

Suva Residents' Views on Cancer, Diabetes and HIV in The Fiji Times

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Abstract

The burden of preventable diseases is increasing in the South Pacific Island Countries and Territories. In Fiji, significant media attention and national finances are spent on public dissemination of the modifiable risk factors of chronic illnesses. However, little is known about lay societal perceptions of chronic illnesses and of people living with these illnesses. This preliminary study takes an area-situated approach to lay knowledge and examines Suva residents' moral evaluations associated with socially significant health concerns in Fiji. Using the case studies of HIV, cancer, and diabetes, the research employs content analysis to examine 144 Suva residents' Letters to the Editor, published between 2000 and 2019 in *The Fiji Times*. The findings indicate that letter writers on chronic illnesses are power sensitive, interested in governmental responsibility, and aware of the role of stigma in creating inequitable health outcomes. The study's findings locate chronic illness as not only a medical responsibility but also a social justice and human rights concern that requires a multisectoral approach, with community-tailored responses at the heart of all discussions. The lay-societal recognition of the three illnesses as being socially relevant suggests grassroots support for policies directed towards structural reforms for the prevention and management of these illnesses.

Keywords: Public Health; Media Analysis; Diabetes; Cancer; HIV

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Introduction

Lay experiences of illness, wellness, and healing differ geographically due to resource access, and social and cultural dynamics. These experiences, in turn, impact societal explanations of illness causality, illness burden, prevention, treatment, and management. For these reasons, an analysis within situated neighbourhoods is important to gain in-depth understandings of lay knowledge and experiences that inform societal health conceptualisations (Popay et al., 2003). This preliminary study takes an area-situated approach to lay knowledge, through its engagement with cancer, HIV, and diabetes discourse amongst residents living in Suva. The metropolitan city is Fiji's capital and has the country's greatest population density. Given the associated prevalence of cancer, HIV, and diabetes with increased urbanisation, an analysis of Suva residents' understandings of the three illnesses is particularly important for producing public health information that maximises societal uptake.

This study extends research into lay knowledge of health. While previous research has provided in-depth analysis of societal perspectives of illness, wellness, and healing within the Western sociocultural context, less is known about non-Western, and particularly, Pacific people's perspectives on socially prevalent illnesses (Phillips et al., 2018). Moreover, while a small number of studies have begun in Fiji in the area of knowledge assessment, these have focused on the perceptions and practices of people living with the illness (Philips, 2020; Zibrán, & Mohammadnezhad, 2019). This study expands on such research by taking a wider societal lens into lay-societal evaluations of illness' causes and consequences, as well as the efficacy of prevention and management options, and societal responses to people living with chronic illnesses.

Literature Review

Diabetes and cancer are both reported to be leading causes of morbidity and mortality rates in the Pacific Island Countries and Territories (PICTs), including Fiji (Bray et al., 2018; Tervonen et al., 2017). Today, the region has the highest global diabetes prevalence, with an estimated 30 million people living with diabetes. The number is predicted to increase to 55 million by 2025 (Foliaki, & Pearce, 2003). Moreover, Fiji has the highest diabetes-related mortality rates in the world, according to the latest World Life Expectancy Rankings (World Health Organisation, 2018). As is the general global trend, the predominant diabetes form is Type 2 diabetes, which is

considered to be a “lifestyle disease”, in contrast to type 1, which is thought to be a genetic condition. Type 2 diabetes is strongly influenced by lifestyle factors of urbanization, a move away from traditional lifestyles, and a combination of highly refined diet, physical inactivity, genetics, and increasing obesity rates (International Diabetes Federation, 2017). The prevalence of cancer is another significant concern for Fiji. Cervical, liver, and uterine cancers are the most common cancer types in the PICTs, and have elevated levels compared to Pacific people living in New Zealand. For people living in Fiji, the predominant cancer types for males are lymphoid and haemopoietic, prostate, liver, and lung, while for females the predominant cancer types are cervical, breast, uterine, and ovarian (Foliaki et al., 2011).

