Nursing care for people living with diabetes and associated conditions in Fiji: an iTaukei community context

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Dedication

This thesis is dedicated to the memory of my father, Joji Rokotinono Kasami, who was aware of my intentions to start a PhD journey. Through the way he lived his life, he has taught me the importance of hard work, determination, character strength, and unconditional love.

I also dedicate this thesis to my friend, Mrs Marieta Atalifo, who was called to eternal rest shortly before I commenced my PhD journey.

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Abstract

This research examined the experiences of *iTaukei* (indigenous people of Fiji) patients and nurses in the context of the diabetes epidemic in Fiji. *Vanua* theory, which has some influence on *iTaukei* health beliefs and practices through its physical, social and cultural elements informed the design and conduct of the research. Despite the voluminous global literature on diabetes and non-communicable diseases (NCD), there was little written about the topic for Fiji and the Pacific. Fiji was among the first few countries to adopt public health initiatives that were developed to curb the incidence of NCD. However, such initiatives have faced a perpetual challenge in terms of implementation, monitoring and evaluation.

The research used the Fijian *Vanua* Research Framework and *veitalanoa,* a data collection method, to gather information from twelve patients and eleven nurses from four medical areas in Fiji. The *veitalanoa* groups were complemented by four *veitalanoa* individual sessions and field observations. Findings revealed that patients struggled to cope with diabetes and associated complications while nurses were challenged to deliver best practice in inadequate nursing practice environments. Specifically, patients had difficulties both living with diabetes and accessing planned care and were culturally unlikely to question or challenge medical decisions, simply expecting safe and trustful care. Nurses were not able to nurse in the way they know is needed; they provided rudimentary and sometimes inappropriate care, and experienced extreme frustration while attempting to provide holistic care in a highly medicalised model of care.

The nurses were aware of *vanua* etiquette and their connections with *iTaukei* patients, however, they could not apply such protocol. Despite study findings revealing significant challenges for patients and nurses, the participants suggested a way forward for the improvement of nursing care and primary health care in Fiji. Such changes may represent considerable challenge to the accepted hierarchies of power and decision making and will need to be strongly supported by a focus on patient centered care.

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Abbreviations

BKA: Below Knee Amputation

BMI: Body mass index - the calculation of weight divided by height

BP: Blood Pressure

CBG: Capillary Blood glucose

CCM: Chronic Care Model

CHWs: Community Health Workers

CNMO: Chief Nurse and Midwifery Officer

CPD: Continuous Professional Development

CVD: Cardiovascular Disease - Heart conditions that include diseased vessels, structural problems and blood clots.

CRF: Chronic Renal Failure – Longstanding disease of the kidneys.

CWMH: Colonial War Memorial Hospital

DKA: Diabetic Ketoacidosis

ED: Erectile dysfunction

FHEC: Fiji Higher Education Commission

FHSIP: Fiji Health Service Improvement Program

FHSSP: Fiji Health Sector Support Program

FSM: Fiji School of Medicine

FNC: Fiji Nursing Council

FNU: Fiji National University

FVR: Fijian Vanua Research

GDM: Gestational Diabetes Mellitus

GDP: Gross Domestic Product

GNI: Gross National Income
ICU: Intensive Care Unit

LTCs: Long-term Conditions

MBBS: Bachelor of Medicine and Bachelor of Surgery

MCH: Maternal Child Health

MDGs: Millennium Development Goals

MOH: Ministry of Health

NCDs: Noncommunicable Diseases

NP: Nurse Practitioner

PCP: Primary Care Provider

PHIS: Public Health Information System

PICTs: Pacific Island Countries and Territories

PEN: Package of Essential NCD Interventions

SDGs: Sustainable Development Goals

SOPD: Special Outpatient Department

SNAP: Smoking, Nutrition, Alcohol, Physical Activity

T1DM: Type 1 Diabetes Mellitus

T2DM: Type 2 Diabetes Mellitus

UPSM: Umanand Prasad School of Medicine

VKB: Vola ni Kawa Bula

WDF: World Diabetes Federation

WHO: World Health Organization

WPR: WHO Western Pacific Region

Chapter One: Overview of the Study

This thesis considers the *iTaukei*[1] perspective of the ideal nursing care for people living with diabetes and associated conditions drawn from two samples: patients living with diabetes and nurses who care for them in Fiji. The interest to turn diabetes into a study topic draws from personal experiences of working as a registered nurse at the Colonial War Memorial Hospital in Suva, Fiji, in 1999.

Chapter One introduces the study, describing the background in context, my personal motives for doing the research, and the rationale for the study regarding the research problem. The chapter then outlines the overall research aim and subsequent research questions that guide the study, and a brief overview of the thesis structure is given. In this thesis, all indigenous Fijian words are italicised, and all indigenous Pacific words are italicised and underlined.

My positionality

This section briefly discusses how I positioned myself during the conduct of this research, which has had an inevitable effect on the data collection and is discussed in detail in Chapter 6. First, the research participants knew that I was a nurse. Their prior knowledge challenged my role as a researcher because participants assumed, I knew what they experienced. While adding to their discussions, participants looked at me and said '*iko kila, iko na nasi*'- "you know, you are the nurse." I explained my position as a researcher and reassured them, saying that I was there to listen to their stories. Second, as an *iTaukei*, I have protocols and tribal connections to the *vanua* and its people. For this reason, my participants and I share tribal links, meaning I automatically have a relationship with the participants.

To present as a woman leading the research is a challenge to Fiji's patriarchal set-up. I observed that my status as an indigenous woman disallowed male participants (both nurses and patients) from openly discussing their experiences**.** Also, *iTaukei*

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[1] *iTaukei* - indigenous people of Fiji

communities have had researchers that collect information about other issues of development. A patient participant was thankful that someone has finally arrived to investigate patients' issues because his community had always received people who collect information about water source and agricultural products. When I mentioned *' na noqu vakadidike'*- (my research), one participant asked whether there were other people involved as people typically arrived in groups to investigate how they were doing things in his community.

The Research Background

The research explored the experiences of 12 *iTaukei* persons living with diabetes as a primary disease, but, inevitably, they had coexisting long-term conditions (LTCs). Their experiences and needs are compared and contrasted with the care that 11 *iTaukei* nurses delivered or would like to deliver for patients with diabetes in an *iTaukei* community setting in Fiji. Fiji's leading health-care concern is the high incidence of severe but preventable lifestyle-related diseases, such as diabetes, coronary heart disease, high blood pressure, obesity, anaemia, and malnutrition in children (Ministry of Health [MOH], 2015b). These preventable conditions are known as noncommunicable diseases (NCDs). High levels of incidence burden the economy with high medical costs in relative and absolute dollar terms (Snowdon et al., 2013), not to mention the loss of human productivity. Good health and well-being are also fundamental human rights (World Health Organization [WHO], 2017a).

While researching a topic never previously told or openly shared, the participants' stories became complicated for me as an insider and outsider to the research. I carefully chose the words to best show findings that were emotionally overwhelming. Writing the data and the discussion chapters were the most difficult, truly time-consuming and emotionally draining as I focused intently on what transpired during the fieldwork experience.

The thesis represents the voice of people living with diabetes and associated conditions and nurses who care for them in an indigenous Fijian context. Most of those patients who participated are no longer on this earth physically. I hope to use my research to improve nursing care delivered to patients living with these conditions. The participants shared their experiences of accessing health-care services, for the first time, and wished they had talked about it sooner after their diagnosis. Hence, participants had the opportunity to talk about their experiences freely. Participants shared their stories in a typical *iTaukei* way, with jokes to eliminate other participants' painful experiences as they carefully chose culturally appropriate words to describe their journey.

My Story

Part of the job description of a surgical ward registered nurse at the Tailevu–Namosi Surgical Ward of the Colonial War Memorial Hospital [CWMH] in Suva, Fiji, is to attend to patients' wound care. In 1999, nursing care at the Tailevu-Namosi ward was mostly for postoperative patients with diabetes foot sepsis. One of my patients (Ms G) was crying on a particular day and, in between sobs, asked for assistance with her situation. She asked for the chance to try and heal her foot wounds rather than proceed to amputation. The surgeons were awaiting consent for a forefoot amputation. While it was hard for me to fully comprehend Ms G’s request, especially as discussions with surgeons by patients or nurses were not well received, I sought to advocate on her behalf. I agreed to support Ms G and discussed my plans with the surgeons regarding what we could try and do for her.

I took the responsibility of taking care of Ms G’s wound during all my shifts as an extra patient to my already allocated ones and as my unique patient on my days off. Our relationship was special because she was from another Pacific Island country and had been referred to Fiji for further medical management and interventions. Thus, in a two-bed cubicle, Ms G was a foreigner, hardly visited, and left alone in the top ward corner. According to her, I was her only hope, second to God, in the absence of family and friends.

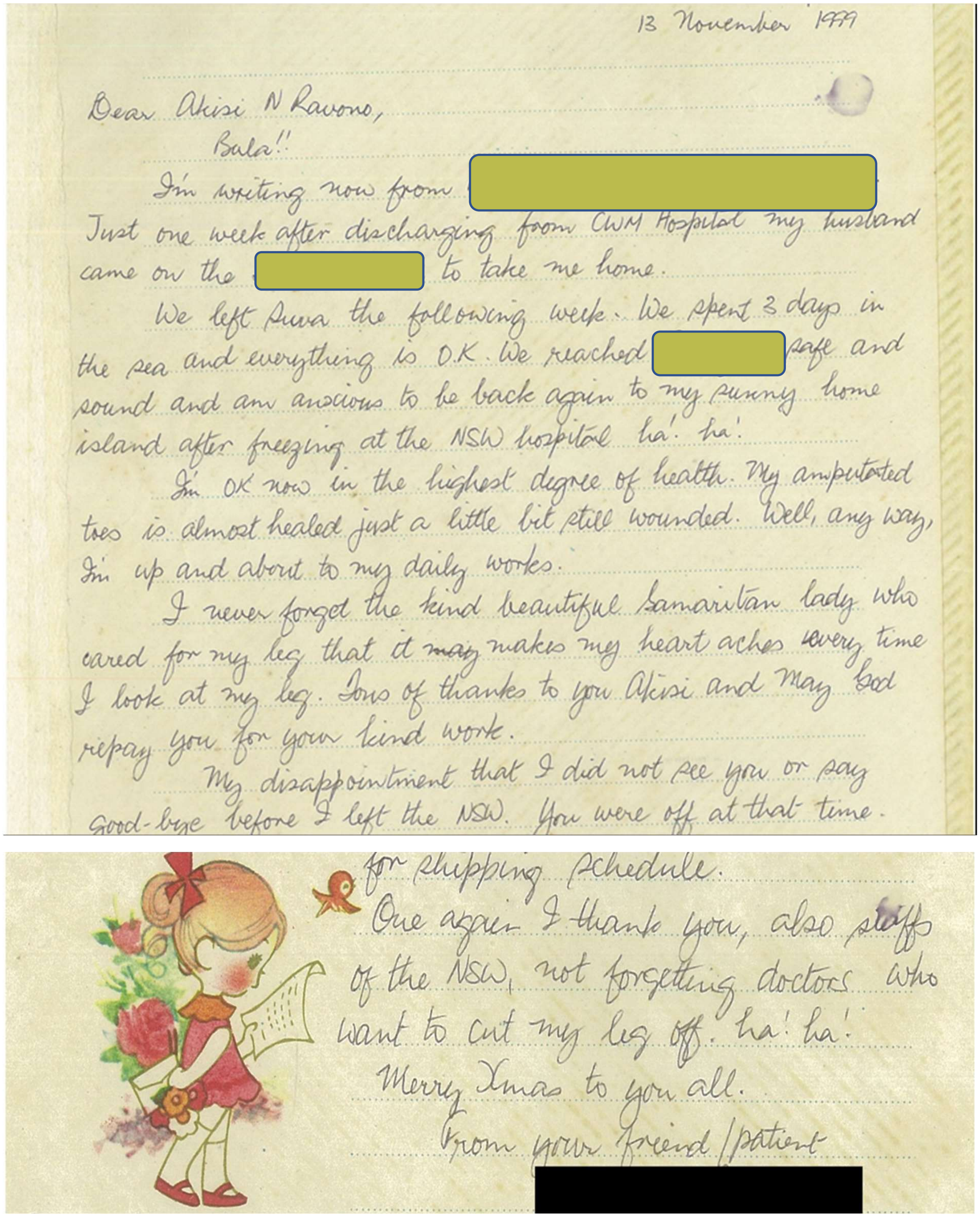
The excitement to see granulating tissues fill the once slough-occupied gaps was something I looked forward to each day. After a three-month hospital stay, Ms G had a skin graft, a toe amputation instead of a forefoot amputation, and could freely use her foot. I did not say goodbye to her because I was working in another ward. In appreciation, Ms G sent specially made hand-woven gifts for my family (see Figure 1) and a letter (see Figure 2).

Figure 1

Ms G's gift to my daughter

Figure 2

Ms G's Letter



13 November 1979

Dear Akisi N Ravono,
Bula!!

I'm writing now from [redacted]. Just one week after discharging from CWM Hospital my husband came on the [redacted] to take me home.

We left Suva the following week. We spent 3 days in the sea and everything is O.K. We reached [redacted] safe and sound and am anxious to be back again to my sunny home island after freezing at the NSW hospital ha! ha!

I'm OK now in the highest degree of health. My amputated toes is almost healed just a little bit still wounded. Well, any way, I'm up and about to my daily works.

I never forget the kind beautiful Samaritan lady who cared for my leg that it ~~may~~ makes my heart aches every time I look at my leg. Tons of thanks to you Akisi and May God repay you for your kind work.

My disappointment that I did not see you or say Good-bye before I left the NSW. You were off at that time. for shipping schedule.

One again I thank you, also staffs of the NSW, not forgetting doctors who want to cut my leg off. ha! ha!

Merry Xmas to you all.

From your friend/patient
[redacted]

I was humbled by the efforts and the beauty of the carefully woven handicrafts, which were carefully stitched and labelled. As a family, we still treasure these gifts even today. I continue to be inspired when I think of the amount of time and effort used and vision needed to design the individually crafted pieces and understand the interconnections to make a whole. Considering my need for a researchable topic, I related the weaving process and the interconnected woven crafts to mirror nursing care and health frameworks. As such, each of these interconnecting concepts could not perform its function without the support of the other. I found notable conceptual similarities in the different Pasifika health models, which identified similar values that guided their review.

This experience with Ms G has also importantly piqued my interest about whether the widespread amputations in Fiji and patients' subsequent loss of independence, income, and freedom to move about are necessary. I began to think more critically about the role of nurses in caring for people with diabetes and their potential role in preventing or reducing the incidence of amputation.

Accessing Health Care

Patients access health-care services with a "mission" or a short-term goal to improve their current health status. Their experiences of the mission affect their vision - this is their long term goal or what they want to have in place forever. The patients' vision of care embraces their desired long term outcomes and may include essential values and wishes. Some examples of patients' values and wishes are to continue to live in their community and to assist in deciding what type of care is needed and acceptable to them (Young et al., 2017). Achieving the best patient outcomes means that health-care providers must also have a clear mission of the type of care each patient requires (Burden, 2017). Health care should offer the best possible outcomes for each patient with consideration of their illness, disease experience, and existing resources (Young et al., 2017) as well as their specific values and wishes. To achieve the best possible outcomes in patient care, the description of what they consider "ideal" must be known.

The Ideal Nursing Care

This thesis uses the patients' accounts of the type of nursing care they expect and hope to receive as the "ideal care", also known as “best practice”, for people living with diabetes and associated conditions. Their stories were based on their previous experiences while receiving care in a health-care facility in Fiji. Similarly, the nurses' explanations of their mission of care are what they hoped to deliver for patients living with diabetes and associated conditions in Fiji, based on their recent experiences of providing nursing care.

The Rationale for the Study

Fiji is currently struggling to address the consequences of its rapidly evolving NCD epidemic and has been a target area of the World Health Organization [WHO]. The ongoing challenge for Fiji's Ministry of Health [MOH] in diabetes management is to prevent foot sepsis and amputations at a primary-care level (Fiji Health Sector Support Program [FHSSP], 2010; MOH, 2011). As Snowdon et al. (2013) predicted, the problem has worsened, causing a substantial drain on health-care resources and productivity. There is a need for a reorientation of health-care services and systems. Such reorientation must include developing various prevention strategies to accommodate the high levels of chronicity (Phillips, 2020; Snowdon et al., 2013; Zibran & Mohammadnezhad, 2019).

The chronicity of NCDs generates a weighty, long-term cost burden on affected persons. Such patients often require a significant amount of funding allocated for medicines by the Health Ministry (Kontis et al., 2014; Snowdon et al., 2013). The need for funding is more important when patients need special allocation due to their disability. In Fiji, diabetes-related amputations continue to increase at an alarming rate (MOH, 2015a). Amputations of limbs occurred at every eighth hour in 2017 (MOH, 2017a) and every twelfth hour in 2019, and while it seems to be improving, what patients think of these amputations is unknown. There is a strong correlation between the high amputation rates with increased reports of morbidity and mortality. Fiji currently has the highest amputation rates in the WHO Western Pacific Region [WPR] (Morgan, 2015; V. Qio, personal communication, September 15, 2018). The age group most afflicted by diabetes is from 40–59 years, and there are more females newly diagnosed with diabetes mellitus (MOH, 2015a).

The MOH has reported that thirty per cent of Fiji's current adult population has diabetes, which remains a chronic disease of concern for Fiji (WHO, 2012a). The decline of primary health-care activities in the 1980s in Fiji led to the now collective experience of an increase in NCDs (MOH, 2015b). The MOH has identified NCDs as its priority area in its 2018 Corporate Plan and has been the core of weekly programmes conducted by staff (MOH, 2016, 2017b). Despite the readily available information that includes strategy, policy, and ministerial speeches regarding diabetes as an issue, no documentation is available regarding patients' feedback, illustrating the absence of action by the MOH in relation to patient experiences and expectations (Snowdon et al., 2013). Given that the increased investment in the health-care system has not improved people's health (Tukana, 2013), understanding patient experiences and expectations thus seems paramount.

Study Intentions

This research explores patients' expectations of their care and how it connects to the care nurses plan to deliver for a patient living with diabetes and associated conditions in an *iTaukei* community context in Fiji. Unfortunately, there is relatively little literature on how patients' wishes are shared (Young et al., 2017). For this reason, this study is innovative in exploring the patients’ and nurses’ description of the type of nursing care they want to receive and deliver, respectively, regarding diabetes management in the Fijian context. This study will benefit nursing as a profession, patient care, and the MOH in helping address the NCDs crisis in Fiji. This research will contribute to the *iTaukei* epistemology of health care and relationships in Fiji.

Research Aim

The main research aim that guides this study is:

To understand the experiences and expectations from the viewpoints of patients receiving care and nurses practising and delivering care in the context of a diabetes epidemic in Fiji.

Research Questions

- How do patients describe the care they receive and the care they want to receive?
- How do nurses explain the care they deliver and the care they want to deliver?

An Overview of the Findings

The research has identified three main themes from the patient participants. These are:

1. Cultural barriers to care;
2. Expecting safe and respectful care; and
3. Needing health education and health promotion.

Responses from the nurse participants are presented in three main themes. These are:

1. Existence of barriers to care;
2. Care provided is substandard; and
3. More education to support practice is needed.

Also, several subthemes contribute to the findings and discussion of the main themes as explored in more depth in subsequent chapters.

Thesis Outline

The thesis is structured in the following way and organised into nine chapters.

Chapter One is the introductory chapter that has set the scene for the study and provides an overview of the thesis by describing the background and rationale. The chapter includes my personal story and a letter from one particular patient that briefly captures the core issues of the research context. The chapter articulates the overall research aim and the main research questions that guide the study. An overview of the thesis structure concludes the chapter.

Chapter Two is a review of the literature with reference to diabetes management as a disease of specific concern in Fiji. The vast amount of international literature on diabetes and its management is beyond the scope of a literature review for this thesis. Accordingly, I have examined and synthesised the literature in areas relating to NCDs, policy, primary health care, and nursing to understand the patient and nursing experiences of diabetes more deeply in Fiji and the Pacific.

Chapter Three describes the study context by outlining Fiji's geography and economy. The chapter also explains the status of diabetes and health care in Fiji, detailing Fiji's health-care facilities and its settings. The chapter also elaborates on the nature of primary health care and how the Fijian Ministry of Health sets its services that include providing nursing care to people living with diabetes and associated conditions.

Chapter Four introduces *iTaukei* sociocultural ways of knowing and dealing with sickness. First, the chapter provides a general orientation to the *iTaukei* way of life, belongingness, connectedness, and *vanua*[2]. The chapter describes the importance of language and *iTaukei* ways of knowing. Further, the chapter outlines the *iTaukei* worldview on health, including physical, spiritual, and social wellbeing, together with the twenty caring values that distinguish being *iTaukei*. The chapter ends with how *iTaukei* approach biomedical treatments as a last option in dealing with illness.

Chapter Five presents the theoretical lens of the research; as such, it introduces the *vanua* theory. The three elements of the *vanua* are fundamental for identifying and understanding how *iTaukei* maintain balance while living on the *vanua*. The chapter

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[2] *Vanua* – relating to the people, land, and everything on it. It also relates to the chiefs and is announced during traditional ceremonial functions.

presents the eight *vanua* principles that were followed during the research. The chapter also outlines the nine Pacific health and wellness models that describe health concepts among Pacific people from global, Pacific and Fijian perspectives.

Chapter Six contains the method of this research and includes the ethical approvals and the nine stages of the Fijian *vanua* research design and its processes. The chapter includes personal conversation quotes with a key informant, author of the research design used in this research, and ends with my fieldwork reflections.

Chapters Seven and **Eight** present the study results and include translated participants' *veitalanoa*[3] verbatim. Chapter Seven addresses the results from patient participants' *veitalanoa* while Chapter Eight presents results from the nurse participants' *veitalanoa*. Where research findings needed specific clarifications, my field observation notes reinforce the data findings.

Chapter Nine offers a discussion of the results and some recommendations for the ideal nursing care of people living with diabetes and associated conditions in Fiji. The chapter also highlights some of the study's limitations noted while conducting this research.

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[3] *Veitalanoa* – formal account of Talanoa, a conversational method used in this study as a research method

Chapter Two: The Literature

The literature on diabetes and all related matters is voluminous. This review is therefore pragmatically confined to what is known about the topic in Fiji and, to some extent, in the broader Pacific. This literature review is presented in three parts. First, the review focuses on NCDs, including diabetes and their effects in Fiji and the Pacific. The review then moves to the NCD-related policies and legislative frameworks available in Fiji. Last, the supportive mechanisms around health-care systems, such as nutrition and physical activity, tobacco regulatory measures, enforcement of such policies, and primary health-care support, are included. Nursing care for people living with diabetes is part of such support available in Fiji. This review adopted several search strategies using electronic health and nursing databases. The advanced search from the Massey University DISCOVER database using the main keywords resulted in limited literature. The key search terms were "NCDs", "policy", "primary health care", "nursing", "Fiji", and "Pacific". No dates were applied, but the search concluded in July 2021.

The review yielded limited literature on Fiji and the Pacific; therefore, the grey literature as, for example, Ministry of Health reports, conference proceedings, theses and dissertations, and reference lists of identified articles were searched from January 2018 to July 2021. The review found scant literature from Fiji and the Pacific, despite the global, regional, and local efforts to address the NCD burden. For nursing, the search yielded no literature on nursing care for people living with NCDs or diabetes in Fiji. Therefore, my research is original and offers discussion about nursing care for people living in Fiji, which can be generalised in similar cultural and economic contexts to understand patients' expectations of care.

