Violence Among Fijian Indian Women

Investigator: Shayal Prasad Shyprasad@ucdavis.edu (925) 642-9268

Why am I being invited to take part in a research study?

All research participants must meet *all* of the following requirements to participate in this research study

You are being invited to take part in this research study because you are a English speaking, Fijian Indian female, who is 18 years of age or older.
meet the eligibility requirements listed below.

What should I know about a research study? (Experimental Subject's Bill of Rights)

- The primary researcher will explain this research study to you, including:
  - The nature and purpose of the research study
  - The procedures to be followed.
  - Any common or important discomforts and risks.
  - Any benefits you might expect
- Whether or not you take part is up to you.
- You can choose without force, fraud, deceit, duress, coercion, or undue influence.
- You can choose not to take part.
- You can agree to take part now and later change your mind.
- Whatever you decide it will not be held against you.
- You can ask all the question you want before coming to a decision
- If you agree to take part, you will be given a signed and dated copy of this document.

Who can I talk to?

For any questions, concerns, complaints, or if the researcher has hurt you in any way, talk to the research team, Shayal Prasad at (925) 642-9268, shyprasad@ucdavis.edu or Jann Murray Garcia at (916) 734-3635, jmurraygarcia@usdavis.edu

This research will be reviewed by the Institutional Review Board (IRB). To attain further knowledge regarding this research, go to http://www.research.ucdavis.edu/policiescompliance/irb-admin/ . You may talk to a IRB staff member at (916) 703-9151, hs-irbadmin@ucdavis.edu, or 2921 Stockton Blvd, Suite 1400,

Room 1429, Sacramento, CA 95817 for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

Why is this research being done?

This research is being done to determine how culture impacts the perceptions of Intimate Partner Violence. Studies show that South Asian women are at a particularly higher risk from Intimate Partner Violence in the United States. However, there is no research available on the Fijian Indian community and how women are impacted by it. This research study will look at how Fijian Indian women view Intimate Partner Violence. Findings from this study will serve as a resource which will aid in determining the needs of this specific community.

How long will the research last?

We expect that you will be in this research study for approximately an hour. Research will continue for one year.

How many people will be studied?

We expect about 20 Fijian Indian women will be in this research study

What happens if I say yes, I want to be in this research?

The primary researcher will reach out to you (participant) in order to set up a time and place for an in-person or virtual interview through zoom. You should anticipate this interview to last for about an hour. This interview will be recorded. The primary researcher will then transcribe the entire interview, analyze the data, and then reach out to the participants to verify whether the responses were interpreted the way participants wanted to convey their message. You may end the interview or withdraw from the study at any time you desire without consequences.

What happens if I do not want to be in this research?

You may decide not to take part in the research, and it will not be held against you.

What happens if I say yes, but I change my mind later?

You can leave the research at any time and it will not be held against you.

What are the risks and benefits of participating in this study?

There may be risks to privacy, potential disclosure of information that may reveal your identity or a member of the community. All shared information will be kept confidential

and the audio recordings of your interview will be destroyed after analyses are completed.
You may also feel uncomfortable or feel some emotional distress in sharing some personal information. You can opt out of sharing any information that makes you uncomfortable. If participants feel uncomfortable, the primary researcher will stop the interview, and resume the interview, if and when they are ready.

What happens to the information collected for the research?

Efforts will be made to limit use or disclosure of your personal information, including research study, to people who have a need to review this information. We cannot promise complete confidentiality. Organizations that may inspect and copy your information include the IRB and other University of California representatives responsible for the management or oversight of this study.

What else do I need to know?

The principal investigator is a mandatory reporter for domestic violence as a healthcare provider, as required by the State of California.
There is no charge for you to participate in this study and you will be compensated for taking part in this study. A $5 gift card will be given to those who wish to participate, as a token of gratitude.
The interviews will be audio-recorded with your permission, and all information collected will be stored in a password-protected computer. The primary investigator will be the only person who will have access to the interviews. The interviews will be transcribed and analyzed; once transcribed, all interview recordings will be permanently destroyed securely. Any personal information that is shared, will be deleted or removed prior to the transcription process.

For more information, please contact the research team.

Signature Block for Capable Adult

Your signature documents your permission to take part in this research.

______________________________	______________
Signature of subject	Date
______________________________	
Printed name of subject	
______________________________	______________
Signature of person obtaining consent	Date
______________________________	
Printed name of person obtaining consent	

Appendix D: Available Resources

<u>*Covered California</u>
The Covered California Health Exchange is the government agency offering subsidized Obamacare plans for this state.
Phone: 1-877-752-4737
Website: https://www.healthforcalifornia.com/individual-and-family-quote

<u>*Planned Parenthood Northern California</u>
Offers healthcare services for men and women who need them.
Phone: 1-800-230-PLAN (7526)
Website: https://www.plannedparenthood.org/planned-parenthood-northern-california

<u>National Domestic Violence Hotline</u>
The National Domestic Violence Hotline provides lifesaving tools and immediate support to enable victims to find safety and live lives free of abuse.
Phone: 1-800-799-7233
Website: https://www.thehotline.org/about-the-hotline/

<u>Shelters in Northern California:</u>

Shepherds Gates Women's Shelter
605 Sycamore Ave
Brentwood, CA 94513
Phone: (925) 308-7507

Women's Daytime Drop-in Center
2218 Acton St.
Berkeley, CA 94702
Phone: (510) 548-2884

California partnership to End Domestic Violence
1107 9th St. #910
Sacramento, CA 95814
Phone: (916) 444-7163

***A.A. Mental Health Resources**
3515 Grand Ave. Oakland, CA 94610
phone: (510) 706-7721

***Associated Staffing Resources**
2837 Willow Pass Rd, Concord, CA 94519
(925) 798-5500

***Vaya Mental Health Resources**
945 University Ave, Sacramento, CA 95825
916) 648-8082

***Greater Sacramento Area Mental Health Crisis Resources.**
Roseville, CA →Phone: (530) 448-6602
Sacramento CA → Phone: (916) 875-1055

A Community for Peace 24 Hour Crisis Hotline: 916-728-7210
For more information on counseling services, emergency shelter, and other supports offered by A Community for Peace, visit **https://acommunityforpeace.org/get-help**

My Sister's House 24/7 Multilingual Help Line: 916-428-3271
For more information on the Safe Shelter program, counseling, and other supports offered by My Sister's House, visit **http://www.my-sisters-house.org/getting-help/**

Safe Alternative to Violent Environments
1900 Mowry Ave #201,
Fremont, CA 94538
(510) 574-2250
(510) 794-6055 (open 24/7)

WEAVE Sacramento
Service for Survivors
https://www.weaveinc.org/
Support Phone: (916) 920-2952
Business line: (916) 448-2321