The presence of Type 2 diabetes and cancer morbidity exacerbates the cycle of poverty and disempowerment of individuals, communities, and nations. As seen in Fiji and other PICTs, diabetes and cancer-related complications place increasing burden on national economies in developing countries. Moreover, diabetes-related medical interventions, such as cholesterol-lowering drugs, are unaffordable for most countries (World Health Organisation, 2005). The individual-level and community-level consequences of diabetes and cancer are amplified due to limited resources and infrastructure to facilitate specialised treatment (Cheng, 2010; Morgan, 2015; Sarfati et al., 2019). For instance, with national budgets already stretched, there is limited opportunity for Fiji government to provide the specialised care needed for the most prevalent consequences of Type 2 diabetes: retinopathy, kidney failure, and foot ulcers (Damato et al., 2014; Kumar et al., 2014; Pablo et al., 2018). The lack of resources creates a downward spiral into further poverty for individuals, communities, and nations. Due to diabetes-related disabilities, individuals cannot work, decreasing the individuals’ and their family’s earning capacities, increasing dependency and marginalisation, thereby lowering quality of life and exacerbating economic poverty and social isolation (Reubi et al., 2016; World Bank, 2012).

In addition to the high rates of cancer and diabetes-related morbidity and mortality, the HIV status of the South Pacific region is also increasing (World Health Organisation, 2019). The region is categorised into three tiers by HIV prevalence: the first tier comprises of Papua New Guinea (PNG), which has the greatest number of cases in the region; this is followed by Fiji, French Polynesia, New Caledonia, and Guam, which collectively form the second tier; other small island countries form the third and last tier, with few known cases of HIV (Commission on AIDS in the Pacific, 2009).

Poor health infrastructure, low national budgets, and, particularly in the case of Fiji, political instability, means that the PICTs are at a crisis point due to the rapid increase in morbidity and mortality rates through chronic illnesses. The region's ability to overcome type 2 diabetes, cancer and HIV mortality is, therefore, not only a medical responsibility but also a social justice responsibility that requires a multisectoral approach, with community-tailored responses at the heart of all discussions (Glasgow & Schrecker, 2015). Hence, an important area of analysis is the lay society's response to these illnesses.

Methodology

Data

Awareness and access to resources can differ by locality and can result in divergent health outcomes. These experiences, in turn, impact social conceptions of illnesses and people living with illnesses. Although geographical prevalence of the illnesses is currently not available from Fiji's Bureau of Census (Chand et al., 2020), these illnesses are associated with increased urbanisation. For these reasons, the paper situates lay knowledge about health within Fiji's greatest metropolitan city through its engagement with Suva residents' discourse on cancer, HIV, and diabetes in *The Fiji Times*' Letters to the Editor.¹ The timeframe was from 1 January, 2000 to 31 December, 2019. This timeframe was specifically chosen because the year 2000 served as a pivotal turning point in Fiji and other PICTs' emphasis on reducing NCDs (Tolley et al., 2016). Moreover, since 2000, HIV surveillance in Fiji acquired greater significance with a jump in the number of diagnosed cases (UNAIDS report, 2014). Having an almost 10-year timeframe provides an exploration of how health policies have been implemented. Using "diabetes", "HIV or AIDS", and "cancer" as individual search terms, we found 86 letters referencing "HIV or AIDS", 68 referencing "cancer," and 38 referencing "diabetes." Articles that fell outside our criteria were duplicates within the newspaper, or articles that mentioned diabetes, HIV, or cancer only in passing. 48 articles were discarded for one or more of these reasons, and 144 articles met the selection criteria and were included in the study: 65 for HIV, 50 for cancer, and 29 for diabetes.

¹ The data from Fiji's other major daily *The Fiji Sun* was not accessible through its archives at the time the research was conducted, hence the data for this study is from *The Fiji Times*. *The Fiji Times* database resource is limited to 2004 until 2010 and manual searches through physical newspapers were necessary to access data outside this timeframe.

Method

The study implemented content analysis, a qualitative research method used to understand how meaning is created and expressed in context-specific situations in society. Given the limited information on societal perceptions of HIV, cancer, and diabetes within the South Pacific region, an inductive approach is taken in this study, whereby the analytical categories/themes are derived from the data (Elo & Kyngäs, 2008, pp. 108-109). The research implemented the three-phase methodological approach developed by Gounder and Ameer (2018), and modified the codes to the requirements of this study. The researcher and research assistant conducted the research in three consecutive phases of content analysis.