Noncommunicable Diseases (NCDs)

Like other noncommunicable diseases (NCDs), diabetes is non-infectious and results from several factors, including genetic, environmental, physiological, and behavioural (Budreviciute et al., 2020). Globally, NCDs are the leading cause of deaths each year (Budreviciute et al., 2020; Mialon et al., 2016; Snowdon et al., 2011) and account for most deaths among those under 60 years of age (Hawley & McGarvey, 2015). The top four annual killers among NCDs with the highest number of deaths are cardiovascular diseases (17.9 million people), cancers (9.0 million people), respiratory diseases (3.9 million people), and diabetes (1.6 million people; Budreviciute et al., 2020). This trend in mortality has been evident since 2011, and the WHO has declared NCD prevention and control as a priority (WHO, 2012b, 2016). Also, in noting the global concerns about the increasing burden of NCDs among productive adults, the WHO aims to reduce premature mortality by 25 per cent over the period 2010 to 2025 (Santosa et al., 2015).

International literature has identified patient centredness, competent and accessible care, and increasing patient capacity to self-manage as the ultimate goals for nursing care (Catalyst, 2017; Francis, 2017; Kalra et al., 2017; Ratner et al., 2017; Schwartz et al., 2017). Nurses have the highest patient interaction level (DeLucia et al., 2009) and commit to patient-centred care (Hall & Glew, 2017). Evidence has shown the effectiveness of more patient-centred interactions in chronic care through improved patient care and better health outcomes (Mills et al., 2017; Waheedi et al., 2017). People living with diabetes are typically required to be the primary managers of their disease due to the daily management and regular monitoring of their general health, so they need to be part of the care planning (Banerjee et al., 2020; Callaghan & Williams, 1994; Hörnsten et al., 2005; Jutterström et al., 2016). Therefore, patients need to be at the centre of any planning, which requires their involvement from the beginning. This provides an important context for considering the situation in Fiji.

NCDs in the Pacific

From the existing data, the WHO identified that NCDs affect life expectancies, health-care costs, and economic development for people living in the Pacific (Dodd et al., 2020; Tolley et al., 2016; WHO, 2017b). NCDs have been the cause of more than 70 per cent of all deaths in the Pacific Islands (Estime et al., 2014; Hawley & McGarvey, 2015; Latu et al., 2018; Win Tin et al., 2020) and are projected to be in the top five causes of death in the Pacific by 2040 (Dodd et al., 2020), so NCDs have become a priority health and development issue for the Western Pacific region (Tolley et al., 2016; WHO, 2009). Despite these efforts, the disease complications from NCDs remain a threat to the human, social, and economic aspects of the Pacific Island countries (Walker et al., 2017). Reports from the Pacific showed a high incidence of incapacity due to NCDs, with a member country reporting one in ten people with diabetes as having had amputations (WHO, 2016).

Since 2015, the average premature mortality from NCDs has been more than five times higher for Pacific Island states, which has resulted in several commitments at various levels to address NCDs within the Pacific (WHO, 2017b). Achieving healthier populations among the Pacific Island countries has led to developing the framework for the Healthy Islands vision (Tolley et al., 2016; WHO, 2017b). The *Yanuca Declaration of Healthy Islands* concept was announced at the first Pacific Health Ministers' meeting in 1995 at Yanuca Island, Fiji. However, the incidence of NCDs in Pacific populations has been a significant barrier to achieving the vision (WHO, 2017b). Therefore, the overwhelming health and economic burdens from NCDs continue to affect Pacific countries.

The NCD crisis has prompted Pacific Island countries to lead their responses to support the WHO objectives (Piukala et al., 2016; Waqa et al., 2013). Changes in dietary patterns were considered to be the main driver for addressing high NCD rates (Christoforou et al., 2015; Dodd et al., 2020). The urgent need for change would require health-care systems to reinforce prevention programmes and ensure that NCD control is integrated into primary health care (WHO, 2009). In response, 14 Pacific countries met to raise awareness of the relationship between high salt intake and NCDs in 2010 (Christoforou et al., 2015).

NCDs in Fiji

The most prominent health-care concern in Fiji is the high incidence of NCDs (Hendriks et al., 2015; Wiseman et al., 2017) regardless of the current public health concern of the COVID-19 pandemic. Despite NCDs being a significant cause of mortality and morbidity for Fiji, only 12 per cent of studies were registered under the Fijian Ministry of Health (Sridharan & Gowri, 2016). The escalation of the NCD crisis remains a challenge for Fiji's health system (Snowdon et al., 2013; Chand et al., 2020). NCDs in Fiji have caused many premature deaths, permanent disabilities, and associated complications (Mavoa et al., 2012; Mialon et al., 2016; Wiseman et al., 2017). This places a significant economic burden on Fiji's health-care system, which is associated with high medical costs (Chand et al., 2020; Snowdon et al., 2013). The chronicity of NCDs causes long-term costs and a burden on affected persons, their families, and the Health Ministry (Kontis et al., 2014; Snowdon et al., 2013).

NCDs in the *iTaukei* language is translated as *mate sureti*[4] which implies that people are responsible for inviting the disease because of their lifestyle (Phillips et al., 2018; Ratubalavu, 2017). Torres and Atkinson (2018) state that the term “NCDs” is confusing to people, especially for people in the Pacific, because its incidence relates to and involves social interactions. Social events are often associated with food, and the *iTaukei* way of life and its social functions revolve around food (Ravuvu, 1983). Food, as stated on page 17, has been associated with NCD incidences (Gounder, 2020; Hendriks et al., 2015). Also, the increasing impact of changing lifestyles on health in Fiji has prompted the implementation of several important public health initiatives related to NCDs by the MOH while becoming a triple burden for the Ministry of Health, which now has to cope with communicable diseases, injuries, and NCDs (Wiseman et al., 2017). Due to its increasing prevalence, there is a high level of commitment and recognition of the NCD problem scale in Fiji, supported by the WHO (Snowdon et al., 2013). From the WHO’s perspective, Fiji has the world’s highest proportion of deaths from diabetes; yet, in Fiji, cardiovascular diseases have an even higher tally (MOH, 2020).

As a noncommunicable disease, diabetes is highly likely to be comorbid with other diseases, meaning that additional health conditions may occur with the

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[4] *Mate sureti* - Invited diseases relating to NCDs

primary disorder (Budreviciute et al., 2020). Therefore, the management of diabetes as a noncommunicable disease must focus on the main factors of illnesses, which are medications, blood pressure, lipids, glucose, viruses, obesity, and stress. Other dietary factors include consuming too much meat and sugar-sweetened beverages related to NCD development (Budreviciute et al., 2020).

Policies and Legislation Relating to NCDs

Due to the substantial economic burden on small island states' economies, the WHO has led initiatives to address the NCD crisis in the Pacific (WHO, 2012b), which is challenged by the lack of data from several island states (Hawley & McGarvey, 2015). Global and Pacific regional leaders have widely acknowledged the critical role of policy and legislation to address NCDs, out of which the region developed prevention and control programmes in 2014 (Win Tin et al., 2020). Fiscal policies are in place to promote healthy eating, and there are legislations on tobacco and alcohol control, which support the Global Action Plan on NCDs (Win Tin et al., 2020). The Global Action Plan has substantial inclusion for critical decision-making related to regulatory consistency for NCD-related issues (Thow et al., 2015).

In Fiji, despite the 1998 document on policy recommendations to support health promotion, there were no actions on review, development, implementation, and coordination of health-promotion activities (Roberts & Kuridrani, 2007). The lack of action is because health promoters could not analyse policies in the Pacific, which is an area that needs strengthening (Roberts & Kuridrani, 2007). Opportunities for a coordinated approach to developing policies will enable a healthier environment that promotes better lifestyle choices (Waqa et al., 2013; Win Tin et al., 2020).

Policy advice is needed to influence social determinants in health and illness matters, and health promotion councils must be involved at the highest levels of national development planning (Roberts & Kuridrani, 2007). Lifestyle is noted to be one of the social determinants of diabetes (Akbar, 2018; Gounder, 2020; Hendriks et al., 2015). In this context, it is again important to note that the *iTaukei* way of life and its social functions revolve around food (Ravuvu, 1983). The NCD burden in Fiji has prompted the Ministry of Health to focus on strategies that promote healthier food alternatives. One such strategy was the "*From supermarkets to market, go local and low fat, low sugar and low salt strategy*" in all hospitals for hospitalised patients (MOH, 2020).

For Fiji, several distinctive policy documents appear to be relevant for targeting NCDs. I have chosen five existing strategies that correlate with the Ministry of Health's direction to address the NCD burden. First, I highlight the role of trade and taxation measures related to pricing and affordability issues of goods, which promote good health or prevent illness. Second, I discuss the health systems support programme set in place by the Fijian Health Ministry in response to the high NCD-related morbidity and mortality rates. Third, I review the Public Health Nutrition Policy, which provides guidelines on healthy food consumption and the Fijian government's response in promoting physical activity in schools. Fourth, the Framework Convention on Tobacco Control is discussed, highlighting the government's efforts to address the effects and relationship between tobacco use and NCDs. Last, I note the government's initiative through enforcement of the above policies relating to the control of NCDs.

Trade and Taxation

Fiji's entry to the World Trade Organization (WTO) since 1996 has increased imported food availability (Ravuvu et al., 2018). Through the manufacture, sale, and promotion of tobacco, alcohol, and ultra-processed food and drink (unhealthy commodities), transnational corporations are major NCD drivers (Moodie et al., 2013). For example, food, which relates to NCDs, is the main part of global trade (Swinburn et al., 2013). Furthermore, the impact of trade and investment liberalisation correlates with the rapidly increasing prevalence of NCDs in developing countries (Phillips et al., 2020; Ravuvu et al., 2018). Reaching the Sustainable Development Goal[5] [SDGs] targets are challenging for governments of low and middle-income countries (Thow et

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[5] The Sustainable Development Goals (SDGs) or Global Goals are a collection of 17 interlinked global goals designed to be a blueprint to achieve a better and more sustainable future for all (United Nations [UN], 2015). The SDGs were set up in 2015 by the United Nations General Assembly and are intended to be achieved by the year 2030. Goal 3 specifies "Good Health and Wellbeing for all": Target 3.4 looks to reduce premature mortality from noncommunicable diseases through prevention and treatment, and Indicator 3.4.1 refers to addressing the mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease (UN, 2015).

al., 2021). These countries face limitations in regulating the commercial causes of NCDs due to the increasing influence in policymaking of industries that produce unhealthy commodities. Although the literature shows the Fijian government's various approaches to maintaining or strengthening regulatory power on the trade of such commodities, the impact of these strategies on the governance of commercial determinants of NCDs remains unclear (Patay, 2018).

There is little systematic monitoring of new and current trade agreements in areas that concern trade from an NCD and health perspective (Friel et al., 2013; Ravuvu et al., 2018). The literature review findings have generated discussions on how implemented policies on nutrition have difficulty thriving in small island states like Fiji because influences from the trade market continue to dominate marketing (Estime et al., 2014; Thow et al., 2021). Trade agreements, such as the Trans-Pacific Partnership Agreement, affect Pacific governments' ability to expedite operative policies to improve nutrition and prevent NCDs. These agreements also make it difficult for governments to implement the recommendations outlined in the 2013–2020 Global Action Plan to prevent and control NCDs (Dodd et al., 2020; Thow et al., 2015).

In Pacific Island states, government action is weak in restricting unhealthy food marketing, especially to children (Foster et al., 2018; Thow et al., 2021). In Fiji, monitoring of trade agreements and their impact on the food environment is lacking. The laxity in monitoring calls into question the government's focus on current trade and health policies to ensure the provision and consumption of healthier food choices that reduce the burden of NCDs (Ravuvu et al., 2018). Mialon et al. (2016) note that strategies and practices relating to food policies and the food industry need greater transparency to enable positive prevention and control efforts relating to NCDs.

Health Systems Support Programmes

Policies relating to NCD management ensured that national guidelines were in place to manage at least one of the four main NCDs with preventative policies that focused on NCD deterrence for Pacific Island countries (Win Tin et al., 2020). They include the assessment and treatment of people who present with NCD symptoms. Win Tin et al.

(2020) further add that most Pacific Island countries have national guidelines to diagnose NCDs. For healthcare interventions to best fit their intended objectives, services must potentially benefit consumers (Sridharan & Gowri, 2016). For example, Fiji has a diabetes management guideline (MOH, 2012). Also, in Fiji, a key focus area ensured that basic medicines - including those for NCDs - were part of the national list of essential medicines (Win Tin et al., 2020). In 2013, the Ministry of Health also established a Health Policy Technical Support Group (HPTSG) to monitor health-related issues and initiate policies with multi stakeholders and key representatives in Fiji (MOH, 2021). The HPTSG aimed to prioritise wellness, the social determinants of health, the obtaining of a better quality of life, and the provision of holistic solutions for the burden of diseases in Fiji (MOH, 2021). The Wellness Strategy has target areas established by the Ministry of Health in Fiji using the “Rainbow Approach to Healthy Living” framework to promote wellness (MOH, 2015b).

Nutrition and Physical Activity

Nutrition policies, in general, affect the reshaping of food systems due to their influence on availability, promotion, nutritional quality, and price (Friel et al., 2013; Swinburn et al., 2013; Waqa et al., 2017). The food environment plays a vital role in influencing food choices related to NCDs (Bradshaw et al., 2014). There is a strong relationship between NCDs and poor diet (Estime et al., 2014; Snowdon et al., 2011); therefore, policies around nutrition play a vital role in controlling NCDs (Bradshaw et al., 2014; Latu et al., 2018; Mavoa et al., 2012; Mialon et al., 2016; Snowdon et al., 2011; Waqa et al., 2017). Nutrition significantly influences the morbidity, comorbidity, and mortality statistics relating to NCDs (Snowdon et al., 2013).

Taxes on unhealthy food have been accepted as an essential NCD policy response (Dodd et al., 2020). For example, taxes on food affect its price, and food prices affect dietary choices (Swinburn et al., 2013), which are related to NCDs. For a long time, the Fijian government has aimed to address the Public Health Nutrition Policy as a way of dealing with the burden of NCDs. Many obstacles have prevented its effective implementation (Latu et al., 2018; Thow et al., 2021). For example, in 2012–2013, the government announced a 27 per cent increase in fiscal duty on imported palm oil and monosodium glutamate and freed up the duty on all imported fruits and off-season vegetables (Bell et al., 2020; Coriakula et al., 2018). In another example, the government implemented a landmark duty on sugar-sweetened drinks (Phillips et al., 2019). In 2012–2014, tariffs on all imported fruits remained unchanged (Bell et al., 2020), which meant that imported fruits and vegetables were still the expensive alternative food choices. Also, the government's initiative to address NCDs in Fiji through its taxation policies is undermined by some local businesses' vested interests and by multinational food and beverage corporations (Phillips et al., 2019).

In 2009, the government of Fiji adopted the National Nutrition Policy, a comprehensive document labelled the Fiji Plan of Action for Nutrition (FPAN) that focused on improving nutritional status and population health (WHO, 2021). The public health National Nutrition Policy had established many strategies despite the uncertainties of its maintenance in Fiji. In Fiji, working women are allowed 84 working days of paid maternity leave, which is an initiative similar to that of other Pacific Island countries, to promote breastfeeding (Win Tin et al., 2020). Antenatally, women are educated and encouraged to breastfeed their babies, an initiative supported by the breastfeeding policy (Phillips et al., 2019), which promotes exclusive breastfeeding for the first six months. Also, restrictions on marketing promotions of breast milk substitutes make breastfeeding an accessible and economical alternative in Fiji (Phillips et al., 2019). In 1992, talk of a Baby-Friendly Hospital Initiative (BFHI) was welcomed in Fiji (Shrestha & McCaig, 1994). After its establishment in 1994, 12 government hospitals were certified "baby friendly" (International Baby Food Action Network [IBFAN], 2014). However, the BFHI suffered some setbacks due to staff shortages that impacted its implementation. Nevertheless, nurses, doctors, and midwives received continuous education of its importance (Hassan, 2015).

During 2013–2014, several initiatives were developed by the MOH around healthy living and its association with food. The Food Fiscal Policy and the Food-based Guidelines in Fiji aim to ensure people eat healthily (Win Tin et al., 2020). The MOH adopted initiatives to follow these policies to maintain healthy eating and monitor all refreshments consumed at work to overcome premature deaths and complications from NCDs (Fiji Government, 2013a). Another initiative revised the School Canteen Guidelines for the Ministry of Education National Food and Nutrition Policy for schools in 2014. Also, following the WHO set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children, Fiji became the first Pacific nation to draft subsequent guidelines (Swinburn et al., 2013). Fiji has salt iodisation regulations in place and aims to reduce the population's salt intake by 2025 (Christoforou et al., 2015; Win Tin et al., 2020). To address NCD prevention, the Ministry of Education ensured that physical education was a compulsory curriculum component for all schools in Fiji (Win Tin et al., 2020).

Framework Convention on Tobacco Control and Alcohol

Fiji was the first developing country to sign the WHO Framework Convention on Tobacco Control in 2003 and updated the Tobacco Control Act with the Tobacco Regulation in 2012 (Fiji Government, 2013b; MOH, 2020). The Ministry of Health has developed several strategies to protect and safeguard Fijians from ill-health resulting from tobacco use, including the Framework Convention on Tobacco Control 2030 Fiji Project (Hassan, 2020). Strategies for protecting people from secondhand smoking have been implemented. For example, smoking has been banned from public areas, as documented in Section 19 of the 2010 Tobacco Control Act (Chandra, 2014; Hassan, 2020). In addition, the government has introduced annual registrations and licensing of distributors and wholesalers of tobacco products in Fiji (Win Tin et al., 2020). Graphic health pictorials are included on all tobacco packages, with 30 per cent on the front and 70 per cent on the back (Fiji Government, 2013b; Win Tin et al., 2020).

The Ministry of Health partnered with the Fiji National University to declare all campuses within the institution as "no tobacco" zones (MOH, 2021). Since 2013, the Fijian government has consistently increased tobacco taxation and prices to deter tobacco product users (Hassan, 2020). The Ministry of Health Ministry supports the National Tobacco Control Multi-Stakeholder Taskforce, which comprises the Fiji Police force, Fiji Revenue and Customs, and local municipal councils, to enable a faster synergistic network to access information and address the illegal tobacco trade in Fiji (Hassan, 2020). In relation to alcohol use, policies reflect three focus areas: alcohol licences to restrict sales, alcohol taxation regulations, and the drink and driving rules in Fiji (Win Tin et al., 2020).

Enforcement

Fiji has a government-led structure to support the enforcement of laws and regulations relating to NCD risk factors (Win Tin et al., 2020). Despite this, the system is weak in monitoring and reporting, leaving gaps that will need immediate attention should policy and legislation be used to scale up the NCD action (Win Tin et al., 2020). Unless such gaps in the system are rectified, the NCD burden strains the primary health care initiatives that seek to promote wellness in Fiji.

Primary Health Care

It is essential for health-care professionals to have a holistic understanding of the people they care for, including their cultural, political, economic, and social environments, which are important determinants of health (Tukana, 2013). Tukana further adds that there has been a paradigm shift in the management of primary health care services in Fiji. From a purely biomedical perspective, global health models are now inclusive of the multifactored, social-ecological model supported by epidemiological research on chronic diseases. Such research has helped explain the causes of illnesses and supports health-promotion activities (Tukana, 2013). For example, social determinants of health are important factors to explain incidences of long-term conditions [LTCs] Francis, 2017).

Fiji was one of the many countries that signed the 1978 Alma-Ata Declaration of “*Health for all by the year 2000”* when the WHO outlined the necessity of providing primary health care (Tukana, 2013). Primary health care in Fiji has steadily progressed since, and the Fijian government took ownership of the five fundamental values of being essential, accessible, affordable, appropriate, and available in providing care. These values reflect the Ministry of Health's vision and mission statements (MOH, 2014; Usher et al., 2004). In addition, the Ministry of Health strengthened its partnership with communities to improve quality of life (MOH, 2015a).

In contrast, the primary health-care operation occurs on a vertical orientation, adopting a top-down approach: it is health-facility and disease-based orientated (Tukana, 2013). The reduced primary health-care activities in the 1980s in Fiji led to the now-common experience of an increase in NCDs (MOH, 2015a). The premature mortality rate from NCDs has remained consistent for almost two decades, accounting for around fifty per cent of Fiji's total deaths (Zibran & Mohammadnezhad, 2019). The Fijian Health Ministry identified NCDs as its priority area in the 2018 Corporate Plan (MOH, 2017b), which has been the core of the weekly programmes conducted by staff in most subdivisions (MOH, 2016).

Nursing stations, health centres, and private general practitioners' clinics provide primary health care involving health assessments, awareness, and education (Usher et al., 2004). Lack of expertise, proper diagnostic tools, facilities, and access to medicines at the primary care level prohibit easy access to diabetes services (Phillips, 2020). Many patients seek private or traditional care (Snowdon et al., 2013). In supporting secondary level care, primary care focuses on patient adherence to medical advice by implementing the Package of Essential NCD interventions [PEN] (WHO, 2010). PEN is used throughout the Special Outpatients Department Clinics in hospitals and health centres around Fiji (MOH, 2017b).

The Ministry of Health established a Wellness Unit in 2012 to strengthen primary health care in controlling NCD, which aimed to lessen premature deaths among people less than 60 years of age (MOH, 2021). Since its establishment, the unit has developed the Public Health Protection Bill, National Wellness Policy, National NCD Strategic Plan (2015–2019), and the Competency Manual for Community Health Workers [CHWs] (MOH, 2015b). The Ministry of Health also initiated the consultation of a CHWs' policy. CHWs are now formally engaged as support people in every village and are the link between villages and the medical areas. With help from the Australian Agency for International Development [AUSAID], and the Fiji Health Sector Support Programme [FHSSP], the Ministry of Health developed the Wellness Manual for all public health community workers (MOH, 2021).

As mentioned, the Fijian Ministry of Health's strategies for NCD prevention prioritise the control of risk factors that include smoking, nutrition, alcohol, and physical activity (SNAP). Through community outreach programmes, NCD awareness has been promoted weekly by staff in most subdivisions (MOH, 2015a). In collaboration with the World Diabetes Federation (WDF), some nurses also attended foot care training organised through the Fiji Health Sector Improvement Project and Diabetes Fiji (Hjorth et al., 2012; Royal College of Nursing, 2014). The Ministry of Health also completed health-care professionals' training on the WHO model of care for people living with NCDs using the PEN for primary health care (MOH, 2006).

The Ministry of Health's move to adopt PEN has enabled a prioritised set of cost-effective interventions, supported by the WHO for the Pacific region, that provide an acceptable quality of care, even in resource-poor settings (WHO, 2010). The package includes primary health-care programmes, such as tobacco cessation, availability of essential medications (for example, statins to lower cholesterol levels), and support for healthy eating. In Fiji, the PEN programme strengthens the national capacity for NCD management. The PEN model allows people living with diabetes to access blood sugar, blood pressure, and cholesterol monitoring at any special outpatient department or Hub Centres in Fiji (MOH, 2021). The Ministry's wellness department is determined and strengthened by the belief that throughout their lifespan, all Fijians have the potential to achieve wellness in all settings (MOH, 2014, 2015b).

In Fiji, apart from doctors and nurses, allied health professionals, such as dieticians, have always been an essential element of the health team, complementing medical treatment with proper nutritional and environmental care to improve and maintain health status and lifestyles (MOH, 2015a). Part of the dieticians' work is to assist patients with a proper diet plan and promote nutrition and wellness to improve their quality of life (MOH, 2015a). Due to the high cost of food in Fiji, dieticians struggle with communicating affordable and balanced diet plans.