Phase 1 was the development of the following variables: “Illness type”, and “year of publication”. The researcher and research assistant read and classified the articles according to the first variable of “Illness type”. Article discussions fell into one of the following categories: “HIV”, “Diabetes”, or “Cancer”. We further classified articles by the year of publication. Phase 2 implemented a process of open coding using the qualitative analytical software MAXQDA. Both the researcher and the research assistant independently read the letters and noted themes as they occurred in the data, rather than using preconceived categories. The letters were analysed for manifest and latent thematic content. The manifest content was portions of the text (words, phrases, or sentences), while the latent content involved the interpretation of the underlying meaning of the text (theme) (Graneheim & Lundman, 2004, p. 106; Hsieh & Shannon, 2005, pp. 1279-1281). Words, sentences, or paragraphs related to manifest and latent themes were highlighted. The highlighted sections were then labelled. We constructed culturally situated thematic labels, comprised of metaphors, arguments, presence of characters, sources of information, and images that indicated value judgements associated with illnesses and people living with illnesses. Once the researcher and research assistant had exhausted all possible themes within the cohort of Letters to the Editor, the labels were then consolidated into categories expressing commonality of an overarching theme. Each category was then given a code to reflect the thematic domain of that code. Using the information, we developed the coding sheet (see Figure 1). In Phase 3, the coding sheet was applied by the researcher and research assistant to each letter. The codes were first checked for presence. The codes were further analysed for aspects of the theme (code categories).

Figure 1. Coding Sheet.

Codes	Code descriptors	Code categories
Metaphor	The cross-domain mapping which involves borrowing one set of concepts to visualise another.	The occurrence of metaphors to describe the illness
Disease-to-person ratio	What is the locus of the disease	<ol style="list-style-type: none"> 1. Does the disease affect a portion of the person or 2. Does the disease affect the whole person
Responsibility attribution	The agency associated with aspects of the illness	<p>Who is held responsible for the illness's:</p> <ol style="list-style-type: none"> 1. cause 2. prevention 3. treatment 4. management
Cause	Ways in which the illness occurs	<p>Is the causal reference weighted towards:</p> <ol style="list-style-type: none"> 1. Medical causes 2. Societal causes 3. Behavioural causes
Burden of the illness	Why the illness is a problem and for whom	<p>What are the impacts of the illness on:</p> <ol style="list-style-type: none"> 1. people living with the illness 2. on the levels of society: <ol style="list-style-type: none"> a) family b) community c) national d) regional e) global
Solution: Prevention	Interventions to avoid the illness	<p>Is the prevention of the illness weighted towards interventions that are:</p> <ol style="list-style-type: none"> 1. medical 2. cultural 3. societal 4. behavioural
Solution: Treatment	Interventions to cure the illness	<p>Is the treatment of the illness weighted towards interventions that are:</p> <ol style="list-style-type: none"> 1. medical 2. cultural 3. societal 4. behavioural
Solution: Management	Interventions to ensure quality of life for people living with the illness	<p>Is the management of the illness weighted towards interventions that are:</p> <ol style="list-style-type: none"> 1. medical 2. cultural 3. societal 4. behavioural
People living with illness	The reference to people living with the illness	<p>Is the reference oriented towards:</p> <ol style="list-style-type: none"> 1. Agent-mode 2. Victim-mode 3. Medical-mode 4. Other <p>Is the reference empowering or disempowering people living with the illness?</p>
Overall tone	An evaluation of the above points to determine how lay society orients discussion around the illness	<p>Is the tone overall:</p> <ol style="list-style-type: none"> 1. optimistic 2. pessimistic 3. moralistic 4. neutral

Limitations

Letters to the editor have been found to be one of the most read sections of a newspaper (Wahl-Jorgensen, 2002). At the same time, letters to the editor have a contested presence in the media landscape: they are non-journalistic opinion pieces, which provide a site for public participation in “debates about current affairs” and the section, thus, provides a public space with the potential “for a more deliberative form of democracy” (Young, 2013, p. 3). Those who write letters to the editor tend to be non-professional members of society who have strong viewpoints about controversial topics. A limitation of such letters is that while this is one indication of public views, it is not a random sample of community perspectives and may or may not be representative of wider societal understandings. However, such discourses provide an important site of engagement with societal viewpoints, which may not align with mainstream discourses but which are nevertheless given prominence and legitimacy through their publication (Wahl-Jorgensen, 2002).