Nursing

Globally, nursing represents the largest group of conventional health professionals (WHO, 2016). Nursing practice is becoming more diverse due to swift variations and demands in health care (Shalala et al., 2011). In Fiji, district nursing, also known as community nursing, was introduced in 1895, and the nurses were sent to the outer islands to improve obstetrical care and influence women in their communities. Nursing practice in Fiji has expanded with education in specialised areas and needs

(Vudiniabola, 2011). One such field is the foot management clinic, especially, but not limited to, people living with diabetes and associated conditions (Hjorth et al., 2012).

The struggle to address the consequences of its rapidly evolving NCD epidemic in Fiji has resulted in a marked improvement in managing diabetes complications. Foot care clinics are available at the subdivisional level and are staffed by nursing personnel who have received foot care training for people living with diabetes and foot problems (Hjorth et al., 2012). The new initiative has shown marked improvement in limb amputations: these now occur every 12.5 hours rather than every eight hours (MOH, 2019b, 2020).

There is relatively little literature about NCDs from Fiji (Sridharan & Gowri, 2016), despite the vast global literature on nursing and nursing care. This review found thirteen articles that focussed on nursing education, Nurse Practitioners, nursing administration, neonatal nursing, assessment on community orientation scale, and human resources. Despite the high NCD prevalence and incidence of diabetes in Fiji and among Pacific Island countries for more than two decades, there has been no research regarding nursing care for people living with NCDs or, specifically, diabetes and its associated conditions.

Chapter Conclusion

The incidence of NCDs in Fiji and the Pacific is rising. The influence of the food environment has been identified as the main contributing factor to diabetes. Fiji has developed some critical public health initiatives to address the NCD burden. Still, the ongoing challenge for Fiji is in the implementation, monitoring, and evaluation of initiatives. For example, the Ministry of Health is challenged in areas concerning diabetes management, particularly in preventing foot sepsis and amputations at the primary health-care level (Roberts et al., 2011). Fiji needs to reorientate its health care services and systems to cater to chronicity and develop various prevention strategies (Snowdon et al., 2013).

The review highlighted the absence of research and literature on nursing care in the context of this study. Despite diabetes being a major cause of premature death and disability in Fiji, there is no Fijian scholarship on patients' viewpoints, nursing care, or health professional perspectives on care for people living with diabetes. There is a lack of literature relating to Fiji and the Pacific as a whole. Despite NCDs being a significant cause of mortality and morbidity in Fiji, only 12% of studies were registered under the Fijian Ministry of Health (Sridharan & Gowri, 2016). Therefore, my study innovatively considers nursing care specifically directed at the care of people living with diabetes and related NCD complications in Fiji and the Pacific.

Chapter Three: The Study Context

Chapter Three presents an overview of the study setting. It highlights the geographic information of Fiji, its people, and the economy. The chapter also provides an orientation to the medical facilities, division of medical areas, and nursing services to people living with diabetes and associated conditions in Fiji. The various functions of nursing care in the primary and secondary care levels are discussed. The discussion then moves to the Ministry of Health's responses to the statistics on diabetes and the healthcare service provision for people with diabetes and associated conditions in Fiji.

Fiji's Geography, Demographics, and Economy

Viti (Fiji) draws its name from one of the many activities of the early settlers who were breaking (*vitia)* small branches and leaving them on the ground to keep a track route during their journey from Vuda to Nakauvadra (Tuwere, 2002). Fiji is in the continent of Oceania and has approximately 18,300 square kilometres of land scattered over 650,000 square kilometres of ocean and is between latitude 15ºand 22º South, longitude 177º West and 178º East on the world map (Tuwere, 2002). Fiji is an island nation in the South Pacific region with 332 islands and islets, about 1,760 kilometres north of Auckland and 2,700 kilometres north-east of Sydney. Fiji is the second-largest Pacific Island country after Papua New Guinea (Taylor et al., 2018). There are two main islands, which account for almost 90 per cent of Fiji's population, and Fiji is home to 884,887 persons enumerated in the 2017 population and housing census (Fiji Islands Bureau of Statistics, 2018).

The population consists of *iTaukei,* who are Melanesians, although many also have Polynesian and Micronesian ancestry. Half of Fiji's people are descendants of Indian indentured labourers contracted by the British colonial powers in the 19th century to work on farms. A substantial number of Chinese in Fiji arrived as free settlers and are now trading, shopkeeping, and market gardening (Yee, 2014). Fiji also has a small but significant group of descendants of labourers from the Solomon Islands, a practice known as the blackbirding system. Through intermarriages, there are existing mixed groups of people in Fiji alongside other economic groups of people, such as expatriates. In 2007, the population comprised 57 per cent *iTaukei* (indigenous Fijians) and 37 per cent of Fijians of Indian descent; the remaining 6 per cent are from other ethnic backgrounds (Fiji Islands Bureau of Statistics, 2008; Taylor et al., 2018).

Under the British policy of cultural preservation, indigenous values and protocols were maintained in Fiji (Ravuvu, 1988). However, many changes have materialised faster over the years; therefore, most traditional *iTaukei* values and cultural practices have been reshaped to suit people's socioeconomic conditions. The socioeconomic conditions are associated with political impacts that discontinue traditional practices and increase disparity among the *iTaukei* (Ravuvu, 1988). As of 2019, Fiji's life expectancy at birth stood at 67 years—higher for females than males—compared with New Zealand's life expectancy, which was 82.8 years (United Nations, 2019; World Bank Group, 2019). The Fiji population's median age is 27.5 years, meaning that Fiji has relatively young people, and 69 per cent are below the age of 40 (Fiji Islands Bureau of Statistics, 2018).

Fiji has been through periods of disasters and turmoil brought on by political and natural events that have impacted the economy, health system, and people's health significantly (Mansur et al., 2018; Taylor et al., 2018). The devastating effects of category five tropical cyclone Winston (2016), and tropical cyclones Yasa (2020) and Ana (2021) diverted most government functions to the restoration of necessities. As with most countries worldwide, the 2020 public health effects of the COVID-19 pandemic affected Fiji's economy. Fiji is heavily reliant on the tourism sector (Scheyvens & Russell, 2012), and the pandemic has affected Fiji's primary source of foreign exchange. Job losses contributed to changes in people's lifestyle, forcing them to live more stressfully and unhealthily. Fiji's response to the public health crisis moved quickly to the setting up of several COVID-19 testing centres, contact tracing, community education, and quarantine facilities, creating a diversion of resources and staffing among health-care professionals. As of July 2021, the situation regarding COVID-19 has deteriorated dangerously, with a seven-day average of 500 cases per million people per day, meaning that Fiji is leading the world in the number of infections per one million people (MOH, 2021b).

Thus, Fiji is labelled a developing country and, by world standards, is one of the upper-middle-income countries (World Bank, 2020). Countries with a middle-income economy experience a swift epidemiological shift and have a lesser capacity to prevent, control, and treat NCDs (Hawley & McGarvey, 2015). A critical issue in Fiji's economy is not the level of national income but its distribution, which affects people's lives (Tuwere, 2002). Uneven distribution creates a disparity and further marginalises those on the lower end to succumb to poor health. Financial incapability limits patients' ability to manage diabetes due to the high costs associated with the disease (Tripp-Reimer et al., 2001). Poverty is rampant in Fiji as forty per cent of the population live below the poverty line (Gounder, 2021; World Bank, 2015). Most families have a sole breadwinner who barely earns enough to sustain their family's needs at the mandated minimum wage rate of $FD2.32 per hour. The 2017 census recorded the lowest unemployment rate in Fiji in twenty years (Fiji Bureau of Statistics, 2017).

Simultaneously, the gap widens between those that can afford to pay and those who cannot, especially for expensive, unsubsidised services like renal dialysis (Phillips, 2020). The lack of resources further enhances poverty for individuals living with diabetes, affecting communities and nations (Gounder, 2020). More than 14 per cent of Fiji's population live with one form of disability (Fiji Islands Bureau of Statistics, 2018), including limb amputations from inadequately treated diabetes mellitus.

Almost 60 per cent of Fiji's population reside in urban areas (Fiji Islands Bureau of Statistics, 2018) due to the urban drift since the turn of the century. There has been a building boom in Fiji with an upsurge of high-rise buildings with shopping malls, within which are numerous food outlets. Such food environments encourage people to eat ready-made takeaway food, which has a significant association with obesity (Wate et al., 2013). These developments are changing people's lifestyles and are fast replacing traditional practices of preparing healthy meals.

Health Care in Fiji

Fiji is a member of the World Health Organization (WHO) and follows its guidelines in managing diseases. Under the WHO classification, Fiji falls under the Western Pacific region, including 21 other countries within the Pacific Islands Countries and Territories (PICT), grouped culturally into Melanesia, Micronesia, and Polynesia. Melanesia includes Fiji, Papua New Guinea, New Caledonia, Solomon Islands, and Vanuatu. Most health-care services in the PICT are government operated, either free of charge or at a low cost (WHO, 2012b). Some of the PICT, including Fiji, rely on overseas support from traditional associates, such as Australia, France, New Zealand, and the United States of America, to assist government functions (WHO, 2017b).

The Fijian government finances most of Fiji’s health-care system and is supported by some international funding programmes, such as the AusAID’s Fiji Health Service Improvement Program [FHSIP] (Hjorth et al., 2012; Soar et al., 2012; Snowdon et al., 2013; Wiseman et al., 2017). Fiji's other primary health-care source is through the private sector, which is financed by out-of-pocket payments or private insurance and donor organisations (Snowdon et al., 2013; Vudiniabola, 2011).

While Western medical science emerged with three practice models identified by Szasz and Hollender in 1956, two are paternalistic and doctor centred, while the third is patient centred (Kaba & Sooriakumaran, 2007). Fiji’s current health-care system is underpinned by a paternalistic model, which means that those in power decide the best treatment option for patients’ illnesses (Tukana, 2013; Zibran & Mohammadnezhad, 2019). The one-sided health approach in Fiji allows the health-care provider to dictate the entire patient management process, resulting in a lack of acknowledgement of patient perspective, understanding, and self-care motivation (Zibran & Mohammadnezhad, 2019). The patients’ culture of reverence for authority becomes a determining factor in how they receive medical treatment. Due to their cultural values, patients respect medical practitioners and their opinions and, therefore, accept medical decisions made for them.

In Fiji, the Ministry of Health implemented few in-house training programmes to address increasing health-care demands. Retaining skilled health-care professionals has been problematic for Fiji due to political upheavals (Usher et al., 2004). To address the shortages of human resources in Fiji, the MOH implemented several strategies. For example, the medical assistant model, also known as the Primary Care Provider (PCP) with limited access to patient care services, was established in 1992 (Vudiniabola, 2011). Also, the Fiji Nurses and Midwives Board (now the Fiji Nursing Council or FNC) approved the Nurse Practitioner (NP) course in 1999 to help fill the vacant medical officers' posts (MOH, 2014; Usher et al., 2004).

The MOH strategy to meet the human resource need successfully enabled a more readily available workforce to fill the gaps for medical officers in Fiji's more remote areas (Downes, 2001). At the same time, a privately funded medical training facility, the Umanand Prasad School of Medicine (UPSM), was established in the West of Fiji. Also, the Fiji School of Medicine (FSM) upgraded the PCP programme to a Bachelor of Medicine and Bachelor of Surgery (MBBS). It continues to train future doctors for Fiji and some Pacific countries. The shift in the number of graduates from the two medical schools soon filled the vacant medical officers' posts. By 2020, the MOH announced the change in its medical internship programme to two years and, at the same time, slowly shifted Nurse Practitioners to health centres.

Medical Facilities

The health systems in Fiji provide comprehensive health-care services based on its provincial arrangement, such as the Central, Eastern, Western, and Northern (Yoon et al., 2019) as shown in Figure 3. In 78 medical areas, Fiji has 102 nursing stations, 86 health centres, 18 subdivisional hospitals, three divisional hospitals, and two specialised hospitals (MOH, 2019a). There are a substantial number of private medical centres and clinics operated by medical practitioners throughout the country. Three private hospitals in Fiji offer services to people who have health insurance and accept out-of-pocket payments. Patients requiring renal dialysis for diabetes-related complications are referred to a few privately operated dialysis centres around the country. Also, some private doctors, dentists, and laboratory technicians work on a fee-for-service basis (Usher et al., 2004).

The increasing prevalence of diabetes in Fiji leads to rising rates of people who need renal dialysis due to kidney disease (Morgan, 2015). It is highly likely for people with NCDs to experience financial stress despite the free government-provided health services (Snowdown et al., 2013). Medical insurance is not a benefit everyone can afford in Fiji and renal dialysis costs aproximately $250.00 per cycle – an amount that is beyond a patient's means (Morgan, 2015). The Health Ministry has entered into an agreement with the National Kidney Foundation to pay for several free dialysis treatments before patients pay their own (Snowdown et al., 2013). In its 2021 budgetary address, the Fijian government has announced government-assisted renal dialysis payment of $150.00 per patient (Fiji Government, 2021).

In Fiji, some health-care services, such as dentistry, require a small fee. Although access to most Fijian health-care facilities is free, the system is under-resourced and understaffed (Phillips, 2020). The health system operates on three tiers that provide integrated health service at primary, secondary, and tertiary care levels. Patients needing quaternary care are referred to other countries, such as India, Australia, or New Zealand, if they have medical insurance or can afford out-of-pocket payments. There are also various statutory bodies, councils, and committees associated with the Ministry of Health. Organisations like the National Food and Nutrition Centre and the National Health Promotion Council support the management and administration of specific health services in Fiji (MOH, 2014). These organisations assist the Ministry of Health in controlling and deterring NCDs (Snowdon et al., 2013).

As there are different levels of health-care services (Usher et al., 2004), health care is provided according to the health-care facility level. There are subdivisional hospitals that offer Level 2 services; health centres that operate at levels A, B, and C; and nursing stations in each division. The service level determines the services available at each subdivisional hospital and health centre (MOH, 2014). For example, health services at a nursing station are limited to the maternal child health (MCH) clinic, family planning, immunisation, outpatients, home visiting, and follow-up cases in their communities (Usher et al., 2004; Vudiniabola, 2011). Nurses typically discuss patients' information through phone referrals with an area Nurse Practitioner or medical officer at the health centre, who will, in turn, provide advice on treatment options, such as medications (Vudiniabola, 2011). In this way, patients do not need to travel to the health centre.

Figure 3

Divisions of Health-care Services in Fiji

Note: Reproduced with permission from MOH Fiji (2016, p no: 25).

Health centres operate in a specifically allocated medical area, determined by the subdivisional level of coverage distribution. People can access pharmaceutical services, special outpatient clinics, and other services as provided at the nursing stations. Typically, the health centre has two or more nurses, depending on its level. For example, a level A health centre would usually offer general and special outpatient, maternal–child health, oral health, pharmacy, laboratory, x-ray, physiotherapy, dietic, school health, and speciality clinic services (MOH, 2014). Each subdivision operates a special outpatient department (SOPD) and a Hub clinic, a centre for chronic medical cases like diabetes and hypertension. The Pacific Eye Institute is based in Suva (Fiji’s capital city) but runs a mobile clinic countrywide for patients needing eye care.

Division of Medical Areas

Each division has its divisional hospital, except for the Eastern, which uses the Colonial War Memorial Hospital (CWMH) in the Central division to receive all patient referrals (Usher et al., 2004). Patients are aware of their medical areas and visit nursing stations or health centres to receive primary health-care services. Cases that need further attention are sent to the subdivisional hospital for a secondary level of care and may be referred to the divisional hospital for a tertiary level of medical intervention (MOH, 2014). Patients are directed to a nearby healthcare facility convenient for them with a note for follow up of care following discharge from hospital care. Zone nurses often follow up cases with the hospital record of admissions, births, and deaths. After hospital admission, the zone nurses become the patients' primary care providers. The registration of patients who have been admitted and discharged is recorded and reported as MOH statistics.

Zone nurses are allocated community visit days to follow up on new or default domiciliary and immunisation cases (Vudiniabola, 2011). Visitations mainly depend on transport availability, the weather, and the country's current health climate. For instance, the measles outbreak in 2019 and the COVID-19 pandemic in 2020 affected most primary health-care resources (MOH, 2021a). The Ministry of Health diverted most of its resources to tracing, vaccination, and conducting awareness and health promotion activities, which halted the follow-up on patients in their communities.

Diabetes

Globally, an estimated 463 million people were diagnosed with diabetes in 2019 (WHO, 2019). This is compared to 422 million in 2014 and 108 million in 1980 (Saeedi et al., 2019; WHO, 2016). Statistically, the global figures for diabetes have nearly doubled since 1980 and even more so in low- and middle-income countries over the past decade (WHO, 2016). According to the World Bank income groupings, diabetes prevalence is higher in high-income countries and urban areas (Saeedi et al., 2019; WHO, 2016). Diabetes occurs at a very high rate in the Pacific region (Sridharan & Gowri, 2016; Waqa et al., 2017).

Diabetes, in particular type 2, is documented in the literature as a lifestyle disease (Morgan, 2015). With the spread of the "Western" lifestyle in low- and middle-income countries, commercial pressures leading to the unhealthy diets associated with NCDs are becoming prevalent across all economic contexts (Budreviciute et al., 2020).

Diabetes in Fiji

An estimated 56,000 people in Fiji have diabetes, one in every three adults (V. Qio, personal communication, September 15, 2018), and Fiji has the highest diabetes-related mortality rates on a global comparison (Gounder, 2020; Morgan, 2015). According to Mataitini (2013), this prevalence indicates that the risks of and impacts on people living with diabetes in Fiji are far greater than the initial estimates. During 2013–2018, Fiji registered 10,312 new cases of diabetes, predominantly for people over 30 years of age (MOH, 2019b) (see Table 1).

Table 1

New Cases (NC) of Diabetes in Fiji 2013–2018

YEAR	NC ≤ 30 YEARS	NC ≥ 30 YEARS	TOTAL NC	TOTAL REGISTERED
2018	33	1157	1,190	13, 356
2017	226	1706	1,932	12, 275
2016	109	1580	1,689	12, 471
2015	24	2240	2,264	11, 908
2014	45	1037	1,082	10, 965
2013	265	1890	2,155	10, 743
TOTAL	**702**	**9,610**	**10,312**	

Note: The data have been sourced from the MOH Fiji Registered Diabetes cases reported from Public Health Information System [PHIS] (2019).

In Fiji, lifestyle is strongly influenced by urbanisation, a move away from the traditional style of living, with a combination of highly refined foods, physical inactivity, genetics, and increasing obesity rates that contribute to diabetes (Gounder, 2020; Hendriks et al., 2015). Consumption of tobacco and alcohol has also been linked to the development of NCDs. However, other factors, such as stress, also play a causal role in this type of illness (Budreviciute et al., 2020). More younger people live with diabetes (Ogle et al., 2016; V. Qio, personal communication, September 15, 2018), a worrying statistic that is rising and burdens the Fijian health-care system in many ways.

Healthcare for Patients Living with Diabetes

Drawing from my personal knowledge of the health-care system, I know that patients who may have diabetes tend to arrive at the outpatient department for further consultation if they are informed of a high reading after a Capillary Blood Glucose (CBG) test, which could be from a community outreach clinic or from triage due to visitation for other ailments. Following this, patients have treatment for their current health condition and are advised on lifestyle changes to assist with their new diagnosis. Often, they are called for follow-up and provided treatment accordingly. Routinely, shift clinics and community outreach programmes test CBG and refer patients with higher readings for further tests and management. Upon diagnosis confirmation, patients are expected to receive lifestyle advice on diet modifications, exercise, follow-up clinics, life adjustments to eliminate stressors, and foot care.

Patients who have received a hospital admission are usually referred to their nearest health-care facility for follow-up care. These follow-ups usually include wound dressings (if any), dietary advice and monitoring, nursing and medical consults, review of medications, and general patient care. Patients with stable readings receive a three-monthly clinic date for follow-up care. The follow-up typically includes blood glucose and blood pressure (BP) measurements, and general health status checks, especially if they have a wound. In cases where a dietician is available, patients may receive dietary advice. Patients needing foot care[6] receive referrals to the "foot care" nurse for further assessment, advice, and treatment (Hjorth et al., 2012).

Some patients travel to relatives who live closer to the divisional hospitals to consult directly from the "bigger" doctors. *Valenibula levu* means "bigger hospital"; this is where everything is assumed to be "big", services are faster, the staff is more competent, and there is more diverse support for people needing health-care services. However, depending on the wound status, most patients who utilise this opportunity still receive amputations. Patients with diabetes-related wounds require robust and aseptic wound care; therefore, nurses provide care from individual care plans. Typically, patients need assistance during hospital admissions and close monitoring upon their discharge. In between, nurses attend to patients' various needs, including admission cares, medication administration, observations, wound dressings, and surgery preparation, to name a few.

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[6] Foot care – care of the foot, a task taken up by nurses in the absence of podiatrists

Nursing in Fiji

The Fiji Nursing Council governs nursing care delivery at public and private hospitals. In Fiji, nursing services are offered according to the two main divisions of health care - the preventative and curative divisions - with different nursing positions existing within each medical area. Nursing in Fiji is directly controlled by the Ministry of Health and principally funded by the government (Usher et al., 2004). Nurses in Fiji are the largest group of health care professionals who play critical roles in determining health outcomes of individuals, families, and communities (MOH, 2015).

To practice in Fiji, nurses must be registered and have a valid annual licensing certificate from the Fiji Nursing Council (FNC). Currently, three institutions offer nursing education in Fiji. Part of the nursing curriculum offered to trainee nurses is the chronic care model (CCM) for people living with chronic conditions. The care model can be used as a guide for improving the quality of chronic disease management (Reynolds et al., 2018). Trainee nurses must accomplish certain competencies and present case studies of their clinical work placements in the community as part of their primary health care rotation. The high demand for nursing exists at every health-care service level in Fiji (MOH, 2016). In 2017, the ratio of nurses was 31.7 per 10,000 population. The Ministry of Health plans to increase the ratio to 40 nurses per 10,000 population (Waqa-Ledua, 2016), which is argued to be a much-improved rate (Wiseman et al., 2017).

A standard part of the community nurse's practice is to support people with diabetes mellitus in different stages of their disease in various settings. Patients often have different needs, which involve being educated and informed of their condition, whether they are newly diagnosed, established, or with complications of their diseases (Burden, 2017). In Fiji, nursing stations and health centres in rural and urban communities are typically operated by nurses and Nurse Practitioners, who are the first contact for health-care needs (Vudiniabola, 2011). As gatekeepers of higher-level care, nurses are responsible for referring patients to district hospitals and major hospitals as needed. In this way, they play a vital role in maintaining population health (Vudiniabola, 2011). Nurses use the PEN package to treat patients living with

NCDs. As mentioned in Chapter 2, some nurses in Fiji have received training in foot care and manage foot clinics in health centres and hospitals. These nurses have positively impacted the management of a diabetic foot (M. Leong, personal communication, January 6, 2020).

Nursing in the Community

As noted earlier in Chapter 2, there is a lack of literature on nursing care in Fiji; thus, the following description depends heavily on my extensive personal experience. In Fiji, nurses can identify and diagnose patients with diabetes through community shift clinics[7], as outpatients to any healthcare facility, or during hospital admission. One of the community zone nurse's critical roles is to follow up patients who do not attend their clinics (MOH, 2012). While the attention has been mainly on MCH defaulters, community zone nurses also follow up their default diabetes cases in their homes, usually when they have missed several follow-up clinics. During such visits, patients receive tests for blood glucose and blood pressure, and advice regarding their health statuses. Such visits allow nurses to understand the patient in their environment better and treat them holistically.

The nurses can also identify reasons for patients defaulting on clinic appointments. On most occasions, patients who have had an amputation face difficulty getting to the clinic. During the home visit, nurses can assist by utilising their network to offer an interdepartmental approach to helping patients who have difficulties travelling to the clinic. The public health zone nurses have specific zone allocations and are responsible for reporting activities, such as births and deaths, as well as providing a report of new cases of diabetes. The Ministry of Health uses this data to produce its annual report, determining the budget allocation for the next government fiscal year.