Results and Discussion

This preliminary study engages with lay knowledge on three chronic illnesses: cancer, HIV, and diabetes. Lay discourse on health is a representation of the accumulated societal and cultural norms developed over time, creating a mental schema on how to respond to illnesses. Such discussions, grounded in the sociocultural context within which people live, offer an important insight into the situated understandings and subjective experiences of illness causality, the manifestations of illnesses, and the efficacy of prevention and treatment options (Putland et al., 2011). As seen below, the study found a greater similarity between the depictions of cancer and HIV than diabetes, through metaphor use, illness-to-person ratio, and the overtones in discussions.

Metaphors

Metaphors are linguistic expressions that engage with the social and cultural beliefs about illness and provide insight into how illnesses are understood in terms of causality, prevention, and management (Wallis & Nerlich, 2005, p. 2629). Metaphors allow people to create a visual image of an illness, which is situated within “the framework of lived experiences” (Penson et al., 2004, p. 713). However, research has identified that ingrained and unquestioned, negative metaphor usage adversely impacts people living with illnesses in several sociocultural domains, including the outcomes of court cases, such as those involving people living with HIV (Drass et al., 1997; Rollins,

2002). This study found three prevalent classifications of illness metaphors. These were war or militaristic metaphors, which referred to the eradication of the disease; the assassin metaphor, which referred to a singular entity that is a killer; and the plague or scourge metaphor, which referred to the illness as a severe affliction. Examples are seen below:

Table 1. Metaphors Used to Describe Diseases.

Militaristic metaphors	Assassin metaphor	Plague/scourge metaphor
Silently fighting renal cancer Battle of all battles	Ferocious monster Grim reaper AIDS is a killer Sword dangling over our heads	Tidal wave Dreaded disease Dreaded scourge

The study found a high usage of militaristic metaphors weighted towards the eradication of illnesses. Further analysis reveals that, for cancer, the battle is at the individual level (“silently fighting renal cancer”), while for HIV, it is at the societal level (“Battle of all battles”) and HIV is depicted as an enemy of the collective society.

A raft of research has identified issues with the use of metaphors in illness-related discourse. Of particular concern is the militaristic metaphor, which permeates the discourses of cancer and HIV. While on one hand, the militaristic metaphor serves to galvanize a nation into fighting a common enemy (Nerlich et al., 2002), the use of militaristic metaphors such as “fighting cancer” and “battling HIV” is deemed problematic because there is an associated responsibility that the person who has the chronic illness is now responsible for “overcoming” the illness. Hence, when a chronic illness progresses, there are feelings of fear, guilt, personal failure, and shame due to the high levels of associated personal responsibility in “combating and overcoming” the illness (Sontag, 1990).

Another prevalent metaphor that is believed to have negative connotations is the plague or scourge metaphor, which was found in this study in reference to HIV. As seen in our study, the metaphor is associated with religious and moralistic discourse. The discourse is correlated with petitions for condemnation and social banishment of people living with HIV, and the prohibition of others from participating in socially immoral sexual behaviours (Sherwin, 2001). The metaphor extends to censoring people living with HIV who have children, as wilfully spreading the plague or

scourge of HIV.

Illness-to-person Ratio

The study found death to be a common theme in cancer and HIV discussions. Diabetes had a different ratio to cancer and HIV, with diabetes having an impact at the individual level on specific areas of a person's body; however, the locus of impact could differ (e.g., kidney failure versus amputation of leg). When the illness-to-person ratio was analysed for people living with cancer and HIV, the study found both illnesses to have "whole person" effects. For cancer, there was a lack of engagement with people's lived experiences with cancer. Thus, cancer was presented as a "losing battle", and persons with cancer depicted as fatal victims of the illness. For example, one letter writer said, "My brother lost his wife and mother of five children to breast cancer on Valentine's Day. He commented that this year's Valentine's Day would be unforgettable" (*The Fiji Times* Letters to the Editor, "Valentine's Day", 2008). Research findings indicate that people have a fearful and fatalistic attitude towards cancer, and, in fact, cancer is reported to be the most feared disease in society (Williamson et al., 2011). The prominence of death and fear in societal discourse on cancer can also be associated with the lack of knowledge of preventing cancer, and also the personal and immediate societal burdens of cancer (Keeney et al., 2010; Vrinten et al., 2017).