There is no registered nursing agency in Fiji to assist the Ministry of Health in its human resourcing needs (Usher et al., 2004). Currently, the Ministry of Health seeks assistance from retired nurses who are available to assist local and other PICTs, particularly in midwifery care provision. In the event of a public health crisis, the

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[7] Community shift clinics – health-care services that are provided at the community, hence the term 'shift'.

community zone nurse’s fundamental role is halted by attending to other health-care emergencies like an outbreak of disease. In such cases, the nurses are directed to care for emerging diseases, thus hindering patients' care and interrupting awareness programmes for people living with diabetes.

Nursing Care for People with Diabetes at the Subdivisional Hospital Level

The nature of nursing work at the subdivisional hospitals depends on the classified level under which the hospital operates, determining the type of patients they can accommodate. Typically, there are two options available to patients - either they continue with treatment at the subdivisional level or receive further medical management at the divisional hospital. Patients needing specialised and expert care are either referred to the divisional hospital or await the divisional hospital's specialist team to review them.

Patients with diabetes who require admission to subdivisional hospitals typically receive nonsurgical interventions. However, their admission status depends on the infection rate and wound status; patients who develop poor wound prognosis receive surgical interventions at the divisional hospital and are discharged to the subdivisional hospitals to free up beds. Patients with improved wound status remain at the subdivisional hospital and receive nonsurgical interventions, including wound dressings, antibiotics, and laboratory and radiography tests.

Nurses at the subdivisional hospitals in Fiji play a crucial role in working with patients who live with diabetes and associated conditions. One of the nurse’s roles is advocating for their patients by communicating and acting on requests and communicating needs regarding nursing care plans to other healthcare professionals like the surgeons. The role of nurses expands further if the patient has a wound and requires wound management. Nurses monitor and attend to wound dressings and routine wound swabbing, administer medications, and advise patients and their families on home care. The position also includes coordinating patients’ activities of daily living and implementing care plans. The effective facilitation of nurses’ roles will lead to a trusting relationship between them and the patients.

Nursing Care for People with Diabetes at the Divisional Hospital Level

Nursing care at the divisional hospital level is provided in specialised nursing units and wards. In Fiji, there is a need to revamp specialised nursing care training (MOH, 2015). Nursing care delivered in these special units differs according to the unit specification of care. For example, in ICU[8], a patient with diabetic ketoacidosis [DKA] (a serious complication of diabetes) will need one-to-one care. In contrast, a day zero below-knee amputation patient will receive nursing care on a 1 to 8 ratio in the Acute Surgical Ward. The same patient on day five postoperatively is likely to be transferred to a step-down surgical ward, receiving a 1 to 12 level of care or being discharged to a subdivisional hospital for continuity of care.

Most nurses working at the divisional hospital do not have a specialised postbasic nursing practice qualification. Therefore, they deliver care to people living with diabetes depending on the knowledge gained from their undergraduate training, CPD[9] sessions, or nursing experiences. The nurse's role is similar to that performed by nurses at the subdivisional level, but it is intensive and includes preoperative, intra-operative, and postoperative care. Nursing care at the divisional wards and units requires a rigorous approach to managing patients' conditions, and patients with surgical wounds require more thorough dressing techniques. Nurses must at all times remain vigilant for bleeds, checking wound drains, monitoring input and output, reinforcing dressings in the case of postoperative bleeding, and monitoring patients' vitals. Most patients who receive amputations have phantom limb pains, and nurses spend a substantial amount of time providing reassurance and administering pain relief.

Nursing Care for People with Diabetes at Private Hospitals

Nursing care in private hospitals is delivered at every level of service from general outpatient care and special outpatient services to specific wards and units within the hospital. The care delivery is similar to that at the divisional hospital level of nursing care.

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[8] ICU – Intensive Care Unit

[9] CPD – Continuous Professional Development

Chapter Conclusion

Fiji is at the centre of the Pacific and is home to less than one million people; by world standards, it sits as one of the upper-middle-income countries (World Bank, 2020). However, there is an unequal distribution of Fiji's national income, which affects people's lives and challenges economically disadvantaged people in their efforts to live healthily. In terms of global comparison, Fiji has one of the highest diabetes-related mortality rates. The health-care system, which operates as a two-tier system, either privately, or publicly, struggles to meet health-care needs. Nurses are part of a team of health-care professionals who care for people living with diabetes and are practising at different care levels and within different settings. Community nurses focus on primary care interventions and support while nurses care for people admitted to hospital care for their disease complications at the curative level (MOH, 2015). This research focuses on exploring the patients' and nurses' experiences in receiving and delivering nursing care in the aforementioned context. As such, the patients and nurses described the type of care they hoped to receive or deliver within their context of health care. As a critical contextual issue for nursing care in Fiji, the next chapter examines the sociocultural ways of knowing and dealing with sickness for the *iTaukei*.

Chapter Four: *iTaukei* Ways of Knowing and Dealing with Sickness

"*Which sick person would refuse healing? Ensure that you are not told 'you brought sickness upon yourself'—being unable to purchase the expensive Western medicine is not a good excuse, for there are equivalent substitutes in our traditional medicine. For now, you will no longer say that you are not aware of its existence and preparatory methods, as they are all explained in this book."* (Translated from the Na Wai VakaViti [Department of Language and Culture, Ministry of iTaukei Affairs, Fiji], 2016).

Chapter Four describes the sociocultural mores of *iTaukei* people that affect their way of life. Such influences are significant in the way that they have become embedded habits as to how *iTaukei* perceive health and live healthily within their communities. Correspondingly, and as mentioned in the above quote, the *iTaukei* people have means of illness management through their ways of knowing that is equivalent to Western medicine. Within these epistemologies, the *iTaukei* person is informed about and orientated to their sociocultural ways of healing, which affects their uses of Western medicine. These ways have affected efforts by the Ministry of Health to address the problem and burden of NCDs in Fiji (Orcherton, 2017).

To explore the *iTaukei* sociocultural ways of knowing and dealing with illness, this chapter provides a general overview of how relationship, which is a significant cultural value for *iTaukei,* are conceived. Establishing good connections and relationships are valuable tools for effective therapeutic care among *iTaukei* (Husband, 2021). Alongside such connectedness is language use, which is also a sociocultural element in a patient's care. Also, the chapter includes *iTaukei* health worldviews that focus on how their definition and understanding of health is grounded. *iTaukei* worldviews have perceptions of ill-health and its effects on how a medical diagnosis is socially constructed. The *iTaukei* health worldview also includes other constructs of illness, like the role of genealogy, in determining healer or sufferer statuses and healing practices, like traditional apologies, massages, and herbal therapies (Orcherton, 2017).

Spirituality has been an important component of how *iTaukei* relate sickness and wellness. This chapter highlights the influences of spirituality in both its old and new forms to the *iTaukei* health worldview. Last, the chapter highlights the *iTaukei* social health system, which connects back to how people introduce themselves and form relationships. Such connections align with how nurses connect to their patients that, in turn, affect their role in caring for people living with NCDs or, specifically, diabetes and its associated conditions. These relationships embody the twenty distinctive caring values unique to *iTaukei* culture that are fundamental to providing supportive care for relatives affected by health issues.

The *iTaukei* Way of Life

An *iTaukei* is a person indigenous to Fiji and is considered to be the traditional owner of the land (Arno, 1993). *iTaukei* people are registered in the *ivola ni kawa bula* (VKB)[10], recording all persons generally to the paternal clan, although some people do register according to their maternal links. *iTaukei* people in Fiji identify themselves and their connections to the *vanua* differently, relating to country, land, and social issues (Tuwere, 2002). Such connections affect the way they live and relate to one another. The *iTaukei* people have a distinct and comprehensive way of life, which uniquely influences their health beliefs and practices.

Vanua means land, forests, seas, rivers, mountains, and its inhabitants (Nabobo-Baba, 2006b; Nainoca, 2011; Ravuvu, 1983). As such, the definition of *vanua* implies that it also refers to the people living on the land. Further to this definition, the *vanua* also identify the relationship that people - herein *iTaukei* - have with the physical environment mentioned above and other *vanua*. This means that *iTaukei,* as people

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[10] *ivola ni kawa bula* – a registry for all indigenous persons in Fiji

or inhabitants of the *vanua,* are important components of the *vanua*. As with other indigenous peoples worldwide, this relationship makes *iTaukei* identify themselves differently from other groups of people living in Fiji (Bia, 2020). Each *vanua* has its totem that is an identity for an *iTaukei* person and connects them to other *vanua* (Becker, 1995). Totems, which are of plant or animal form, are believed to have spiritual significance to the owner - the indigenous person in Fiji - who adopts it as an emblem (Orcherton, 2017). For example, my plant totem is the *Dravo* (*Eulalia japonica – Gramineae*); therefore, I am identified as *Lo Dravo.* Instances when a Dravo is seen to have been severed from its main plant in my presence, is considered an offence. On most occasions, I rightfully can demand an apology from the person responsible.

In relating to the quote at the beginning of this chapter, *iTaukei* rely on the *vanua* to live in a harmonious and healthy manner through their relationship with the environment and other people. The establishment of such a relationship affects the *iTaukei* way of life and is seen in their uses of natural resources that can be used as different therapies (Jain, 2015). Such therapies range from herbal medicines, observances of *tabu*[11], and massages, to name a few, which are referenced in this thesis as ethnomedicine. For example, in 1985, more than 200 plants with medicinal properties have been extensively used in villages (Orcherton, 2017).

Typically, *iTaukei* identify themselves to the *vanua* they affiliate with through one of the three *matanitu*[12], *Kubuna*[13], *Burebasaga*[14], or *Tovata*[15] (Veitayaki, 2002). In accordance with their adherence to the *iTaukei* cultural protocols, visitors to the *vanua* must present the *isevusevu*[16] to request entry (U. Nabobo-Baba, personal communication, September 9, 2018). Bounded by the concept of belongingness that

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[11] *Tabu* – taboo, which relates to being prohibited from, either a thing or person

[12] *Matanitu* – confederacies, including several *yasana* (provinces; see more on page 43)

[13] *Kubuna* – people from the provinces of Tailevu, Naitasiri, Lomaiviti, and parts of the western provinces of Ba and Ra

[14] *Burebasaga* – people from the western and southern parts of Viti Levu, belonging to the provinces of Rewa, Nadroga, Serua, Kadavu off the coast of Suva, and parts of Ba and Namosi.

[15] *Tovata* – people from the north east of Fiji, belonging to the provinces of Bua, Macuata, and Cakaudrove on the northern island Vanua Levu as well as the Lau Islands

[16] *Isevusevu* – the formal announcement of arrival and purpose of a visit in an *iTaukei* village or community

affects how they relate to one another, *iTaukei* people introduce themselves according to their *matanitu.* The same applies to *iTaukei* patients and health-care professionals during the initial consultations. The confederacy then becomes an identity that affects their relationships, and *iTaukei* have never perceived their country like any other due to the specifics of their introduction (Tuwere, 2002). This means that *iTaukei* people are related due to their commonness within a *matanitu*. *Matanitu* have paramount chiefs who have approved social insignia, meaning they act and stand for the *vanua*, and their existence is acknowledged through oral ritualised speeches even when they are not physically present (Ravuvu, 1988; Tomlinson, 2006). Such ritualistic addresses are also used to introduce and announce visitors' purposes to *iTaukei* communities and villages, including visits by health-care teams.

Several *yasana*[17] (province) make up a *matanitu*. Fourteen *yasana* form the distinctiveness of an *iTaukei* community in Fiji. Each *yasana* has its own administrative division, governed by a provincial council and headed by a *Roko Tui*[18] (executive head). The *yasana* has subunits called the *tikina*[19] (districts), composed of several *koro*[20] (villages). There are 195 *tikina* and 1,171 registered *koro* in Fiji (I. Loloma, personal communication, March 9, 2021). The most basic administrative unit in *iTaukei* communities is the *koro*. Each *koro* is administrated by a *turaga ni koro*[21] (village headman), who is usually elected by the village elders and endorsed by the village chief. Village visits, including those for research purposes, must engage the *turaga ni koro,* who is the key person to meet before approaching the chief for their approval to conduct any business within the *vanua*. In addition, each *koro* has a *nasi ni koro* (village health worker), who must be present during each health-related village visit. Each *yasana, tikina,* and *koro*, has a presiding hierarchy of chiefs who have their *icavuti* (title). Within the administrative unit are social groups of the *tokatoka* (extended families), *mataqali* (clan and landowning unit), *yavusa* (tribe), and *vanua* (land), which signify that the *iTaukei* community is very stratified (Ravuvu, 1983; Veitayaki, 2002).

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[17] *Yasana* – province

[18] *Roko Tui* – executive officer of the *yasana*

[19] *Tikina* – districts formed by several villages

[20] *Koro* – villages

[21] *Turaga ni koro* – village headman responsible for supervising all activities in a *koro*

Connectedness Between the **iTaukei**

iTaukei people identify with each other through their interconnecting provincial tribal relationships. A more formal connection is established during intermarriages when two *vanua* form tribal ties, hoping that they will continue to support each other through their newly strengthened relationship (Arno, 1993; Ravuvu, 1983). Through marriage, *iTaukei* women become the interconnecting tie between the two *vanua.* The relationship becomes more potent when they bear children, providing stronger kinship ties to her side of the family - known as the *vasu*[22]—and their husband's side (*taukei*[23]). It is normally mentioned that without the women's *vanua*, the men's *vanua* is barren (Ravuvu, 1983). Such relationships ground the *iTaukei* worldview that existed on three interrelated dimensions: *Lagi* (heaven), *vuravura* (physical world), and *Bulu* (the underworld) (Vudiniabola, 2011).

The love for another (*veilomani*) has been the fundamental teaching that supports *iTaukei* cultural values that are presented later in this chapter. These values are important components of the *iTaukei* way of life that enhances good relationships within all *iTaukei* communities. This implies that relationships are strengthened through traditional connections that affect emotional wellbeing (Ravuvu, 1987). During significant social events, the connectedness of tribal associations is present to bless and strengthen relationships. Such relationships extend to people in the community, expanding to other tribal linkages when a *vanua* hosts a function—whether it be a celebration or mourning (Ravuvu, 1983). The *iTaukei* belief system is deeply rooted in the *mana*[24] of their physical presence during significant *vanua* events (Marsh, 2007). There is not much focus on the quantity and quality of gifts people bring to the hosting *vanua*; however, each visiting *vanua* will get the best they can. Disturbances to such relationships tarnish harmony in the community.

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[22] *Vasu* – relations of a woman accorded as descendants of a female member of the tribe/clan

[23] *Taukei* – dominant owner of something; for the *iTaukei*; it is always referred to as the landowners

[24] *Mana* – blessings, of a supernatural source, something powerful, miracle or omen

Obligations to the *vanua* are not as mandatory as in the past; however, attendances and contributions to any functions are still profoundly valued. Physical distance affects relationships in that participation in social activities is missed by community members who live far away. In instances when people are physically distant from each other, their relatedness remains important (Mila, 2017). *iTaukei* who are away from Fiji are excused from traditional obligations even though most still contribute significantly to family and community events. To make up for missed participation in family or community functions, the conduct of a *boka*[25] on arrival in Fiji looks to amend their absence (Kuridrani, 2014; Meo-Sewabu, 2015). In this way, the *boka* as compensation of absence is considered necessary to align and make peace with others (Kuridrani, 2014; Meo-Sewabu, 2015). Such practices imply that physical distance affects relationship spaces within the *iTaukei*, making the reunion a celebrated event with traditional ceremonies to physically welcome relatives.

An *iTaukei* person's connection to a new *vanua* is also identified when introducing oneself to another. Likewise, the *icavuti*[26] connects their tribal (*vanua*) affiliations to other tribes. Typically, it is custom for *iTaukei* to use their *icavuti* while being introduced to a new *vanua*. Similarly, health-care professionals who arrive at a new *vanua* for their job posting must also introduce themselves and, while doing so, must announce narrations of their *icavuti*. For *iTaukei* people, this is a way in which they identify their traditional relationships with each other. Nonindigenous professionals usually use the government Ministry and their role as their *icavuti* to introduce themselves. Such means of introduction identify people's connections and respect for health-care professionals. The *iTaukei* custom of respect for health-care professionals is witnessed as an act of *veidokai*[27], *veikakamenemenei*[28], and *veivakaturagataki*[29]. In instances when professionals receive job postings to a *vanua*, they are ranked as members of the chiefly family and *mataqali* (clan). Rank in an *iTaukei* society is a

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[25] *Boka* or *cokonaki* – presentation of goods to compensate for absence from the community

[26] *Icavuti* – title accorded to the chief; also a reference to their people, an identifier of the *iTaukei*

[27] *Veidokai* – respect

[28] *Veivakamenemenei* – offering special treatment

[29] *Veivakaturagataki* – diplomatic and careful display of respectful behaviour

birthright; however, it can also be afforded to people due to status as a health professional.

The belief and value system of the *iTaukei* define who they are through their *itovo vakavanua* (conduct that is expected of those who belong to the *vanua*). *Na veiwekani* (relationships) are established between individuals, and within and between groups (Ravuvu, 1988). These relationships are affirmed and cemented through the values of sharing and caring, togetherness, and respect for authority. The observance of the *iTaukei* belief and value system makes *veiwekani* an important component of nursing care in Fiji.

iTaukei nurses and patients introduce and identify themselves according to their existing tribal connections. Such connections establish respectful, profoundly rooted, and trustful relationships (Ravuvu, 1983). For example, according to the existing connections, an *iTaukei* nurse or any health-care professional is already connected to any other *iTaukei* person, regardless of their status or social standing. Such relationship carries much weight and value in an *iTaukei* community. In knowing their traditional connections with health-care professionals, community members develop *veivakadeitaki* (trust in the relationship space) in knowing that their health-care needs will be protected. In this way, health-care professionals are respected not only for their knowledge and contributions to improving community health and wellbeing in Fiji but due to their existing tribal connections.

The* Vanua *has "Eyes and Teeth"

Given the connectedness that exists among *iTaukei*, relationships have been essential determinants of health. As explained on the *iTauke*i way of life, this relationship is seen in how people relate to the people and environment (Nabobo-Baba, 2006a). Disturbances to the *vanua* appear as a violation of its social norms and can be in several forms. Some common forms of wrongdoing in the *vanua* are disturbances of divine forces, not upholding customary observances, breaking the *tabu*, or as consequences of strained or fractured relationships within a family or community (Kuridrani, 2014; Meo-Sewabu, 2016; Tomlinson, 2006). Also, failure to fulfil social obligations, wearing inappropriate or inadequate clothing (especially by women), making many noises in the village or forest, wearing a hat or any head covering in the village, and not presenting the *isevusevu* are some examples of breaking the customs and have also been linked with illness, or death (Nabobo-Baba, 2006b; Orcherton, 2017; Ravuvu, 1983; Spriggs & Scarr, 2014; Vudiniabola, 2011). These common belief systems that illness results from such instabilities allow *iTaukei* to relate to the *vanua* as one with “eyes and teeth”.

Among *iTaukei*, the traditional culture that guides people’s way of life was the law (Tuwere, 2002). In instances of disruptions to the *vanua* and its relationships, the presentations of *yaqona*[30] and *tabua*[31] typically resolve them; hence, these items are known as the “policeman” and “mediator” for such differences (Arno, 1993; Kuridrani, 2014; Orcherton, 2017; Ryle, 2016). At times, people are not aware of protocols, and, in the event of sickness, they usually relate to possible causes of their illness (Meo-Sewabu, 2015). When people realise that they have wronged the *vanua*, seeking forgiveness from the head of the *vanua* is requested to improve their relationship and health (Orcherton, 2017). Some have used the spiritual undertone of *veivui yava* (washing of feet), where there is a deep sense of remorse and exchange of forgiveness from both parties involved (U. Nabobo-Baba, personal communication, September 9, 2018).

Ways of Knowing and Learning for the iTaukei

Similar to most indigenous cultures, *iTaukei* have unique ways of knowing about customs and traditions, which map out protocols for their ways of life (Ragland, 2016.). Such protocols include their ways of knowing and informs their relations and connections to other people. It also includes how they traditionally connect to their *vanua* through which traditional practices and values are learned. Inclusive of such

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[30] *Yaqona – Piper mythesticum*

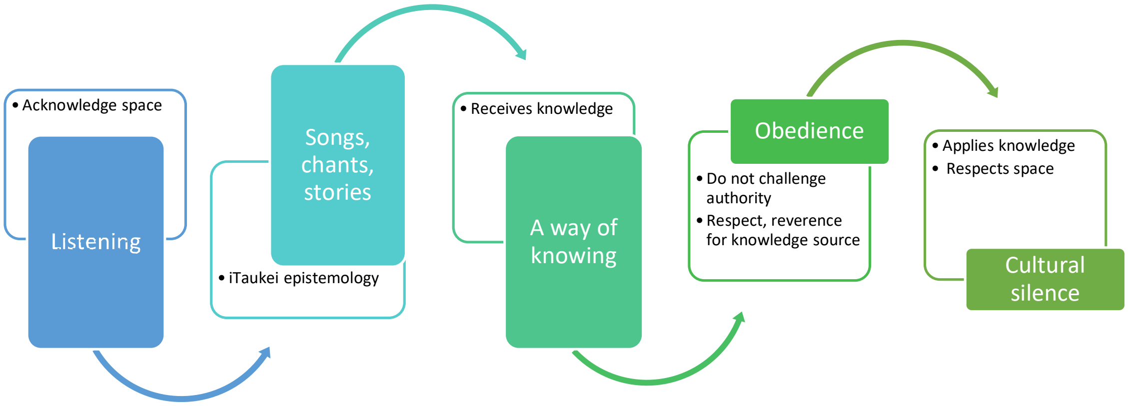
[31] *Tabua* – a whale’s tooth, a most valuable *iTaukei* traditional artefact used for formal ceremonial purposes

practices are conflict resolution and ethnomedicine, which are sourced from the *vanua*. One example is how people have discovered new healing waters, practices, and medicines (Ragland, 2016.). Traditional health-care systems rely on medicinal plants, and the *iTaukei* cultural history of traditional medicines, as shown in the quote at the beginning of the chapter, are sourced from Fiji's rainforest ecosystems (Shah & Bhat, 2019). In Fiji, some communities have government support in providing access to places that have healing water from a river (Lutu et al., 2017). It is common to have people from overseas and nonindigenous people seek such treatment. Such practices connect the people back to their *vanua*.

Most of the *iTaukei* history and way of life appear in stories, chants, and songs, so for people to know, they must listen to what is relayed by the people who know. As illustrated in Figure 4, an *iTaukei* person acknowledges their space by remaining quiet, and it is a space where most younger people are situated (Nabobo-Baba, 2006b). For *iTaukei*, ways of knowing are through listening to sources of information, which is often relayed by an older person who is the source of information because of what they know. Typically, a young *iTaukei* respects the source of information for their wealth of knowledge and responsibility to transmit such information. Therefore, this information is not usually challenged by the younger listener even though some questions may be raised (Nation, 2017). In this regard, the listener, who has become more knowledgeable, becomes responsible and obedient to the information they received, forming trustful and respectful relationships with others.

Figure 4

The iTaukei Oral Tradition



Ways of Knowing Health Information

In Fiji, as in other Pacific islands, the oral tradition is an effective means through which the younger generation observes and acquires life learnings and essential cultural information and values (Ravuvu, 1983). The distinctive *iTaukei* ways of knowing also include *iTaukei* worldviews on health (Meo-Sewabu, 2016). In a health-care setting, the *iTaukei* way of learning through their oral tradition influences how patients receive health information, which emphasises the need for health-care professionals to be orientated to people's ways of knowing and communicating what they know or need to know.

The *iTaukei* oral tradition and system of communication affects relationships with health-care professionals. As shown in Figure 4, the *iTaukei* oral tradition and ways of knowing follow a top-down and hierarchical descending order where people of authority must speak. Yet, at the same time, subordinates listen and become silent (Nabobo-Baba, 2006a). Such practices imply that the tradition among the *iTaukei* can pose a dilemma to open communication between patients and health-care professionals.

To explain further, *iTaukei,* on one level, are aware of ethnomedicinal practices from their ways of knowing through the *vanua*. However, during illness events, patients also accept information from health-care professionals. Health professionals must respect that people already have their traditional disease management practices (Orcherton, 2017). Due to cultural values of reverence for the health-care professionals, *iTaukei,* as a receiver of medical knowledge, are silenced. Therefore, it is unlikely that an *iTaukei* patient would defy medical professionals' opinions and decisions about their treatment even though what they know may seem like a better alternative. However, it is also likely that *iTaukei* patients then do not apply new health-care information from professionals. Indeed, such customs can challenge health-care professionals. Thus, what occurs is a real conundrum for both the patient and health professional.

Language as a Sociocultural Element in Patient Care

Language is an important cultural indicator for indigenous people due to variations in dialects that appear among different groups of people, linking them to separate settings (Chilisa, 2020). Such variations are determined by relationships (Havea et al., 2020). In Fiji, English is the medium of instruction in the education system and parliament. Thus, all documents and speeches presented in parliament must be in English, as noted in standing order Chapter 3, 28 and 29, which was adopted on December 1, 2014 (Fiji Government, 2014). Regardless, *iTaukei* people use their traditional language while conversing for it is part of their identity. The prohibition of the indigenous language in such facilities is argued to be a backlash to indigenous researchers' attempts to revive indigenous knowledge and research methodologies (Chilisa, 2020). The concepts of tradition, genuineness, orality, and the proclamation of indigenous identity are also vital components of the educational declaration of indigenous knowledge (Dei, 2000). However, embargoes, such as the prohibition of indigenous language in academic and governmental institutions as seen in Fiji, complicate international efforts to promote indigeneity and are in breach of the United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007).

In Fiji, each *vanua* has distinctive dialects and subdialects. Despite this, some informal similarities enable people to understand other dialects. The standard Fijian - *vosa vaka Bau* - is used when people do not speak or understand *iTaukei* provincial dialects, despite the fact it is almost a different language from villagers' dialects (Ryle, 2016). Therefore, its understanding affects communication. On some occasions, health-care professionals must communicate with people who do not speak the common *iTaukei* language, thus creating a barrier to effective communication of health information. This places extra demands on health-care professionals to be orientated to the language of knowing, which is commonly used by people in their community (Dahlke & Hunter, 2020; Lundin et al., 2018).

Silence is Language and an *iTaukei* Cultural Value

As shown in Figure 4, silence is a learned *iTaukei* cultural value and way of the *vanua* that relates to the concept of space (physical, sociocultural, spiritual, and abstract) by not questioning authority (Nabobo-Baba, 2013). *Vakanomodi* (being silent) is an act of being *vakaturaga* (chiefly behaviour) for *iTaukei* and is also a way of knowing. However, the *iTaukei* person can be silent if they are not treated appropriately (U. Nabobo-Baba, personal communication, September 9, 2018). From my personal experiences as a nurse, I, too, have faced the “culture of silence” when dealing with *iTaukei* patients in Fiji's health-care setting. Indigenous professionals must ensure they do not silence their people (Nabobo-Baba, 2004).

Among *iTaukei* people, there are three distinctive types of talk: people could say anything to one another, joke with another, or not speak (Arno, 1993). The ability to speak or not is determined by the relationship people share, varying between provinces. For example, the younger sister-in-law cannot talk to the older brother-in-law in some regions and must always avoid being alone or having any eye contact. Such practices observe the requirements of the *vanua* and are exercised to respect the relationship that exists between them. In another example, *iTaukei* people hold deep reverence towards their mothers’ male relations (brothers, cousins, or distantly related) and, more significantly, for the elderly. Such social relationships are established once the *iTaukei* person identifies their tribal connections with others. Such relations can be beneficial or a barrier to effective care delivery in a patient–health-care professional relationship.

iTaukei Health Worldview

In 1948, the WHO defined health as the complete state of physical, mental, and social well-being and not merely the absence of diseases or infirmity (Huber et al., 2011). In the *iTaukei* context, health *(bula)* is related to life and is also used as a greeting. Therefore, health in the *iTaukei* context has positive connotations associated with being in a state of wellness. However, because *iTaukei* have deep connections to their *vanua* (Ravuvu, 1983,1988; Tukana, 2013), they have a different explanatory framework related to health. The *iTaukei* also have a holistic connectedness of the mind, spirit, ancestral knowledge, and environment associated with the physical body (Meo-Sewabu, 2016; Orcherton, 2017). Therefore, as explained, *iTaukei* relate physical health or ill-health to the *vanua*. For example, *iTaukei* identify NCDs as Western diseases, for they have their own disease labels with remedies to resolve them (Orcherton, 2017).

Causes of Ill-health

Reasons to explain ill-health in ordinary *iTaukei* thoughts and belief patterns often link to spiritual or supernatural causes of death or illness, even with the presence of Western medicine (Meo-Sewabu, 2016; Newland, 2004; Tukana, 2013). The early Christian missionaries instigated this thinking in the 1800s when one of the critical cornerstones of their teachings was that people who lived in darkness were prone to premature deaths so that people would repent from their sins (Ravuvu, 1988).

According to the *iTaukei* belief system, illness has a social-cultural underpinning that attaches it to the causes (Orcherton, 2017). An *iTaukei* person's ability to execute specific social roles and responsibilities that are significant to the *vanua* (land) and God (spiritual) is linked to their health status (Meo-Sewabu, 2016). Failure to fulfil social roles is pinned with ill-health or "being sick" (Nabobo-Baba, 2006; Orcherton, 2017; Ravuvu, 1983; Vudiniabola, 2011). Hence, the *iTaukei* cultural definition of health has an essential social attachment, influencing how men (and women) perceive and practice being in good health.

As mentioned above on the *iTaukei* way of life, *iTaukei* health and illness concepts are closely related to harmonious relations in their communities. For example, in food taboos, some *iTaukei* communities observe strict consumption of some traditional foods. This relationship is known as *veibatiki,* where one group is *bati* (warrior) to the other (Nainoca, 2011). A member from a group may not eat a certain kind of food, which is *tabu* (taboo) in the other group's presence (Ravuvu, 1983), especially if they are *bati* to each other. Moreover, in some instances, people who could not be treated in hospitals were cured by indigenous healers (Veitayaki, 2002), involving herbal therapies. As illustrated in the quote at the beginning of the chapter, not taking *wainimate* (herbal medicines) is also said to be the cause of illnesses and associated complications.

An *iTaukei* Person Requiring Nursing Care

Personal experiences attest that nurses caring for people who have unique traditional relations with other patients admitted in the same hospital unit have particular tasks of knowing such relations and providing culturally appropriate care plans. Given the point made above about certain people not being able to eat certain foods in front of another, it requires cultural competence among nurses to change care plans to align with patients' needs. Such changes include discussing appropriate dietary needs and changes with patients and the dieticians. Thus, nurses need to be aware of relationships that determine *iTaukei* values and beliefs so as to not break cultural protocols. As mentioned on the *iTaukei* way of life, failures to observe such customs are argued to have resulted in negative consequences, including deaths, which tend to be blamed on breaking cultural protocol (Phillips, 2020; Tomlinson & Bigitibau, 2016). To deliver holistic nursing care in Fiji, nurses must be culturally competent (Vudiniabola, 2011).

Diagnosis is Socially Constructed

It is common to hear during conversations of ill-health that some *iTauke*i would openly declare: *qori na mate ni neitou kawa* (it is our generation's disease). Such declarations would mean they accept the diagnosis. Nevertheless, there also exists the denial of disease inheritance by others because such diseases may not belong to their generations. Also, there is mention of therapies known to alleviate suffering in casual conversations about health, making illness a short-term experience that can be healed. However, such treatments associate with certain taboos, which the person needing assistance must adhere to. Breaking the custom can result in the loss of *mana* (power) of the therapy (Tomlinson & Bigitibau, 2016).

The *iTaukei* cosmology deals with understanding the spiritual connections people have with others to seek assistance for their illnesses. As noted above in the *iTaukei* health worldview, illness is approached differently from an *iTaukei* perspective. It is often related to what people did or did not do and typically includes how they relate to others. The *iTaukei* person must know their place with other people, their traditional practices, and their belief system that leads to the way they view themselves and their surroundings (Spriggs & Scarr, 2014). This implies that the *iTaukei* approach diagnoses from a *vanua* perspective.

Genealogy associate as a Sufferer or Healer of diseases

Part of the *iTaukei* belief system is that curses follow the genealogical lineage: curses on older people will flow on to their younger generations, resulting in illness. Such beliefs prevent proper diagnosis and healing. People tend not to inform medical professionals about the full context of their conditions, leading them to receive the wrong care (Phillips, 2020). In other instances, they may explain a different illness perspective to the medical professional, leading to improper disease management. Such beliefs drive people away from biomedicine (Tukana, 2013). Among *iTaukei* communities, there are claims of people owning the disease (generational) and being custodians of the disease. As such, traditional healers - both men and women - are well known to their communities for their special magical gift-related abilities to persuade gods and ancestral spirits to destroy or overcome such illnesses (Veitayaki, 2002). Such acts of eradicating the condition are usually done through massages, herbal therapies, food taboos, baths, and repeat visits. Typically, the treatment lasts four nights *(bogi va)* and, to complement their treatment and healing, the healed person gives the healer gifts for their services.

A factor that contributes to ill-health amongst *iTaukei* is the long-held belief in ethnomedicine over biomedicine. People who value ethnomedicine approach biomedical advice differently, and they often present late to health-care facilities (Tukana, 2013). At most times, this results in arriving with disease complications (Kumar et al., 2014). Even with painful experiences, most *iTaukei*, unlike Fijians of Indian descent, will try other remedies before turning to biomedicine (Trnka, 2007). The extent to which such behaviours are translated into treatment-seeking from biomedical services is deeply embedded with *iTaukei* sociocultural meaning.

Healing Practices

During illness, *iTaukei* people look to manage their diseases and explore their “known ways of healing” through their connections to and with the *vanua*. These connections, which are informed by their beliefs and values through *iTaukei* ethnomedicinal practices, are established before seeking Western biomedical assistance (Tukana, 2013; Veitayaki, 2002). Thus, according to *iTaukei* perception*,* diseases have less to do with sanitation, nutrition, vector infection, waste control, or animal contact (Tukana, 2013). Healing practices have been in the forms of traditional apologies, massage, and herbal therapies, as shown in the quote at the beginning of this chapter. For this reason, the *vanua* and church have been identified as two powerful institutions that have influence over ways of life and are also means through which others can exert impact (Kuridrani, 2014). Health-care professionals use both the *vanua* and the church networks as mediums to set the foundations for healthy lifestyles through health education and healthy living community projects in Fiji.

Conduct of Traditional Apologies

The concept of *isoro*[32] and its relevance in maintaining harmony and wellness among *iTaukei* communities has interested authors like Hooper (2013), Jones (2015), Ryle (2016), and Tomilson and Bigitibau (2016). In illness events, full treatment involves correcting the supernatural causative factors by performing the *bulubulu*[33], *veisorosorovi*[34]*,* and *boka* (Kuridrani 2014; Meo-Sewabu, 2016; Tukana 2013). These three forms of traditional *iTaukei* approaches to apology are an integral part of the *iTaukei* culture and serve to correct any violation of social norms, resolve conflict, and foster healing. From an *iTaukei* perspective, death and illness are likely to continue to affect social relations until ceremonies of apologies (*isoro* and *bulubulu*) are performed and a peaceful relationship with the spirit is established (Tomilson & Bigitibau, 2016).

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[32] *Isoro* – conduct of formal apology to make peace with one another

[33] *Bulubulu* – burying of a wrongdoing through traditional presentation of goods to formally apologise

[34] *Veisorosorovi* – exchange in performance of traditional apologies between two parties

Hence, it is common for an *iTaukei* to seek explanations regarding their illness from other sources. Visits to people whom the sick person feels they may have wronged will occur before seeking medical attention. Such visits intend to properly align fractured relationships so that illness will disappear, which explains many delayed presentations to the health-care facilities. Such practices are discussed in detail later in the spirituality section of this chapter.

In illness events where one is suspected to be afflicted from such violations, immediate family members usually establish the *bulubulu* to the *vanua* in the hope of coordinating reconciliation and ensuring the restoration of fractured relationships. The process includes ritualistic speeches performed to request good relations and love (Kuridrani, 2014). The *bulubulu* is also vital in preparing death for a terminally ill family member. Shadowing the *bulubulu* is the *veisorosorovi*, an act involving the two groups in a severed relationship, and this is usually performed in the presence of a forum. In extreme cases where ties have been severed for an extended period, the presentation of goods during the *boka* make up for the lost time (Kuridrani, 2014; Meo-Sewabu, 2016).

Massage

Another form of therapy is the use of massage, which is considered a vital remedy to take care of body alignments. Pacific indigenous people have always affiliated themselves with massage treatments to take care of health and ill-health-related issues (Singh, 1986). Massage is considered an inherited, and gifted traditional practice carried out in many forms by traditional healers. Massage therapy is regarded as cultural property and can only be successfully performed by custodians of the special gift. Some custodians have successfully put broken bones together and healed burn injuries without leaving scar marks and skin thickness. For example, an All Blacks Fijian-born rugby player miraculously recovered from a broken bone after undergoing a six-day massage and herbal therapy in Fiji (World Rugby, 2015).

In Fiji, there are many forms of massage, and all are traditionally considered a necessary therapy to align the structures of the body. For example, children are given regular *bobo*[35] to prevent fever of unknown origins from unsupervised falls and mishaps that may have displaced their bones. *Yamo*[36]*,* the light and gentle rubbing on the affected area, is another type of massage. People would say: *lako ki vei … me lai yamoca na nomu bo* (go to … to rub your boil gently). Another type of massage is a touch massage, *tara*[37], which is often used for burn wounds. People would say: *lako ki vei … me lai tara na nomu kama* (go to … to touch your burn injury). In Fiji, it is not uncommon for people to look for someone who is the custodian of the gift of touching to attend to burn injuries as a first-aid treatment while waiting for medical assistance or due to affordability issues (Taoi et al., 2012). However, its success depends on factors like pretreatment, the severity of the injury, and how soon the traditional healer attends to the wound. Some successful non-life-threatening burn injuries have been attended by traditional healers (Taoi et al., 2012).

There are also foot massages called *butu*[38], where mostly masseurs use the foot to apply pressure to the affected area. On most occasions, masseurs have also used their elbows to apply pressure to alleviate pain. Some tribes are known to "kick the pain away" from the affected person's back. Such therapies, including herbal ones, are used for preventative and curative purposes. While most masseuses use hand massage, it is not uncommon for masseurs to combine using feet, elbows, and hands during massage therapy.

Herbal Therapies

The quote at the beginning of this chapter authenticates the use of herbal medicines among *iTaukei*. Conventional therapies, such as herbal medicines, have been widely used as curative and preventative strategies by people in Fiji (Singh, 1986). Herbal therapies connect the *iTaukei* person to their *vanua* by using readily available plants and ensuing treatment specific to their natural environment (Chand et al., 2018). This knowledge has been handed down family lines for generations (Veitayaki, 2002). One

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[35] *Bobo* – hand massage

[36] *Yamo* – light hand massage

[37] *Tara* – gentle press on affected area, particularly for burn injuries

[38] *Butu* – foot massage

such treatment is the *wai ni macake*[39] mixture, now commonly known to stabilise blood sugar levels (Kuridrani, 2014). Children often have regular doses of *wai ni macake* commonly used to address instances of oral thrush. *Macake*[40], which also has a strong correlation with diabetes, and its lack of consistent use is believed to cause ill-health among *iTaukei* (Kuridrani, 2014).

There are many types of herbal cures in Fiji. While people have used plant products for rejuvenating purposes, there are currently an uncontrolled number of herbal juices being sold that claim to eradicate diseases like diabetes alongside boosting overall health status (Prasad, 2019). Such promises draw people living with diabetes to purchase and consume these drinks and, in the process, disregard medical advice. Apart from herbal drinks, some herbal therapies are used as topical applications. For example, boils are covered with warm chilli leaves to remove the core. Also, septic wounds are usually filled and covered with scraped pawpaw stem to allow tissue granulation. There are also many other therapies, such as using a warm glass cup for incision and drainage on carbuncles. There is also mention of different treatment forms like dew therapy and *sili*[41] *or sili waitui* (dip in the sea) to heal wounds. It is also common for people on herbal treatment to be on certain food taboos, usually instructed by those performing massages or administering herbal therapies. However, the success of all these remedies depends on the individual's or the family's belief system as, in many instances, people will deny having the disease and justify their generational wellbeing.

Spirituality and *iTaukei* Health

Most indigenous people believe all things are permeated with spirit, which affects their epistemology (Christian, 2017). The *iTaukei* have always believed in the spirit world, whether by the older or newer system, or both. Within an *iTaukei* context, there exist

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[39] *Wai ni macake* – bitter drinks prepared to counter blood glucose levels

[40] *Macake* – generalised sickness; in children, it is oral thrush

[41] *Sili* – digital examination of a woman normally performed by a traditional midwife

two forms of spirituality—the god of the spirit world, understood as the older system (*Kalou mai bulu)* and the God in Heaven (*Kalou mai lagi*), which is understood as the newer system perceived through Christianity (Meo-Sewabu, 2015).

Despite the presence of Christianity in Fiji, the traditional system of supernatural belief still survives and influences the *iTaukei* people's lives (Ravuvu, 1983). Such beliefs have seen witchcraft and sorcery practices to have caused ill-health. These blaming impressions have resulted in some case examples where accusations have resulted in violence. One such case was that of Namoumou versus Lule, which was heard on May 17, 1993, at the High Court of Fiji (Pacific Islands Legal Information Institute, 1993). The court heard that the plaintiff was accused of practising witchcraft that caused illness to the defendants and their families. Such beliefs and practices have led to constitutional changes in Fiji. It is now illegal to accuse anyone of witchcraft or sorcery (Fiji Government, 2013c; Phillips, 2020). In sickness circumstances where witchcraft or sorcery is suspected, spiritual healing is sought. Spiritual healing is performed by specially anointed persons, such as priests, who make special prayers to free the sick person from their illness (Phillips, 2020).

The Older* iTaukei *Spiritual Health System

To do well while on earth and in the afterlife, one must follow the proper conduct of the *vanua* and respect the chiefs, who are overseers of peaceful living and decisions regarding each *mataqali* (landowning unit) (Ravuvu, 1987). During pre-Christianity times, the *iTaukei* worshipped many gods, who helped with the harvest, war, weather, illnesses, and other aspects of their lives (Naitini, 2020). Not adhering to the requirements of the *vanua* can disrupt relationships with both the earthly world and the world of the spirit beings (Ravuvu, 1987). Ravuvu (1987) further adds that such beings have the power to cause illness or make someone’s life miserable. *iTaukei* believe there is a strong interrelationship between the spirits and their human descendants (Spriggs & Scarr, 2014). Any form of disturbances or neglect of the spirits must follow the traditional presentations of the *isoro* to appease them.

Of interest is the prospect of mental illness due to wrongdoing as reported by Suaalii-Sauni et al. (2009):

> Pacific peoples generally do not consider mental illness to necessarily originate entirely from within a person. Pacific peoples often view mental disorder as ‘spiritual possession’ caused by the breach of a sacred covenant between peoples or between peoples and their gods. The traditional Pacific approach to healing is to seek the input of traditional healers believed to have the spiritual powers necessary to restore spiritual, physical, mental, and social balance. (p.19)

The spirits who play the *vanua* guardian role are believed to be on the watch for such breaches of customary codes of conduct, propriety, and behaviour. They usually appear before the offenders, causing spiritual punishment, such as sickness or, worse, death (Spriggs & Scarr, 2014). It is commonly accepted that deaths can and have occurred to people without a medical diagnosis and are consequences of a spiritual breach to the *vanua* (Meo-Sewabu, 2015; Nabobo-Baba, 2006). As noted in the *iTaukei* health worldview, where illness results from a violation of the *vanua*, apologies from the spirit gods of the *vanua* are conducted through traditional apologies.

The Newer* iTaukei *Spiritual Health System

The Christian belief system (that God in Heaven is the God of the past, present, and future) and its movements also govern the spirituality aspect of an *iTaukei* person in most communities in Fiji, although this occurs through different denominations (Naitini, 2020). With the new form of spirituality in place, spiritual health includes making links to the church and believing in God's transformative power (Kuridrani, 2014). Some *iTaukei* keep both traditional and Christian beliefs. A few *iTaukei* who have converted to other religions, such as Islam, face criticisms in their communities (International Religious Freedom Report, 2019).

Through prayers, the dominant Christian discourse has been considered a useful paradigm in determining people's choice of biomedicine (Phillips, 2020). Since its existence in Fiji, Christianity is now the new foundation of the *iTaukei* level of being. Most *iTaukei* believe in their connections to the church, the need to repent from their sins, and live a loving relationship with others, including conversion to new church movements (Kuridrani, 2014). Despite the church and its dues[42] becoming the new burden that causes stress to people's health, the *iTaukei* still try their best to fulfil them (Ravuvu, 1988). Reverence allows people to connect to their inner being and each other (Archibald & Parent, 2019). Spiritual health can be affirmed to include showing love and caring, which is essential when caring for the sick. Love and caring are considered the fundamental teaching of Christianity and the basis for a good foundation in all *iTaukei* communities (Kuridrani, 2014).

The church became a modern institution that disapproved of the traditional social framework and became part of the new control system that encouraged forgiveness (Ravuvu, 1988). This new spiritual framework influenced faith among *iTaukei* through fasting, prayers, and spiritual deliverance to assist in healing a sick person (Christian, 2017; Meo-Sewabu, 2015; Newland, 2004). Most *iTaukei* communities have sacrificed traditional cultural ornaments and artefacts due to revelations from spiritual revival campaigns and outreach programmes through Christian prayer crusades. There has been burning of such items believed to have associations with the older spiritual world of *iTaukei* (Newland, 2004). Such changes support how the *iTaukei* culture deviates from identifying what is essential now and adopts aspects of the new culture while people still believe and experience "supernatural" illnesses and deaths. Meo-Sewabu (2015) found that *iTaukei* women refer to their Christian faith to protect themselves and their families from supernatural happenings. The sick role is also determined by how *iTaukei* people describe their social reality. However, the influence of religious prayer groups and other spiritual practices is changing the way *iTaukei* describe their social existence, even though some have held on to both Christian and traditional practices (Tuwere, 2002).

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[42] Dues – also referred to as tithes or one-tenth of annual earnings, formerly taken as a tax for the support of the church and clergy.

***iTaukei* Social Health**

Most indigenous communities are attentive to relationships (Chilisa, 2020). *iTaukei* social health, as mentioned above in the section on the connectedness between *iTaukei*, denotes how connections to the *vanua* are maintained through observations of protocols and active participation. A person's worth is determined by the extent to which they carry out cultural obligations and maintain relationships (Ravuvu, 1988). The *iTaukei* people are known to have widespread social networks where each person is obligated and responsible to everyone else in an involved manner. For physical and social needs, the *iTaukei* embrace solidarity and harmony among community living (Ravuvu, 1988).

iTaukei are more concerned about their social status than their financial or economic position (Arno, 1993; Bakker, 1988; Qalo, 2011). Development areas in education, successful entrepreneurships, and representations in government or nongovernmental organisations are considered to be important as the reputation of the *vanua* to which the person belongs. The *mana* that connects people to their *vanua* is believed to enhance economic productivity in terms of wealth, which depends on their observance or nonobservance of the customarily accepted behaviours (Spriggs & Scarr, 2014; Tomlinson & Bigitibau, 2016). The exchange of goods through tribal connections and reactivated relationships of *solesolevaki* (exchange of goods) provides the essence of the *iTaukei* economy (Arno, 1993).