HIV was similarly depicted as a losing battle for individuals with HIV when written by the lay population. A high reference to death, as seen in the cases of cancer and HIV, comes at the expense of discussions on the prevention and management of an illness. Also, a high mention of death implies that there is "no life" after diagnosis. In recognition of these societal perceptions, letters written from the perspective of people with the subjective experience of living with the illness is evident for HIV. Advocates wrote about their public declaration of being HIV positive as an outreach to put a "human face" to HIV. For example, one person wrote:

I went public about my HIV status so that people can put a human face to HIV and be convinced that one can look as healthy as I do but be infected. The reason is to treat everyone as HIV-positive and make responsible decisions about sex as Doctor Jiko Luveni continues to emphasise. For those of us who are infected, we can only take drugs so that in our own way we can continue to contribute to national development and the welfare of our families and at the same time stop the spread of HIV. The purpose of my campaign is to save lives and the taxpayer's money. (*The Fiji Times* Letters to the Editor, "AIDs dilemma", 2005)

Similar advocating was not found in letters about diabetes or cancer.

Burden of Illness

Another consideration of the study was on who bears the burden of an illness. The study found that the burden of the illness was similar for cancer and HIV, but that both differed from diabetes. The most referenced burden of cancer and HIV was the societal impact. On the other hand, for diabetes the impact most referenced was on the individual who suffered the side-effects of poorly-managed diabetes, despite evidence showing diabetes' profound effects on the family (Rajaram, 1997) and the wider socio-economic fabric of society (Cheng, 2010; Morgan, 2015). The societal level at which the burden was borne differed between cancer and HIV. For cancer, the emphasis was on the immediate social sphere, where individuals had to cope with the emotional burden of the death of a person with cancer. These individuals and families were portrayed as isolated in their grief from the rest of society. For HIV, the impact was at the macro-societal level, as the emphasis was on the decimation of small island nation populations.

A common theme across the three illnesses was the burden on the national economy. The emphasis on how this burden on the national economy occurs differed by illness. For cancer, it was due to the progression of the illness and the loss in productivity. As cancer progresses, it impinges on a person's ability to work, until the illness's final manifestation. As one person said, "It is a sad loss to the newspaper industry because gone is a man who stood only for the best quality work" (*The Fiji Times* Letters to the Editor, "Moce Magnus", 2010). For diabetes the burden on the national economy was due to the increased rates of amputation and resultant loss in productivity. For HIV, the burden on the national economy was due to a shrinking population through HIV-related mortality rates.

Cause, Solution, and Responsibility Attribution

The study found that knowledge about causal factors and solutions matched each other. For illnesses such as cancer, where the causal factors were not well understood, the solutions were also vague. A few articles briefly mentioned specific cancer types and associated them to specific causes. For instance, lung cancer was attributed to the soot emitted from the sugar mills, while the use of oral contraception was linked to increased risks in breast cancer. However, most discussions of cancer were generic, with a wide range of causes attributed to generalised cancer

occurrence. Cancer causes ranged from “mysterious” causes, to air pollution, such as through smoking and car emissions. As one person noted, “tobacco use has been proven to cause cancer and numerous other serious illnesses” (*The Fiji Times Letters to the Editor*, “Smoke in our face”, 2005).