Reciprocity, which has social implications, is significant among *iTaukei* communities (Meo-Sewabu, 2015). Such practices are seen in how an *iTaukei* person identifies their communal responsibilities. For *iTaukei*, participation in rituals and events affects the social person's construction, and their performance affects other people's emotions (Bakker, 1988). However, contact with the outside world has brought many changes to *iTaukei* notions of reciprocity, such as the implementation of caring values (Ravuvu, 1988).

Colonialism and Gender

Colonialism has influenced the traditional way of living by displacing gender roles and ranked responsibilities within the existing *iTaukei* way of life. The colonial administrators and missionaries worked with the support of chiefs to enforce such moves (Haggis, 1990; Meo-Sewabu, 2015; Vudiniabola, 2011). One example is how the new system taught women to sew, cook, and rear children while men focused on farming (Gravelle & Sutton, 2009; Haggis, 1990). The changes birthed patriarchy, a system that placed women within the domestic sphere and inferior to men. From a male-dominated and capitalist viewpoint, women's work is not valued despite their immense contribution to *iTaukei* sociocultural wellbeing (Meo-Sewabu, 2015). Such a viewpoint is evident when men have the last say in family decisions, even though women may have made a major contribution to those decisions.

There is an increase in the number of Christian denominations among the churches in the Fijian community. From an *iTaukei* perspective, the church has always been viewed as a Western concept, brought by the *kaivalagi* (White people). Among these concepts are the family dynamics and their gender roles, responsibilities, and expected behaviours are known as *vakamarama*[43] (Meo-Sewabu, 2015). Typically, *iTaukei* women were subjected to small finger amputation in the event of their husband's death until the 1900s. In the context of health, women have many roles and responsibilities for their family members before they worry about their own health.

Patriarchal ideologies in Fiji affect women so that they still assume their domestic responsibilities at home despite suffering from chronic diseases like diabetes or any other conditions for that matter. Their chores are relieved if they have a daughter-in-law or a niece to assist them. Apart from their household responsibilities, women are also actively engaged in an extended family and village obligations. Another

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[43] *Vakamarama* – chiefly demeanour of women

influencing factor is the community responsibilities that people must align themselves with to maintain an insider position.

From the legacy of the Christian missionaries, the *iTaukei* community set-up is patriarchal and, even today, favours *iTaukei* men to be the primary providers for their families (Meo-Sewabu & Koro, 2013). An example of this is seen in the case of *iTaukei* men's ability to share remittances from sports such as rugby to elevate family profiles in their communities (Stewart-Withers et al., 2017). While men’s role as the main economic provider is changing, especially when considering women's growing presence in the formal Fijian workforce, there is still a prevailing preception that men are providers for their families. What this means for *iTaukei* men is that being sick is considered a sign of weakness and failure, especially when they cannot fulfil their responsibilities of providing for their families and satisfying financial obligations. Subsequently, when men become sick, women are pushed to engage in income-generating activities or to find paid employment so as to ensure family survival, yet this is not valued.

Within the patriarchal environment, it is common for men not to openly declare that they are sick; therefore, they often present themselves to the health-care facilities at a very late stage in their illnesses (Tukana, 2013). These ideologies further worsen the health status of a person living with diabetes as it delays the management of their disease and results in complications. Kumar et al. (2014) suggest that these risky behaviours have contributed to the higher incidence of amputations among *iTaukei* men in Fiji.

Social Responsibility to the Sick

Given the communal set-up of *iTaukei* people, in a case of illness in one of the members of the group, family members feel obligated to inform other members of a member’s ill-health. Detail surrounding illnesses are no longer held in confidence as it is standard practice for the family to help the sick. The help offered is usually as food, ethnomedicine, visitations, or companionship, hoping to bring healing (Kuridrani, 2014; Vudiniabola, 2011). Communal assistance to the sick is reflected in the *iTaukei* caring values discussed below.

Women assume the traditional roles of taking care of those who need assistance within their household, including their husbands' relatives. In circumstances where women cannot do so, family members will request other female family members' assistance. Therefore, most women relations become regular carers for the sick at some time (Meo-Sewabu, 2015). However, in some instances, some men have assumed carer roles, especially for male patients. Due to the relationship between the carer and the sick, the task is generally not regularly rewarded financially.

Food and Food Gifting

Food is an essential component of *iTaukei* culture and afforded significant value in most aspects of *iTaukei* life. Food is thus affiliated with every social function. A function without or one that has a food shortage is considered a second-rate function (Ravuvu, 1983). In Fiji, food eaten now is no longer just the traditional food produced locally but includes manufactured and imported foods. Interactions with other people and their cultures have also affected what and how people eat. The traditional two meals per day have been replaced by three meals per day, and school children and workers have a special tea and lunch breaks allocated to their schedules.

Food gifting has been part of the *iTaukei* tradition of showcasing love, responsibility, and well-wishing, hoping that food will foster recovery for the sick (Vudiniabola, 2011). In illness events, the sick person is visited through the conduct of a *veisiko.*[44] A

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[44] *Veisiko* – visitations, normally during illness

common component of the *veisiko* is food. Gifts of food can be cooked or uncooked and presented to the sick person or the family, either informally or formally, through traditional presentations. It is common among the *iTaukei* relatives of the sick person who live close by to share portions of their cooked meals with the sick person, especially if they have prepared a special delicacy. Such *veisiko* would be presented informally. However, formal ones would include uncooked food gifts, such as raw or live meat and root crop bundles.

Social Roles and Responsibility of the Sick

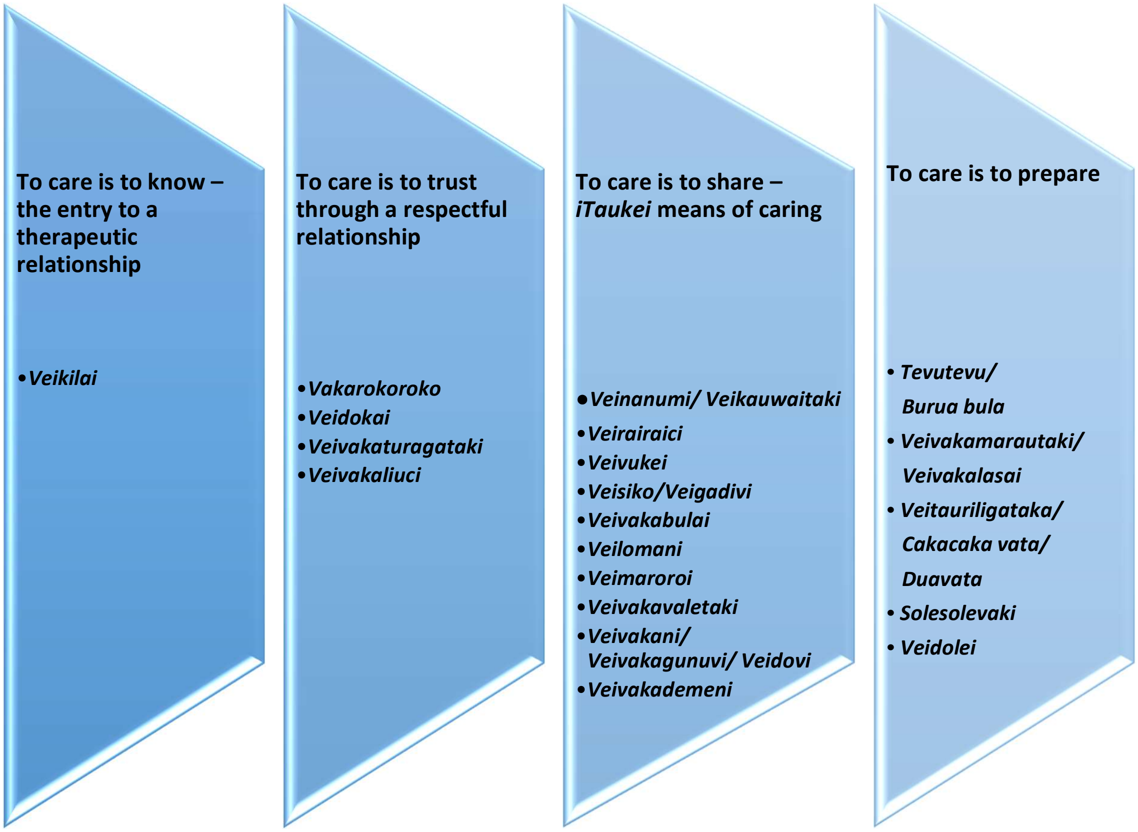
Commonly*, iTaukei* people perform a *matanigasau* - the traditional presentation of goods to make peace with others in cases where an offence has been committed (Bia, 2020). The task can be performed individually or in association with familial tribe members, depending on the extent of the offence and the peacemaking process (Bia, 2020). People who are sick feel obligated to seek forgiveness from individual persons or the *vanua* they assumed to have wronged. As mentioned in the conduct of traditional apologies, the process of seeking forgiveness also include *bulubulu*, *cokonaki*, *veisorosorovi,* and *boka*. The *vanua* as a skeleton for the *iTaukei* living and being is enriched with its three elements - the physical, cultural, and social foundations - which birth the concept of caring to promote health and wellbeing in a typical *iTaukei* community.

The *iTaukei* Sociocultural Values of Caring

There are a number of the *iTaukei* cultural values that directly relate to how *iTaukei* live and take care of one another in their communities. These values are in the form of sharing material goods and providing support to another person during a life crisis (Ravuvu, 1983). During illness, the *iTaukei* concepts of caring are increased to another level to take care of the disadvantaged person. Despite the challenge of high living costs in Fiji, the *iTaukei* share and care values remain fundamental within their culture (Ravuvu, 1983). The fundamental value-based caring concepts, as depicted in Figure 5, provide an orientation as to how the *iTaukei* way of life contributes to wellness (Ravuvu, 1988).

Figure 5

iTaukei *Caring Concepts*



To Care is to Know - The Entry to a Therapeutic Relationship

Veikilai

The concept of *veikilai* sets the platform of introduction from an *iTaukei* perspective. Naturally, it takes time to build rapport between *iTaukei* people. However, they generally overcome this behaviour by identifying themselves and their place through a proper introduction (Bia, 2020). *Veikilai*, which is forming *veiwekani* (relationships) through knowing and identifying oneself, is an essential component of understanding existing tribal relations between the two *vanua* (Meo-Sewabu, 2015). The connection allows the sick person to know their place and identify how this relationship will meet their health-care needs. As discussed in the *iTaukei* way of life, trustful relations are gained and retained between health-care professionals and patients when they establish rapport by introducing themselves and learning about their traditional relationship with one another.

To Care is to Trust Through a Respectful Relationship

Vakarokoroko

Vakarokoroko is the act of being respectful towards another. *Vakarokoroko* is displayed through the way people talk and behave towards one another. The context in which *vakarokoroko* is accorded depends heavily on one's social status. In social events, younger *iTaukei* learn to be *vakarokoroko* by keeping quiet but observing and listening to the adults and remaining vigilant in how such social processes unfold (Bia, 2020). To be *vakarokoroko* means to appreciate someone's presence, knowledge, and space where people value relationships that exist between them (Ravuvu, 1983). A patient is said to be *vakarokoroko* when they appreciate and respect the health-care professional's knowledge and value tribal relationships with their health-care providers and other patients in a health-care setting. In cases where older patients are cared for by a young health-care professional, it is expected that the younger person will show *vakarokoroko* to the patient unless their traditional relationship means otherwise.

Veidokai

Veidokai is holding reverence for another. Similar to *vakarokoroko*, *veidokai* is a cultural value deeply acknowledged and practised amongst *iTaukei* people (Ravuvu, 1983). The common saying is that the value of *veidokai* is provided and earned

(Nainoca, 2011). *Veidokai* also acknowledges someone's status, which, among *iTaukei,* is earned through genealogical lineages, age, and experiences (Meo-Sewabu, 2015). In relating *veidokai* to health care, patients respect professionals due to their status in society, which is achieved through education and service. Similarly, health-care professionals are expected to respect patients and uphold their rights to be treated fairly.

Veivakaturagataki

Veivakaturagataki is the respect accorded to someone of authority (Ravuvu, 1983). Through respectful attitudes, *veivakaturagataki* is the diplomatic and careful display of behaviour, ensuring not to accidentally misconduct oneself, such as unintentionally saying something against another person (U. Nabobo-Baba, personal communication, September 9, 2018). The cultural value is the essence of the *iTaukei* ethos by providing the custom of respect and caring. In nurturing a caring relationship, names are never mentioned, but respect is shown in the manner of *veivakamenemenei* that includes identifying people through their links to the older generation (Meo-Sewabu, 2015). For example, a young female named after her father's mother is most likely to be addressed as *Nei* (aunt) or *Nana* (mother, aunt) by her uncles and aunts (Bia, 2020). In instances where people are not related, the traditional connecting title is used. This translates to mean that in a health-care setting, for health-care professionals and patients who share traditional relationships, *veivakaturagataki* is displayed and experienced during the treatment process.

Veivakaliuci

Veivakaliuci is respecting each other's space and prioritising other people's needs over one's personal needs. *Veivakaliuci* is a typical cultural *iTaukei* value (Qalo, 2011). Typically, the elders are respected and given priority in every community activity. In a health-care setting, younger health-care professionals are expected to display acts of *veivakaliuci* to align their conduct with cultural protocols of care for the elderly in the community. Not adhering to *veivakaliuci* is disrespectful and insulting to the communal system and *iTaukei* ethos (U. Nabobo-Baba, personal communication, September 9, 2018).

To Care is to Share - **iTaukei** ***Means of Caring***

Veinanumi *and* Veikauwaitaki

Looking out for the needs of others embraces the concept of *veinanumi* among *iTaukei* (Becker, 1995; Meo-Sewabu, 2015; Ravuvu, 1983). *Veinanumi* and *veikauwaitaki* are applied when people consider how others live and gift them items that enable self-sustainability (Becker, 1995; Meo-Sewabu, 2015). The *vanua* remains united, and all its members are provided with a comfortable life if the needs of the present situation are fulfilled (Nainoca, 2011). Difficulties are handled unitedly and with care (Ravuvu, 1983). This translates to mean that everyone in an *iTaukei* community is able to have similar life experiences, despite differences in education and economic status (Bia, 2020; Qalo, 2011). Similarly, health-care professionals are expected to consider their patients' needs and work out ways to fulfil them. For example, health-care professionals may use their networks to improve transportation accessibility for patients with limb amputations. So, in the same way, the patients are expected to respect the health-care professional's needs. An example of *veinanumi/veikauwaitaki* by *iTaukei* is allocating special planting plots for visitors, including health-care professionals who are newly posted to their community.

Veirairaici

Veirairaici is another crucial concept of caring among *iTaukei* people and involves looking out for other people’s needs and ensuring balance in distributing wealth for sustainability (Bia, 2020). Before they are satisfied with personal achievements, people look out for each other in their community and try to uplift standards to match theirs (Qalo, 2011). An example of *veirairaici* will be when a person with a vehicle may willingly transport the sick person with an amputated limb to the health-care facility.

Veivukei

Veivukei is the act of helping one another and extends to assisting the needy, including the sick (Ravuvu, 1983). A person is said to be *veivukei* if they share food, wealth, and labour by temporarily fulfilling other people's needs. In doing so, the person is practising the concept of *veinanumi* (Meo-Sewabu, 2016). The act of *veinanumi* (thinking of others) is done to support the good image of others. People who are *veinanumi* help the weak and helpless (Ravuvu, 1988). An example of *veivukei* is normally witnessed in events of natural disasters or emergencies. People would be seen to be *veivukei* among others, and, on several occasions, people from afar would reach out to those who need assistance (Bia, 2020).

To be *veivukei* is a prosocial characteristic of a person (Ravuvu, 1983). In matters regarding health, people act in a *veivukei* manner to assist the person who requires immediate health care. For example, during medical emergencies, people willingly help in any way they can. However, the context in which people have been said to be *veivukei* has been affected by sudden technological advancements like mobile phones; people have become obsessed with taking photos of health disasters and emergencies in a bystander mode and not attending to the person in need.

Veisiko *and* Veigadivi

Concerning illness, to do a *veisiko* (visit to the sick) is an act of *veinanumi* (thinking of others) by visiting the sick person (Meo-Sewabu, 2015). This visit is conducted either formally or informally by relatives or those known to the sick person and their families who would gather mostly food, among other things, that promote healing (Kuridrani, 2014; Vudiniabola, 2011). *Veisiko* is only accorded to specific sick relatives as visitors from the *vasu* (maternal links) are assumed to bring the last breath (Nabobo-Baba, 2004). The *vasu* person's responsibilities compound the belief in ensuring the protection and safekeeping of a person who succumbs to their illness. *Veigadivi* or *gade* is the informal visitation to the sick and can be done on many occasions, depending on the distance travelled and how closely related the sick person is to the visitor (Bia, 2020). For worsening or deteriorating health conditions, it is common for closely related visitors to remain nearby and help each other in supporting the sick person.

Guilt is often associated with not making time to visit a sick relative and can increase when the ill person succumbs to their illness. *Veisiko* can be performed many times during the illness period, and it is habitually related to availability and affordability issues (Bia, 2020). Careful attention is diverted into ensuring the totems of the person to be visited are not presented to them. Presenting totems as *veisiko* items is not only an insult to the sick person, but it defeats the purpose of the visit as they would not be able to consume them. The general assumption is that those visiting the sick are aware of such protocols, and, in situations where they were accidentally presented, a traditional ceremony of *ore*[45] will be conducted to put things right.

Veivakabulai

Veivakabulai is the process of providing healing to the sick person. People who can perform *veivakabulai* are commonly referred to as *Na dau soli wai*, meaning a person who gives medicines. They are the custodian of the gift of healing, a hereditarily earned role, and are revered within their communities and widely known (Meo-Sewabu, 2016; Veitayaki, 2002). *Veivakabulai* is a service given to those who need healing, mostly in herbal or physical therapies like massaging the broken bone (Veitayaki, 2002). There is no monetary charge for the gift of *veivakabulai,* for it is known that *mana* is lost once the traditional healer receives monetary gifts. A more contemporary approach is through the spiritual healer, who performs *veivakabulai* via prayers to remove the evil spirit that causes sickness and restores good health through healing (Kuridrani, 2014). In Fiji, more spiritual warfare and revival groups have surfaced, and more people are turning to spiritual interventions to manage their illnesses.

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[45] *Ore* – realising one's wrongdoing by form of apology to make peace for an unintentional mishap

Veilomani

Veilomani is another important *iTaukei* concept of caring, which involves loving and being friendly (Bia, 2020; Ravuvu, 1983). *Veilomani*, *dua vata*[46], and *yalo vata*[47] are all manifested when people live and work together in friendship and harmony (Bia, 2020; Nainoca, 2011). *Veilomani* has always been the fundamental teaching of the *iTaukei* people, instilled in young children by showcasing love through upholding traditional obligations and responsibilities (Bia, 2020). For example, at funerals, community members are expected to contribute food and artefacts to assist the grieving *vanua*. The concept of *veilomani* in promoting harmony is witnessed in all *iTaukei* functions that fulfil the expectations of the *vanua* (Ravuvu, 1983). In health matters, *veilomani* promotes wellness by ensuring that the sick person is forgiven for their wrongdoing and harmony is promoted within the community.

Veimaroroi

Veimaroroi is an act of caring for people in the form of housing the person in need and is comparable to *veivakavaletaki*. This type of care is usually accorded to people who have suffered due to unforeseen circumstances (Bia, 2020). It is also common for families living in urban areas to accommodate extended family members from rural areas who seek better education or employment opportunities. Another important concept of *veimaroroi* is the care of the elderly, which may be shared among relatives depending on the family agreement (Nainoca, 2011). In health-care arrangements, geriatric care is community care undertaken among *iTaukei* communities (Bia, 2020).

Veivakavaletaki

The concept of *veivakavaletaki* extends to when a person loses their dwelling house (*vale*). It is common practice for people to accommodate those in need of a temporary living arrangement (Bia, 2020). In cases where there is conflict in a household, a family or couple with their family may decide to move out, and other family members will step

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[46] *Dua vata* – togetherness

[47] *Yalo vata* – agreeing together

up and help by giving up their house. The arrangement is usually short term. The family seeking temporary accommodation may make a new house for themselves or move back to their old dwelling once the conflict is resolved.

In illness events, housing the sick and their immediate relatives is a standard practice among *iTaukei* (Bia, 2020). *Veivakavaletaki* is expected if the sick person needs to travel from rural areas to receive complex or tertiary levels of care in urban areas (Bia, 2020). Typically, the urban dweller has no choice in accommodating the sick person and their relatives. This act is called *veivakavaletaki* and is one of the *iTaukei* caring values. *Veivakavaletaki* is an act of *veilomani*[48], *veimaroroi*[49], and *veidovi*[50]. While such an undertaking may require extra resources, fulfilling the housing need of another person is often appreciated, and the accommodator is accorded respect from members of the community (Ravuvu, 1983).

Veivakani, Veivakagunuvi, *and* Veidovi

Veivakani and *veivakagunuvi* refer specifically to offerings of *kakana* (food) and *gunu* (drinks) to a person in need. A typical *iTaukei* house would have three entry doors, two on the side and one on the lower end of the house (Ravuvu, 1983). Often during meals, those who are seen walking past the home are invited to partake in the food prepared for the family (Bia, 2020). Food and drinks are freely given with no expectation of return favour. The value of *veivakani, veivakagunuvi,* and *veidovi* are all part of the custom of sharing despite how little people have and no matter the quantity of food in the pot (Nainoca, 2011). The invited person may refuse the offer, and, usually, some may say that they are on their way somewhere else, perhaps to a plantation or to see other people (Bia, 2020).

People who join the family just for a conversation that continues to a meal period are always welcomed to join the meal. Often, the visitor is offered the best, and, on most

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[48] *Veilomani* – showing act of *loloma* (love) towards another

[49] *Veimaroroi* – the act of keeping someone safe from harm

[50] *Veidovi* – sharing food and drinks with another

occasions, cooking is done in bigger pots. It is also common for the *iTaukei* in a community to share their food around. Young girls are often tasked with *takitaki* (taking plates of food) to other family members (Bia, 2020). In instances when there is a sick person in the community, other members of the community may share their food by taking a portion to the house where the sick person is receiving attention.

Veivakademeni

Veivakademeni is an act of giving special attention to someone. *Veivakademeni* is also referenced as *veivakamenemenei*, which is providing special attendance to a person. People needing special attention may be a sick person, a grandchild, or a *vasu*. The *iTaukei* hold a deep reverence for their maternal links, and the *vasu* are specially treated in their mothers' community (Bia, 2020). Similarly, the *iTaukei* culture upholds women's connections in their *vanua* due to the tribal linkages during matrimonial ceremonies (Ravuvu, 1983).

To Care is to Prepare

Tevutevu *and* Burua-bula

In cases where the sick person has been chronically ill and shows no sign of improvement, closely related female relatives gather mats and bedding to perform the *tevutevu*. Generally, *tevutevu* is a symbolic tradition to prepare the *iTaukei* person for their next chapter in life (Ravuvu, 1983). It is often accorded to a newly wedded person, when a person has come of age, during birthday celebrations, and other developmental stages, like the onset of menarche for a young woman. *Tevutevu* is also accorded to mark someone's achievement in life, whether it be academic or retirement from work. From a health perspective, *tevutevu* is accorded to a person who is likely to succumb to their illness. *Tevutevu* has the same connotation as the *burua-bula*, where feasting that usually happens after death is brought forward while the person is still alive (Bia, 2020). Typically, the *burua-bula* can be initiated either by the person whose *burua* is to happen or close family members.