In relation to the lack of knowledge and certainty about cause, the only discussion of prevention was a change in societal behaviour towards a Biblically proscribed pattern of living. For example, one letter said that:

Living a healthy life style by following the simple eight laws of health will not only prolong life but also reduce the cancer statistics. Our body needs proper nutrition. We need to return to Eden by eating more grains, nuts, fruits and vegetables. Lean meats can be included if needed. Exercise is a must for all. Drink about two litres of water daily. Get out in the sun. Temperance is important as too much of any good thing is bad for the health. Breath(e) deeply and fill your lungs with fresh air. Rest is important. Sleep for at least six to eight hours daily. Finally, trust in God. He alone can give us the will and strength to break those lifestyle habits which have imprisoned us. Whatever health problems we have is the direct result of breaking one or more of God s health laws listed above. (*The Fiji Times Letters to the Editor*, “Healthy living”, 2006)

Treatment of cancer was not discussed nor was there any mention of medical checks for early detection of cancer forms.

HIV causes were expressed at both societal and individual levels. Causes referenced indicated wider, societal-level issues that were deemed as exacerbating the increase in HIV. Blame for increasing HIV rates was attributed to “lack of vision and leadership”, “non-consensual sex”, and increasing rates of prostitution. Individual-level sexual attitudes were also associated with increases in HIV. Laxity and a lack of responsibility in sexual behaviour, as well as promiscuity, were cited as exacerbating HIV. HIV-related information and societal uptake of this information was a central theme. There was concern about the lack of societal knowledge about HIV causes, on the one hand, due to the societal attitude towards HIV as a taboo subject, while on the other hand, people were blamed for not connecting with the information that was so widely available.

Prevention references corresponded to causal references. The promotion of HIV literacy for HIV prevention was highly advocated. Monogamy, condom use, abstinence, and improved morality were all highly referenced preventative themes at the individual level. The role of religious leaders as advocates was identified as

instrumental in the prevention of HIV. Letters appealed to religious leaders to support condom use. Another recommendation was to discuss HIV with congregations, thus decreasing knowledge barriers. A more extreme societal measure advocated was the segregation of people living with HIV for the protection of the rest of society. Authors argued that the rights of society need to be considered before the rights of those with HIV. Early detection through HIV testing was highly recommended. ARV use was recommended by HIV advocates, while faith-healing and traditional medicinal use were raised as treatment measures by members of the general population.

For type 2 diabetes, with known causal factors associated with lifestyle, there were more concrete discussions about causes and solutions. The rapid increase in diabetes was attributed to social influences in the form of fast-food and junk food advertisements, and manufacturers' practices of promoting high sugar and high-fat products. Diabetes was also presented as a social justice issue of inequitable resource access. As seen in the following example, diabetes was portrayed as the inevitable consequence of poverty and the high price of healthy food, leading to reduced access to quality food:

The prevention of diabetes, heart disease, high blood pressure and obesity depends on a healthy diet. We all know that. The question is, who can afford a healthy diet? The answer is expatriates, professionals, the upper echelons of the public service and ministerial fat-cats. The rest have to make do with tinned fish (in oil, with salt added)-canned bully beef containing globs of fat (and added salt) ... But our government continues to levy huge import duties on healthy foods that enter this country- foods which the average wage earner down to squatter families have no hope of affording. (*The Fiji Times* Letters to the Editor, "Food day", 2005)

The government was attributed responsibility for reduction and management of diabetes: suggestions involved moving the health promotion efforts, such as the establishment of fitness centres, out of the capital to regional areas. Another call established a flow-on effect of government actions to people's actions, for the betterment of society.

What people understand about causal factors behind an illness will influence the actions taken to prevent and/or mitigate the risks of an illness' occurrence. For cancer, causal ambiguity and a fatalistic perspective influenced people's personal abilities and inclination to take risk-reducing behaviours (Han et al., 2007). This is in contrast to diabetes, with its association with lifestyle factors, where more concrete

steps are provided to prevent diabetes (Gounder & Ameer, 2018). HIV is an illness that challenges societal norms about what can be said in public, and this societal attitude has, until recently, been a barrier to HIV information uptake.

Furthermore, perceptions about causal responsibility influence who is held responsible for fixing the problem. For instance, a well-demonstrated relationship is the media's use of episodic versus thematic framing and the audience's corresponding attribution of responsibility for who should fix the problem (Iyengar, 1990). While the episodic frame discusses an issue in terms of individuals' experiences, the thematic frame discusses the same issue as a societal concern. Using poverty as an example, Iyengar demonstrated that the two frames elicit different audience responses: the episodic frame results in greater blame towards individuals for causing their poverty, while the thematic frame elicits more support for government policies to reduce societal poverty. The findings also hold for media representations of health issues (Niederdeppe et al., 2014). Responsibility attribution is associated with causal knowledge. Hence, responsibility attribution is not seen in cancer discussions due to the lack of concrete knowledge about the causal factors. On the other hand, diabetes and HIV use both episodic and thematic frames in discussing causality, and letter writers provide both individual and societal recommendations to reduce illness occurrence.

People Living with the Illness

The study found that when people living with an illness are a prevalent topic, there is also a high reference to stigma. Hence, stigma was a central topic in discussions about diabetes and HIV (as the letters' emphasis was on people living with the illness), but not apparent for letters on cancer (which did not discuss people living with cancer). The stigma faced by people living with diabetes and HIV, particularly by medical professionals when seeking medical attention, was highlighted. The letters were written from the perspective of people not personally living with diabetes or HIV, but by bystanders, whose letters can be read as 'witness statements'. For example:

HIV patients are forced to wait although they arrive early. Why are we doing this to our beloved sisters and brothers? They deserve equal rights and I hope the whole nation will stop criticising them. Treat them like the way you treat your loved ones at home. They still belong to our community. Give them equal rights. (*The Fiji Times* Letters to the Editor, "Equal treatment", 2004)

In the case of diabetes, the patients' fears of the nurses' anger led to a reluctance to ask questions, thus engendering situations of personal knowledge gap in diabetes management and treatment. For example:

I...was astounded by the way patients were being treated by nurses during blood pressure and diabetes checks. One nurse, in particular, was calling names to old women who came for their regular checks. The nurse told a 90-year-old she was "selfish" because she wanted to have her pressure taken again. She was rudely told to return at a later date...What angered me most was that I realised the elderly women were reluctant to ask any question about their health because they were scared of the nurses growling. (*The Fiji Times* Letters to the Editor, "Rude Nurse", 2008.)

In chronic illnesses, such as type 2 diabetes and HIV, an important criterion for ensuring fewer hospital referrals is to empower individuals to become self-confident in their abilities to successfully manage their conditions on a day-to-day basis (Hörnsten et al., 2004; Okoror et al., 2014). As nurses play a significant face-to-face role in providing health-related information, they are critical in helping patients to successfully manage their conditions (Stiles, 2011, p. 37). Hence, the maintenance of a positive nurse-patient relationship is crucial.

Healthcare providers' stigmatised viewpoints towards people living with an illness are correlated with clinical behaviour towards patients with these illnesses, as seen in the healthcare providers' communication, which is less patient-centred towards people living with the illness. Other evidence of negative attitudes on the part of healthcare professionals that is reported to be widespread in the developing world is the nurses' verbal and physical abuse of patients within a clinical setting (Jewkes et al., 1998). Healthcare provision, which includes nurses' negative attitudes towards individuals illnesses, has considerable influence on people living with the illness by causing them to feel "disrespected, inadequate or unwelcome, thus negatively affecting the encounter quality and their willingness to seek needed care" (Phelan et al., 2015, p. 320). These embodied feelings of stigma, in turn, create stress, a higher risk of non-adherence to medical treatment, mistrust of health professionals, avoidance of healthcare personnel, and poorer health outcomes (Browne et al., 2013, p. 6).

Overall Tone

The overall tone of the discussions was assessed by taking into consideration the specificity of discussions of cause, solution, and the portrayal of people living with

an illness. For cancer, the discussion was uncertain and pessimistic in relation to ambivalence in causal knowledge, which is correlated with a lack of solution knowledge. The only discussion of cure is a change in behaviour to a proscribed, Biblical pattern of living through diet, exercise, and rest (see letter, “Healthy living”, above). Due to the lack of a cure for HIV, which was highly associated with a behavioural cause, the overall tone for HIV was pessimistic with moral overtones. Prevention-oriented discussions had a high moral overtone, arguing for promotion of abstinence, monogamy, and morality to reduce the incidence of HIV in the society. There was also a lack of engagement in the letters with medical advancements in HIV. Moreover, with a lack of cure, there was considerable emphasis on highlighting prevention. Diabetes, which was perceived as preventable, had an optimistic but antagonistic overtone. Letter writers appeared to express an opinion that diabetes was avoidable and the increasing national diabetes rate was due to a lack of effort on the part of the relevant responsibility attributors. There were concrete suggestions for all levels of society to prevent further diabetes occurrence.