Veivakamarautaki *and* Veivakalasai

Typically, the *iTaukei* way of life is about maintaining harmonious relationships with others. During *veisiko* events, it is common for visitors to share jokes and funny stories and reminisce about childhood memories with the sick person (Bia, 2020). People do not freely talk about their sickness or illness processes and, when they do, less time is spent talking about the negative. In certain instances, visitors often share other people's experiences and how they coped with ethnomedicine. Visitors usually do not talk about the future but divert more time towards making the sick person happy (Bia, 2020). The symbolic meaning of *veivakamarautaki* is to remove any *madua* (feeling of shame by shying away), which can result in people not disclosing full details of their illness. The main objective of the *veivakamarautaki* or *veivakalasai* is to redirect suffering and experiences of pain and help the sick person feel less stressed about their condition. Another objective of the *veivakamarautaki* is to leave the sick person with fond memories even after the *veisiko*. Usually, both parties will feel good by sharing happy and fun moments. In cases where the sick person succumbs to their illness, the group that conducted the *veisiko* typically feel satisfied that they had shared some fun during the *veisiko*.

Veitauriligataka - Cakacaka vata *and* Dua vata

Veitauriliga, *cakacaka vata,* and *dua vata* are key identifiers of unity in a *vanua* (Ravuvu, 1983). However, these critical identifiers of unity are changing slowly and challenging the values of the *vanua*. *iTaukei* people have made changes to and are remodifying some of their traditional values to suit their current situation (Bia, 2020). If the unity among the *vanua* is not maintained to accommodate changing circumstances, the *vanua* is doomed to suffer (Arno, 1993). *Cakacaka vata* enables a platform of working together to achieve unity and success of the *vanua*. It is customary for close relatives of the sick person to collectively gather and provide any type of help during illness events.

Solesolevaki

Solesolevaki is an event of communally working together (Vunibola & Scheyvens, 2019) for a person who cannot attend to their daily duties or assist in roles and obligations (Meo-Sewabu, 2015). Vunibola and Scheyvens' (2019) concept of *solesolevaki* draws towards the socioeconomic development paradigm. During illness events, *solesolevaki* carries the same meaning as the *veirairaici*. *Solesolevaki* comes in many forms, and people participate according to the tasks to be performed, which are gender-specific. Consequently, if the sick person is a male, men will gather to complete the *solesolevaki*, and if the sick person is female, women will gather. The practice allows the achievement of a common task and lessens the burden for a clan member who needs help (Meo-Sewabu, 2015).

When people carry out the opposite gender's tasks, they are often ridiculed, mostly if men perform female roles. Men involved in the *solesolevaki* typically attend to "manly and strenuous" tasks like tending the plantation, weeding, or building construction. The women are usually involved in household chores, cleaning the sick person's house or tidying up flower gardens. *Solesolevaki* is continued until the sick person is fully recovered from their illness.

Veidolei

Most meaningful social activities among the *iTaukei* people are conveyed by gift-giving (Ravuvu, 1983). Typically, it is customary to reciprocate, even during casual visits, to show hospitality (Nabobo-Baba, 2006). *Veidolei* is an immediate response to return the favour people received. For instance, during visits to the sick, it is normal for the visitors to receive meals prepared by the sick person's family (Bia, 2020). Hence, people are always prepared to receive unexpected visitors and reciprocate at any time.

The twenty related concepts of caring are bounded by the idea of showing love, affection, and responsibility to the sick person. The caring concepts are broadly identified in other literature (Nainoca, 2011), and their meanings and application extend to different directions of understanding due to the complexities of the *iTaukei* language. For example, *bula*, which means life, is used as a greeting word and also means health. However, the broad sense and background remain whereby *iTaukei* people live their lives so as to maintain harmony with the *vanua*. The concepts of caring support the ultimate purposes of the Fijian ethos. The *iTaukei* way of life is framed around relationships that support the continuity of life, the interdependence of the people, and the preservation of the identity of the *vanua* (Ravuvu, 1983).

Using Biomedical Treatments

Herbal therapies, as discussed earlier, have been used by *iTaukei* people - who have a deep-rooted ethnomedical system of managing diseases like diabetes. The biomedical approach has been regarded as another layer of colonialism and Western influence (Oliver, 2013). Also, Oliver (2013) adds that, in general, biomedical practices have been alleged to replace the use of local healing traditions, thus destabilising the maintenance of tradition, empowerment, and self-determination. In Fiji, the *iTaukei* have always assumed biomedicine as the *wanimate vakavavalagi* (European medicine) and approach its use differently. For example, its uses would be halted once they are symptom-free and would not complete the entire dose, both short-course and long-term medications. While people from some countries use both approaches concurrently (Phillips, 2020), for *iTaukei*, its options for use depend heavily on health-care access, cultural values, and socioeconomic status (Tukana, 2013).

Biomedical treatments are also sought to complement traditional *iTaukei* therapy; however, its barriers, like the lack of choice available to patients, prohibits its success (Kuridrani, 2014). The cultural inappropriateness to discuss health issues with members of the opposite sex is also a barrier and prevents adequate data collection through history taking from patients (Kuridrani, 2014). For example, *iTaukei* female patients prefer to seek medical attention from female doctors and nurses, particularly regarding reproductive and sexual health issues, the discussion of which is still considered taboo. Nevertheless, the problem is that there are more male than female doctors in Fiji (Kuridrani, 2014), which suggests that *iTaukei* women's health-care needs may be at risk of being missed. Language has been identified as another barrier to accessing the best health care. Most *iTaukei* people cannot openly express their illness matters to others, particularly to health-care practitioners from other ethnic backgrounds, while *iTaukei* health-care professionals are expected to share respectful cultural relationships with patients of the opposite sex.

Chapter Conclusion

The *iTaukei* have differing perceptions of health and healing, which is seen through their health belief system regarding illness, influencing their health-seeking behaviours and practices (Tukana, 2013). There is a considerable gap between *iTaukei* cultural knowledge, practices, information need, and health-care services in Fiji (Kuridrani, 2014). The chapter is orientated to reveal *iTaukei* sociocultural ways of life that affect their wellness and health beliefs. Beliefs impact health perspectives that affect decisions regarding health. Such decisions influence how people deal with illness, which, for the *iTaukei* person, has a different orientation. The *iTaukei* ways of life value relationships, which approach connections among people from a holistic perspective that includes all components of the *vanua*. In this regard, the *iTaukei* viewpoint about their connections to other people is special; therefore, they have always seen themselves differently from other ethnic persons living in Fiji. Such relationships relate to their use of language, which is a sociocultural element in health care, making communication with an *iTaukei* extremely important and essential in terms of planning care.

The chapter described how knowledge acquisition, including health-related knowledge, is communicated through the *iTaukei* oral tradition. For an *iTaukei* person, their oral tradition commences at a young age when they learn history and traditional cultural practices through conversational methods, chants, songs, and observations. Included in these practices are ways of dealing with illness, which is done through mending relationships with the *vanua*, using its elements. Such behaviours to treating ill-health affect how *iTaukei* manage health and illness through relating to the three elements of the *vanua*: the physical, social, and cultural elements. Valuing these elements gives way to twenty concepts of caring, which illustrate how *iTaukei* approaches health care. Also identified in this chapter is the value of knowing before entering a therapeutic relationship as patients trust professionals through respectful relations, like sharing, as means of caring and as preparing for what they may encounter. The practice and upholding of such values and how each value's relatedness affects relationships influence the way *iTaukei* approach Western medicine. In honouring these traditional values, I put forward a paradigm of caring perspectives from an *iTaukei* worldview, which brings discourse about relationality—the state of being related—among nurses and their patients to the fore. Conclusively, it can be affirmed that *iTaukei* uphold and link concepts of the *vanua* to determine and manage illness or wellness.

Chapter Five: Theoretical Framework

Chapter Five discusses how the *vanua* elements formed into theory situating *iTaukei* belief systems, protocols, and worldviews to explain wellness and illness matters. Wellness is defined as *bula sautu*, meaning holistic living (Nabobo-Baba, 2006b), prosperity (Meo-Sewabu, 2015), and stability (Ministry of Social Development, 2012). The Fijian Ministry of Health encourages people to “harvest wellness in them” as the driving factor behind efforts to curb the incidences of NCDs, including diabetes. As discussed in Chapter Four, wellness and illness, and to live peacefully or not, are associated with people’s connection to and with the *vanua* (Meo-Sewabu, 2015; Nabobo-Baba, 2006b). The links to the *vanua*, core concepts, values, and beliefs determine relationships, inform behaviours, and guide diabetes nursing in the *iTaukei* context.

My personal experience presented as a story in Chapter One describes how caring for a patient from another Pacific Island nation symbolises my traditional caring values naturally linked to restoring health, preventing complications, and avoiding the burden of diabetes. In return, I received gifts and was reciprocated traditionally, which is also discussed as an important component of many Pacific health models. As such, I explore the *Tuvaluan Ola lei* health framework's interconnectedness, the *Fonofale* model, the *Te Whare Tapa Wha* model, the *Te VakaAtafaga* model, the *Fonua* model, the *Te Pae Mahutonga* model, and the *TiVaevae* model. I also used the two Fijian health models - the *Tanoa* and *Vale ni Bula* - to locate *iTaukei* health beliefs and behaviours, which are essential for understanding *iTaukei* health issues. These different health models guide my research from a global, Pacific, and Fijian perspective. To position my research within the known theoretical underpinnings, I have included the *vanua* health and illness model, which has four parts that support how *iTaukei* view the *vanua* elements as sources of health and illnesses. The *vanua* health and illness model shows how *iTaukei* amend their ways back to rightful and healthy living according to protocols of their *vanua*. Also, I highlight the relationship between the *vanua* and biomedicine and their influence on community health. I begin with how the *vanua* theory informs the study.

The *Vanua* Theory

Vanua theory is based on several fundamental principles that proclaim the uniqueness and legitimacy of *iTaukei* relationships with the land, forests, seas, rivers, mountains, and inhabitants (Meo-Sewabu, 2015; Nabobo-Baba, 2006b; Ravuvu, 1983). Building and satisfying relationships is a fundamental aspect of community life, and researchers must negotiate their ways around considerations of accountability to the researched community (Chilisa, 2019). Within a *vanua* paradigm, the *iTaukei* ways of knowing, doing, and understanding the world are considered valid in their own right. In its most straightforward translation, *vanua* means land, and its *iTaukei* cultural translation means tribe or clan (Naitini, 2020). However, its meaning to the indigenous Fijian goes further as *iTaukei* refer to the *vanua* as physical, social, and cultural elements that direct their self-awareness (Ravuvu, 1983). The *vanua* that one belongs to defines relationships amongst *iTaukei* and is responsible for their shared standard links and allegiance to a recognised authority (Ravuvu, 1987). The *vanua* exemplifies the *iTaukei* values like *veidokai* (respect) and beliefs like not wronging or insulting the *vanua,* including traditional viewpoints.

Elements of the **Vanua*****—Physical, Cultural, and Social***

The *vanua* and its three elements - physical, cultural, and social are a source of security, confidence, and belonging for an *iTaukei*. Further to the *vanua* elements, three dimensions surface to explain the relationships between the *vanua* and the spirits, places, and people, which are closely related and directly associated (Spriggs & Scarr, 2014). *iTaukei* people are connected to their land through the spirits; hence, the land has a significant value for them and is directly inherited from a common ancestor and distributed among male descendants. The people are identified through their *vanua*, which originates from their tribes of common ancestry (*yavutu*), called the *yavusa*[51] (Bia, 2020). *iTaukei* describe themselves in terms of their communities in uniting connections, identification, dynamics, and organisational leadership, which are significant factors that link their tribes into confederations with others (Ravuvu, 1983; Tuwere, 2002). People are identified through their common name, origin, and ancestral links, with similar totemic features and standard dialects shared with related communities. To better understand the framings of the research through the eyes of the *vanua*, I will discuss the three elements of the *vanua.*

The Physical Element as a Source of Health

The general translation, which refers to *vanua* as the physical elements, is inclusive of the land, and people are known as the *lewe ni vanua* (inner part of the *vanua*), but, in terms of nuances, *vanua* has many meanings and applications (Meo-Sewabu, 2015; Nabobo-Baba, 2006b; Naitini, 2020). Typically, in an *iTaukei* community setting, the land is distributed among members for various purposes that range from habitation to allocations for farming activities (Ravuvu, 1983). There is a planting calendar that *Taukei* people follow, which people use to relate to social networks (Veitayaki, 2002). For example, people in the highlands would plant crops, such as yams, which have a specific harvest period to barter with people in coastal areas for fish or seafood. Typically, land use has never been associated with preparation for illness, death, or health insurance. As a matter of course, people in rural areas plant for their families in urban areas to supply fresh vegetables and food. Food, in its abundance, has a significant standing in the *iTaukei* sociocultural space (Ravuvu, 1983). The sharing of food is regarded as a cultural value that enhances good health and wellbeing. The physical element of the *vanua* includes medicinal plants, which are now more accepted by Western medicine (Veitayaki, 2002). In an *iTaukei* context, totems are associated with reproduction, which is also an essential physical element of the *vanua*.

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[51] *Yavusa* – tribe

Cultural Observance and Guardedness of Longevity

The *vanua* also denote the values, beliefs, and customs cultivated to achieve prosperity, solidarity, and harmony (Tuwere, 2002). As such, the *vanua,* as a cultural concept, is shaped by the ethos of the people living on it (Kaplama, 2016; Ryle, 2016). As discussed in Chapter Four, a common saying among the *iTaukei* taken from an ancient Rotuman proverb translates as “the land has eyes and teeth and knows the truth”, which often relates to supernatural watching of the land with actions. The belief system is based on a relationship with the land that provides and cares for its people (Marsh, 2007). The proverb means that when people do not follow proper protocol, meaning if people wrong the *vanua*, there are likely to be repercussions, including illness or death. The saying is often a reminder for members or visitors to the *vanua* to behave appropriately. The custodian of such etiquette is the *matanivanua*, a hereditarily assumed role that translates as the “eye of the land”.

In a *vanua*, direct and indirect physical contact with the chief is prohibited; therefore, the *matanivanua* becomes the interconnecting link between the chief, *vanua,* and the people (Ravuvu, 1983). In association with the spirits of the land, the *matanivanua* is the link to balance within a *vanua*. Therefore, people adhere to the requirements of the *vanua* to avoid adverse filtering effects like illnesses and deaths upon themselves or to their future generations. Maintaining harmony and keeping the spirits happy leads to prosperity that includes health and wellness among the community members (Spriggs & Scarr, 2014).

The Social Relation is a Health Archetype

While *vanua* belongs to the *lewe ni vanua* (people) living on and through it, their customs and *icavuti* are the extensions of the *vanua* on which they dwell, live, and regenerate (Ravuvu, 1983). The *iTaukei* social system has an intriguing relationship feature as people are related to one another because of their *vanua* (Veitayaki, 2002).

These links and cords between people and *vanua* (also between different *yavusa* and *mataqali*[52]) are mentioned continuously in Fijian ceremonies. With this ongoing affirmation of the need to revitalise and strengthen the existing kinship bonds, the *iTaukei* people value their socioeconomic interdependence in terms of reproduction through marriages for the sake of the *vanua* (Becker, 1995; Ravuvu, 1983).

Respectful relations exist between the *mataqali* among people from the *Kubuna* confederacy and the *tovata* from the *Tovata* confederacy. A more jovial and joking connection exists between the *Tauvu*[53], who are closely related because of their ancestral gods, and the *Naita*[54] from two different areas (Becker, 1995; Veitayaki, 2002). There also exists the *Tako Lavo*[55] from two districts within Viti Levu, a jovial relation between the *Dreu*[56] who are from some parts of the *Tovata* confederacy and some parts of Viti Levu, and *Kai*[57] who are from the same province. The widespread *iTaukei* social networks and relationships ensure people care for one another (Becker, 1995; Veitayaki, 2002). Some *vanua* from the West are *Koicalevu*[58] or *Maseki*[59] with each other and share a respectful relationship. People from the islands would refer to each other as *Yanu.*[60]

Such relationships also exist between health-care professionals and their patients. Newly formed relationships often enhance existing tribal connections between the two *vanua*. As mentioned, it is common for people to identify their tribal relationships while introducing themselves to another *iTaukei* person. This means that once tribal links are recognised, it is common for the *iTaukei* person to take extra care of the newly introduced person. The *iTaukei* concepts of caring extend to both immediate and

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[52] *Mataqali* – land-owning unit; *mataqali* is also used as term to show relations from the same tribe

[53] *Tauvu* – relations between people from different tribes through friendship that exist between their ancestral gods

[54] *Naita* – respectful relation between certain tribes

[55] *Takolavo* – relation between two tribes from the West

[56] *Dreu* – relationship between tribes from Vanua Levu to one part of Viti Levu

[57] *Kai* – relation between people from the same province

[58] *Koicalevu* – relation between two tribes from the West

[59] *Maseki* – relation between two tribes from the West

[60] *Yanu* – relationship between people from the islands of the Lau group to that of specific smaller isalnds in Fiji

distantly related persons (Becker, 1995; Veitayaki, 2002). Thus, the *vanua* and its relational components have wellness connotations.

Concepts of Caring as Social Elements of the Vanua

The *iTaukei* people are well known for their caring values for one another (Becker, 1995; Orcherton, 2017; Ravuvu, 1983). These values are part of their ways of living, incorporating their social health, as discussed in Chapter Four. *iTaukei* understandings of their existence as human beings relates to applying the values of the *vanua* (Meo-Sewabu, 2016). They hold the value of care as not in and for themselves but rather as the members of the *vanua*. Their belonging to the *vanua* is demonstrated through relationships with each other if they live through unity and regeneration (Kaplama, 2016; Ravuvu, 1987). The people who constitute the *vanua* must continually strengthen its importance to preserve its values, giving them their identity.

Pacific Health and Wellness Models

Literature indicates that most Pacific health models identify common values and beliefs that direct Pacific people's health-seeking behaviours (Meo-Sewabu, 2015; Tiatia, 2008). They include having a common belief in spirituality, particularly Christianity, which is an important concept that displaces every other archetype and component of their lives and permeates therapeutic and restorative health practices and belief patterns (Mila, 2017). These models show the structure surrounding and protecting the individual from opposing forces that cause illness or, worse, death. For example, in the *iTaukei* context, spirituality encompasses psychological connotations where emotions depend on one's spiritual health (Meo-Sewabu, 2015). Spiritual capability is associated with faith in God and wisdom (Meo-Sewabu, 2015; Nabobo-Baba, 2006b). Through fellowship with others and common forms of worship, the spiritually filled *iTaukei* harvest wellness and establish healthy relationships within their communities.

People of Pacific origin share a genealogical-based identity where people are identified through their land, origins, and family connections (Manuela & Sibley, 2015). Of particular interest is how they maintain relationships with both paternal and maternal links. There is a sense of extended family accountability where people are obliged to take care of each other and contribute to family and community functions (Tiatia, 2008). The concepts of sharing and caring are seen in how they share food among themselves, where expectations are associated with wellness linked to social and economic wellbeing (Ravuvu, 1983). There is a variety of beliefs within the Pacific that extend to a range of views on health (Mauri Ora Associates, 2010). Compatibly, there are multiple worldviews and varied perceptions of illness, treatment, prevention, and various belief systems, including cultural and religious factors, that influence attitudes and health behaviours (Finau & Tukuitonga, 1999; Finau & Finau, 2007; Mauri Ora Associates, 2010).

Pacific health experts have proposed the different belief systems and various metaphoric frameworks for thinking about how Pacific health is conceptualised and how service approaches should be framed (Agnew et al., 2004; Suaalii-Sauni et al., 2009). Such framing has shown how these belief concepts, which have outstanding symbolic features, tend to be rooted in values, customs, and traditions (Cammock et al., 2014). As a result, health service delivery to Pacific communities often fails due to the lack of appropriate cultural context inclusion (Meo-Sewabu, 2015); therefore, health inequalities exist in health care for Pacific people (Mauri Ora Associates, 2010; Ryan et al., 2019).

Pacific health researchers like Pulotu-Endemann (2001), Kupa (2009), Vudiniabola (2011), and Meo-Sewabu (2015) have outlined a variety of context-specific and cultural-appropriate health care models. The rising scale of NCDs among Pacific people requires in-depth knowledge of lifestyle factors and an understanding of cultural and family responsibilities (Firestone et al., 2020). The following section discusses nine Pacific models that connect to understanding cultural components of health behaviours related to the twenty caring concepts in Figure 4.

The *Ola Lei* Framework

The Tuvaluan *Ola lei* health and wellbeing framework identify the concepts of caring through fostered relationships or partnerships *(tausi te vasia)*, which is central to all aspects of health (Panapa, 2014) and is similar to the caring concepts of the *vanua* and *iTaukei* health beliefs. The model signifies the holistic interconnectedness of the *ola lei* components, which has four main qualities in a cultural community context that form together to provide a holistic approach to understanding health (Sanga & Reynolds, 2017). They are peacefulness and harmonious relationships, happiness and contentment in life, the absence of illnesses, and longevity (Panapa, 2014). The *Ola Lei* adopts a more Pacific community-based approach like readiness, traditional skills and knowledge, spirituality, and richness, which connects to the *vanua* caring concepts and relates to how people living with diabetes receive community support.

The *Te Whare Tapa Wha* Model

The *Te Whare Tapa Wha* model of wellbeing (Durie, 1998) presents the four cornerstones of health as a model for understanding Māori health and identifies the concepts of both wellness and its absence. Colonisation has pushed Māori, the indigenous people of New Zealand, to social and economic deprivation, contributing to poorer health outcomes compared to Pākehā (Rochford, 2004). The *Te Whare Tapa Wha* model identifies the physical, emotional, social, and spiritual realms that promote Māori health and helps identify the complex nature of both wellness and illness (Rochford & Signal, 2009).

Fijian authors like Vudiniabola (2011) and Meo-Sewabu (2015) have both explored *Te Whare Tapa Wha* that can be seen as having influenced the development of *iTaukei* health and wellness models, which identify the impacts of the *vanua* on health. Similar to the *vanua* concepts, the four realms of the *Te Whare Tapa Wha* tease out the cultural, social, psychosocial, and physical determinants of health. These four realms enable effective health promotion programmes to respond to the key determinants in both health and community development (Rochford, 2004; Rochford & Signal, 2009). The *Te* Whare Tapa *Wha* model emphasises the *wairua* (spiritual) component, which is similar to *iTaukei* cosmology, in its worldview on negative consequences of behaviour contributing to illnesses.

The *Fonofale* Model

The *Fonofale* model is a pan-Pacific island and Samoan health model developed by Fuimano Karl Pulotu-Endemann for use in New Zealand. The *Fonofale* health model has three components - the roof, the foundation, and the posts, which are related to safely and effectively understanding people using a holistic approach to health (Pulotu-Endemann, 2001). The roof signifies culture and its associated values and beliefs that are identified as the shelter for life. The foundation is the family, which is the substance for all Pacific cultures (Ioane & Tudor, 2017). Finally, the four *pou* (posts) connect the foundation and the roof, linking the culture and the family. The *pou* components are spiritual, physical, mental, and other variables that can affect health.

The model forms a *fale* (house) that is encircled by the interrelated dimensions of environment, time, and context that impact a Samoan person's health and wellbeing (Ioane & Tudor, 2017; Meo-Sewabu, 2016; Pulotu-Endemann, 2001). *Fonofale* is widely used as a pan-Pacific framework. This model's application depends on the family orientation, whether the family sticks to their original values and belief systems or has adopted the "borrowed" Western concept. The Western influence, which best suits the changing health and life patterns for many people in the Pacific, has also impacted the *iTaukei* way of life (Orcherton, 2017). For example, many Western factors have impacted the dimension of context and environment for rural versus urban patients in Fiji, which implicates contexts for health and health-care seeking and delivery.