Recommendations

The study’s findings locate chronic illness as a social justice and human rights concern. The findings indicate the different societal domains in which stigma can and does occur in Fiji, and particularly, Suva. For diabetes and HIV, the stigmatised response of health professionals was emphasised. It is heartening that lay society acknowledges and condemns stigmatised behaviour within the medical domain towards patients. Moreover, within the lay knowledge, there is recognition of the detrimental effect medical personnel’s stigma can have on personal management of illnesses. However, there was also the stigmatised discussions within the Letters to the Editor towards people living with HIV, through blame for spreading HIV. Ongoing efforts are needed to further counter the stigma within the medical and lay society towards people living with HIV and diabetes. Another concern with the representation of people living with illness was the lack of engagement with people’s lived experiences of cancer. The discourse is instead weighted towards a fatalistic portrayal of cancer through metaphor usage and emphasis on illness burden. The findings indicate that societal awareness needs to be raised on the detection and prevention of predominant cancer forms and treatment options.

The findings also provide support for more specialized media training in discussions of the intersections of resource access, power distribution, and illness occurrence. Media often frame chronic illnesses as an individualised responsibility for cause, prevention, and management. Such discourse is, on the one hand, perceived as

empowering people to make better health choices; however, as noted by the letter writers, the emphasis on the individualised health behaviour framing of illness overshadows the political economy of illnesses discourse, and the responsibilities of policy makers in providing more equitable social healthcare (Marmot, 2005). Media, through what it considers worthy of publication, is likely to play an important role in shaping societal awareness and response. Through responsible reporting on chronic illnesses, identifying the multiple complexities of illness causality and risk management in Fiji, and taking a considered approach in which letters to the editor are published, media could play a significant role in shaping health response in Fiji.

Finally, the three illnesses were represented as socially relevant concerns. Cancer and HIV were presented as socially significant illnesses through discussions of the burden of the illnesses on society. On the other hand, diabetes was presented as a socially significant illness through discussions of causal and solution factors, which positioned the occurrence of diabetes as a social justice concern linked to poverty and lack of access to quality food. The lay-societal recognition of all three illnesses as being socially relevant suggests grassroots support for multisectoral policies directed towards structural reforms for the prevention and management of these illnesses (Glasgow & Schrecker, 2015).

Future studies

In this preliminary study, there was an underlying theme of Christian values in relation to lifestyle choices, particularly in reference to prevention of cancer and HIV. Future research could investigate the role that religion plays in people's responses to cancer and HIV causes, prevention, and treatment options (cf. Phillips 2020 for a study on indigenous Fijian diabetics' experiences and management of diabetes-related risks). From the names of the letter writers, it would appear that writers came from different ethnic backgrounds, and reflect Fiji's rich diversity of cultures. There were also approximately equal representations of male and female letter writers. The study, thus, appears to indicate that there is widespread societal concern about the presence and prevalence of diabetes, cancer, and HIV in Fiji. Further analysis could determine whether the combination of ethnicity and gender, in relation to other demographic factors, plays a significant role in societal responses to significant illnesses within the community and to people living with these illnesses. The use of this study and proposed future studies could help tailor Fiji's public health messages in order to develop a better reach with the audience.

Conclusion

This research provides an analysis of lay societal perspectives on illnesses and people living with those illnesses. Lay perspectives on health lie at the intersection of biomedical, health behavioural, and political economy discourses. The favoured discourse is tied to a person's social, political, and economic power, resource access, sociocultural context, and subjective experience. Thus, an analysis into lay knowledge is vital for understanding societal perspectives on the importance of social determinants on health outcomes, the understandings and experiences of the manner in which power, macro and micro-level politics, and governance intersect to provide different causal pathways for resource access to prevent illnesses, or, if an illness is present, to determine what resources are available to people to respond to the illness.

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