The *Te Vaka Atafaga* Model

The *Te Vaka Atafaga* is a Tokelau health assessment model that was developed for use in the New Zealand context (Kupa, 2009). The *Te Vaka Atafaga* is similar to the *Fonofale* model but is specifically for the Tokelauan people (Manuela & Sibley, 2012). The model has six essential health concepts representing the spiritual or belief systems, the mind, and the physical body, with all its interrelated parts that cannot be separated from the mind. Parallel to the *iTaukei*, these belief systems have been applied to mental health and the holistic approach to illness (Orcherton, 2017). This was highlighted during the data collection process of this research when participants commenced with a prayer before sharing their stories.

The *Te Vaka Atafaga* also includes accounting for individual family members, which extends over time and looks to form stronger relations (Kupa, 2009). Also included in this model is the importance of the social structure of a person that becomes their source of stability and support. Similar to the Fijian *vanua* components, the *Te Vaka Atafaga* model includes all things that make up the natural environment, such as the plantations, mountains, birds, rivers, and seas that can influence a person's wellbeing (Kupa, 2009). The *Te Vaka Atafaga* model reflects the *iTaukei* values of caring in avoiding somatopsychic disorders.

The *Fonua* Model

The *Fonua* (land) is a Tongan health model developed by Sione Tui'itahi to improve Pacific people's health and wellbeing using their worldviews to relate to the world. It represents the relationship between the environment and humanity that pays particular attention to the Tongan hierarchy (Cammock et al., 2014). Similar to the Fijian *vanua*, Samoan *fanua*, Māori *whenua* and the Cook Islands' *enua*, *fonua* refers to the complex interconnectedness and ongoing relationships between the entire physical and social environment and humanity. The relationship focus aims to maintain harmony in life in workable ways. The concept of the *fonua* model relates to community and individual health and wellbeing from a holistic view, including spiritual, mental, and physical wellbeing. This interpretation is consistent with the Pacific's holistic worldviews (Cammock et al., 2014).

The *Te Pae Mahutonga* (Southern Cross) Model

The *Te Pae Mähutonga* model was developed by Mason Durie, a Māori doctor and academic who was informed by Pomare's work on Māori health and the Ottawa Charter. Pomare adopted a five-point health promotional plan and realised that Māori health does not take shape in the human body alone but within the trials and prospects that individuals journey through (Durie, 1999). The *Te Pae Mähutonga* aligns with thinking regarding primary health care services in Fiji and development efforts to promote healthy living in *iTaukei* communities.

Te Pae Mähutonga signifies the importance of having a secure cultural identity, inner strength, vitality, and links to the external world and a spiritual element that connects human wellness with natural and water environments (Durie, 1999). It also relates to healthy lifestyles that link to how risks are significant threats to health and safety and can alter human experience. *Te Pae Mähutonga* also focuses on how participation in society and the goods and services people can count on and their voice in deciding how those goods and services are made available is an important concept. Last, the conditions in which individuals participate in society and the confidence they can access such things as good health services, the school of their choice, or sport and recreation are noted as necessary to people (Durie, 1999).

The *TiVaevae* Model

The *TiVaevae* is a culturally responsive model by Maua-Hodges, designed for the Cook Islanders, and is displayed as a multicoloured patterned cloth, stitched to reflect the environment in four different styles (Futter-Puati & Maua-Hodges, 2019). The *TiVaevae* model signifies collaboration to achieve shared objectives, including time, inspiration, and patience (Suaalii-Sauni et al., 2009). It resembles respect, including valuing knowledge that promotes learning and cultural values, and emphasises reciprocity to support each other, including the significance of establishing existing relationships that extend to the community. Overall, the *TiVaevae* implies a shared vision through knowledge constructs that are achieved by complementing personal growth, respect, patience, and humility, which also aligns with *iTaukei* ways of knowing, cultural values, and *vanua* concepts.

Appreciating each other in a shared vision is the essence of a Cook Islander way of life, meaning each person is respected and cared about (Suaalii-Sauni et al., 2009). Relating back to the Tuvaluan *Ola Lei* framework, the Cook Island *TiVaevae* model signifies the patterns of stitching together Pacific cultural values that define who they are. The *iTaukei* caring values are present and can be seen in most Pacific cultures, including *iTaukei*, despite not being explicitly mentioned in the literature.

The *Tanoa* Model

Meo-Sewabu's (2015) *Tanoa* framework explains how people's beliefs map their health-seeking behaviours. The *Tanoa* framework consists of five criteria that represent how *iTaukei* women describe their constructs of health and wellbeing. The *Tanoa* has four struts/bars that act as anchors of a large wooden bowl. The *tanoa* is used to serve traditional drinks.

The four bars include the concepts of "*dau veiqaravi"*, "*taucoko ni qaravi tavi"*, "*na veiwekani"*, and "*kena irairai"* that contribute to the fifth criteria, the *"bula vakayalo"*. The *Tanoa* framework sets the totality of caring from an *iTaukei* perspective. In Fiji, women usually assume the carer role when a family member is sick, which is reflected in the constructs of the health and wellbeing of *iTaukei* women. Nursing in Fiji is highly feminised, so it is common to get a surprised reaction when people come across a male nurse. The *iTaukei* mindset is conventional to a belief that all female health-care staff are nurses while male staff are physicians. This outlook is often jokingly shared, aimed towards friends and families, who are neither nurses nor physicians but work in health-care facilities. In 2010, males made up ten per cent of the total nursing workforce in Fiji (Aiyub et al., 2013); however, there is an upward trend (Nanuqa, 2021).

The *Tanoa* concept of *dau veiqaravi* means to be of service (Meo-Sewabu, 2015). Nurses are aware of the extent of the obligations they are undertaking after graduating and signing work contracts. In reciting the international nurses' pledge, nurses promise to be of service to people who need help, alleviate suffering, and promote health (International Council of Nurses, 2012). The essence of "to be of service" in nursing means serving the people and the community and providing professional care competently. However, nurses are changing people's lives in many ways, enhancing health systems, and taking the lead in many areas that were previously not acceptable, such as practising proficiently at higher levels of expertise (Catton, 2019).

The *Tanoa* impression of *taucoko ni qaravi tavi* signifies the completeness of tasks (Meo-Sewabu, 2015). The relationship of the *taucoko ni qaravi tavi* in an *iTaukei* nursing viewpoint means applying a holistic approach to caring. The holistic nursing approach to patient care has been a defining attribute of nursing practice and has become more prominent over time (Kinchen, 2015).

The third concept of the *Tanoa* model, *na veiwekani,* implies maintaining harmony within relationships and family (Meo-Sewabu, 2015). Caring is based on relationships, and nurses establish a professional and ethical stance in doing their work (Rørtveit et al., 2015). *iTaukei* nurses have a special relationship with their patients, and this involves identifying patients through their traditional tribal connections. When *iTaukei* talk about *veiwekani*, it has social inferences.

The fourth concept of the *Tanoa* model is the *kena irairai*, which denotes physical appearance (Meo-Sewabu, 2015). Physical appearance in the *iTaukei* perspective often relates to the overall outward look of a person, including dressing style. In addition, physical appearance reflects emotions that establish how *iTaukei* carry themselves and is often subjected to concerns when people do not gain weight (Becker, 2004). The concept of physical appearance is related to lookism. Lookism was a predominant factor that affected the nursing recruitment of indigenous girls in Fiji during the early days (Anderson, 1902).

The fifth criterion of the *Tanoa* model of health is *bula vaka yalo,* meaning spirituality, and is displayed as an outward reflection of happiness (Meo-Sewabu, 2015). *Bula vakayalo* is determined by how well the four struts of the *tanoa (dauveiqaravi, taucoko ni qaravi tavi, veiwekani, and kena irairai)* are maintained to reflect the carer's ability to perform prescribed tasks and leads to an outward reflection showing faith and happiness (Meo-Sewabu, 2015). The *iTaukei* concept of spirituality has a broad viewpoint from the religious perspective to that of emotional intelligence. From a nursing perspective, nurses are expected to display emotional intelligence. Nurses must also be aware of patients' spiritual beliefs and needs, which directs their treatment wishes and connects to their vision of the nursing care they want to receive.

The *Valenibula* Model

Vudiniabola's (2011) *Valenibula* model theorises *iTaukei* health and wellbeing practices and offers essential frameworks in the care of an *iTaukei* patient. *Valenibula* in the *iTaukei* definition consists of three words - "*Vale ni bula*"—meaning house (*vale*) of (*ni*) health (*bula*) where activities of the restoration of good health occur. It is, therefore, noted that patients would have improved health status after medical treatment at the health-care facility. *Valenibula* is now the positively worded connotation from the previous label "*valenimate*", which means "house of death". The *Valenibula* in the *iTaukei* context signifies the hospital, where only the very sick patients are admitted and assisted. The lower level of care provision is the *valeniwai,* which refers to the health centres and nursing stations in Fiji that became a referring centre for people that needed further health-care management.

The *Valenibula* model realises the relationship between nurses and patients in an *iTaukei* community context (Vudiniabola, 2011). The *Valenibula* model directs the analysis and evaluation of an individual's health, family, and community. The *Valenibula* model has four components—*bou, yavu, duru,* and *lalaga* that are interrelated and interdependent—and references the *Whare Tapa Wha* Māori model for health. The four elements are responsible for maintaining order and avoiding the breakdown of standard functions, which means fulfilling personal, family, and community obligations (Vudiniabola, 2011).

The *bou* is the central beam that signifies identity, viewed as the principal concept in the wellbeing of the indigenous person (Vudiniabola, 2011). The *bou* is a tall post in a house on which the ridge pole rests. The *Valenibula* model identifies the *bou* as a critical component of the *vale* (house) as it signifies spiritual health or God's presence. The ridge pole links spirituality to traditional relationships with people (*vanua)* (Vudiniabola, 2011). Spirituality is an essential component of an *iTaukei* person's life as it connects to one's emotional wellbeing.

The *yavu* is the raised earth or the foundation of the *vale*. It is a raised flat mound of earth and is usually thirty centimetres in height. Round stones are used to edge and maintain the *yavu* carefully, arranged so that they can withstand the environment. The *yavu* has names that are often associated with familial events known to the owners, and their connotations vary (Arno, 1993). The *yavu* is a significant part of the *vale* and the *iTaukei* representation of a good foundation associated with behaviours, morals, and values (Vudiniabola, 2011). An important concept that depicts typical behaviour among the *iTaukei* people is being *vakaturaga*. The *vakaturaga* concept exemplifies loyalty, honesty, compliance, humility, respect, and deference while relating to others (Ravuvu, 1987).

The *duru* refers to the short posts of the house on which the wall plates rest. The *Valenibula* model has four posts that support the four corners of the house. The posts signify the four viewpoints of health for the *iTaukei* - the *physical, spiritual, mental, and socioeconomic* facets of living (Vudiniabola, 2011). The four features of wellbeing signify the "identity" of an *iTaukei*, one that is well pronounced and is inflexibly grounded in the *vanua* and with God. The four aspects of indigenous health define the roles, responsibilities, and obligations of an indigenous person to their *vanua* and God (Vudiniabola, 2011). An *iTaukei* is "sick" when they fail to carry out roles and responsibilities (Nabobo-Baba, 2006b). This belief system has been the cause of further strained relationships as the "blame game" for being sick is socially constructed amongst *iTaukei*.

The *lalaga,* which refers to the walls of the house, signifies the warmth, belongingness, obligations, and relationships that must be maintained and strengthened during the lifespan. The *lalaga* protects the person in the vale (house) from outside physical and spiritual influences (Vudiniabola, 2011). The *iTaukei* are known for their accommodative behaviour. It is proper for an *iTaukei* to share the grief of others and care for deprived or despised individuals or families. An essential element of the *iTaukei* value system is to know and recognise all people, including visitors. The *Valenibula* wellness concept is similar to the Samoan *Fonofale* and Māori *Te Whare Tapa Wha* health models, which identify health structures that may assist the nurse-patient relationship.

Strengths and Weaknesses of the Two *iTaukei* Models

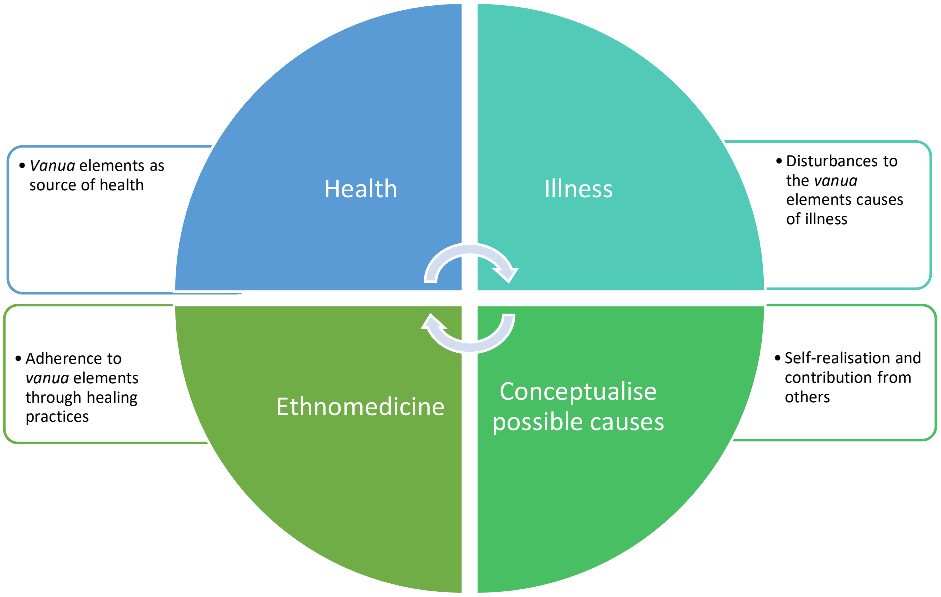
The *Tanoa* and *Valenibula* models have set the platform that orientates factors that affect the health behaviours of an *iTaukei*; both models discuss the expected behaviours of *iTaukei* people concerning their values according to the *vanua* in terms of health. Both models used *vanua* theory and the social and spiritual components, and how people's health is affected by their relationships within the *vanua*. Relating to how the two *iTaukei* models view illness, both models looked at health from a general assumption of ill-health. However, the *Tanoa* model refers explicitly to *iTaukei* women constructs of health.

The* Vanua *Health and Illness Model

My research adds to understandings of *iTaukei* health behaviour as noted in the *Tanoa* and *Valenibula* models of *iTaukei* health, including the three elements of the *vanua* (physical, cultural, and social). However, I look to focus specifically on patient care of *iTaukei* living with diabetes and associated conditions. Twenty *iTaukei* cultural values seen in Figure 5 have been identified and aligned with the *vanua* elements, orientating an *iTaukei* meaning of health and wellness in indigenous communities. I developed a *vanua* health model (see Figure 6) to inform how nursing care is affected by concepts of the *vanua* and what *iTaukei* patients expect health-care delivery to be.

Figure 6

The Vanua *Health Model*



***Vanua* elements as sources of good health**

The *vanua* health and illness model identifies a new causation pathway for chronic conditions for *iTaukei*. When people cannot afford treatment or even when they can, most *iTaukei* seek explanations for possible causes of what lays ahead of them (Orcherton, 2017). As mentioned above, part of the search for causation factors includes looking for relationships that need to be made right. As included in the *lalaga* of the *Valenibula* model, which maintains the "warmth" of the relationships, people search for the loss of warmth and try to reconnect their way back to the *vanua*.

At the beginning of Chapter Four, the opening quote stated there are herbal therapies available to cure diseases or to maintain balance within the body. From the *Tanoa* constructs of health, and as discussed in Chapter Four, the *vanua*, in all its components of people, land, seas, forests, mountains, and rivers, are assumed to have special healing powers, which is ethnomedicine for the *iTaukei*. As such, an *iTaukei* person refers to ethnomedicine when confronted with illness matters. It includes the three elements of the *vanua* - the physical, social, and cultural, in the forms of herbal therapies, massage, seeking traditional apologies, drinking and dipping in miracle water, *sili waitui* (dip in the sea), prayers, and many others. As mentioned in both the *Tanoa* and *Valenibula* models, a new form of healing has surfaced, which is spiritual healing to cast away spiritual forces as part of the social element. These elements are further strengthened when *iTaukei* identify themselves with their cultural values that enable a holistic approach to community wellness.

Disturbances to the *vanua* elements cause ill-health

As mentioned in Chapter Four, the *vanua* has eyes and teeth that watch to ensure all is well within the *vanua* and "bite" those that do not adhere to its protocols. The commonly shared *iTaukei* idiom "*Sega ni ura me sa tei damu*" translates to "no prawn just turns red (unless someone has cooked it)", meaning that there must be a cause for something to happen (Veramu, 2018). In illness, it means that there is a cause for such happenings, and it will take time to become totally known. Such concepts allow people to realise their mistakes and make right with the *vanua* before illnesses become fully advanced. This confirms that *iTaukei* value their relationship with the *vanua*, which has health-related implications.

Self-realisation and contribution from others

As stated in Chapter Four, *iTaukei* approaches to illness set them apart from people of other ethnic backgrounds living in Fiji. For example, and as mentioned previously, in instances where relationships with the *vanua* are suspected to be a causative factor to their illness, individuals will find ways to correct occurrences of diseases related to the *vanua*. Also, as part of the *iTaukei* value of *veikauwaitaki*, others close to the sick person will help investigate possible causes of ill-health and ensure proper protocols are followed to restore good health (Orcherton, 2017).

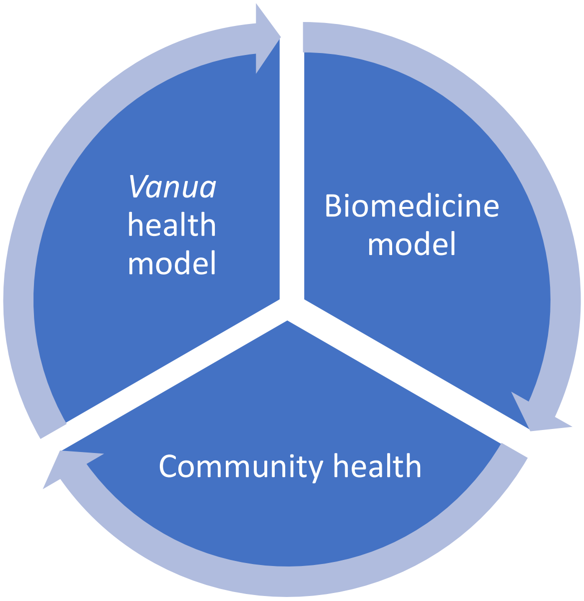
Adherence to *vanua* elements through healing practices

The restorative process of correcting disturbances to the *vanua* is mostly a communal engagement that involves the traditional presentation of goods as reparation for breaking such protocols. This means that relatives must accompany the sick person to perform the *isoro* to the *vanua* that is assumed to have been disturbed. The restoration of good health is within the *vanua* itself, where healing practices are available from forests, rivers, mountains, seas, land, and people (Chand et al., 2018).

The *vanua* illness model relates an *iTaukei* person to a holistic approach to wellness. After exploring the *vanua* healing processes and if symptoms persist, biomedicine is approached, even though some use both systems simultaneously. Figure 6 shows the influences of the *vanua* and biomedicine on community health.

Figure 7

Vanua *and Biomedicine Influence on Community Health*



Vanua health model and community health

The *vanua* health component of the model in Figure 7 shows how the *vanua* support biomedicine in providing healthcare support to people in Fijian communities. During the initial development stages of any government-operated service in Fiji, including health-care facilities, consent is first sought from the *vanua* for facility location. Usually, the *vanua* participates in the official opening of such facilities, which are often celebrated with traditional *iTaukei* protocols, and traditional and spiritual blessings are sought through proper cultural conventions (Fiji Government, 2018a).

In Fiji, support by the head of *vanua* (chief) and its people, and the support of the *Roko Tui* (provincial administrator) through the *Mata ni tikina* (*tikina* representative), *turaga ni koro* (village headman), and *Nasi ni koro* (village health worker) establishes the success of any community health-care facility (Yoon et al., 2019). In this way, the *vanua* traditional relationship with health-care professionals is maintained. Furthermore, the adoption of health-care professionals as members of the chiefly

Mataqali (land-owning unit) enables the chiefly family to take the lead role in health matters.

Biomedicine model and community health

The biomedicine component of the model in Figure 7 above shows how biomedicine, which has the support of the *vanua,* provides health-care support to people in Fijian communities. Generally, biomedicine focuses on the education and training of health-care professionals by ensuring an appropriate curriculum best fits people's health-care needs (Thibault, 2020). Such programmes also include the upgrade of professional qualifications on emerging disease trends and complications, like diabetes. In Fiji, the biomedicine model also uses its association to form a multisectoral approach to coordinate with other government ministries to build and upgrade health-care facilities. Also, the biomedical model of care is responsible for supplying health-care resources to support its facilities. Another critical role of the biomedical model of care is drawing up, implementing, and monitoring health-care policies and promoting health-care research to improve practice.

Chapter Conclusion

The *vanua* and its components are significant for the *iTaukei* people (Nabobo-Baba, 2006). The *iTaukei* ethos is focused on the continuity of life and preservation of the *vanua* through regeneration and unity (Kaplama, 2016; Ravuvu, 1987). One of the critical instruments in upholding the values of the *vanua* is how people get together to promote harmony within their community, which is inclusive of the general concepts of health and wellness. The *vanua* theory is concerned with how the *iTaukei* uphold its three elements - the physical, cultural, and social. The interrelatedness of the three elements of the *vanua* birthed the concepts of caring, which is part of *iTaukei* people’s orientation and lived experiences. The twenty similar but unique caring concepts are essential to the sick person and those caring for them. The sharing and caring concepts are significant determinants in decisions an *iTaukei* person makes when requiring healthcare.

Understanding the *vanua*, its elements, and the concepts of caring enable understanding how health researchers apply the Fijian *Vanua* research framework in an indigenous Fijian setting. Pacific people share commonness in communal land ownership and mythology, which narrates the land, occupation, and values. Health researchers and experts have developed models to include the cultural component in health-care delivery to the Pacific people. These models all point to the importance of focusing on interventions and Pacific understandings of concepts, such as spirituality, familial and community responsibilities, and intergenerational "ethnical" ideas of caring. Each health model applies the same main principle of valuing relationships from a cultural perspective, which is firmly grounded in their cosmology. All the models highlight the relationship, where harmony creates happiness that enables good health. Their commonness in worship, forming relationships, and fellowship provides the theoretical lenses that shape the understanding of participants' *talanoa* and the rationale for their health-seeking behaviours and decisions regarding the care they want to receive.

The *Vanua* health and illness model, which has four parts, affirm how *iTaukei* view the *vanua* elements as a source of health and illnesses that allows a person to amend the offence they caused to the *vanua*. Perhaps it is not correct to assume that the *Vanua* health model in its valued beliefs and practices discourages biomedicine, but it is used as a restorative and balancing approach to living holistically. This is presented in how the *vanua* relate to biomedicine to improve community health in Fiji.

Chapter Six: Method

Chapter Five introduced the *Vanua* theory and its components, which relates to the inclusiveness of traditional cultural protocols that must be understood and practised. This implies that for any process to happen within the *vanua,* there must be alignment to prescribed rules. Such rules involve how research, including health research, must be conducted within an *iTaukei* traditional and cultural setting. The *Vanua* theory encompasses *iTaukei* ontology and a worldview that determines knowledge, philosophies, and knowledge relations in research (Nabobo-Baba, 2008). The Fijian *Vanua* Research (FVR) has aided in navigating the theoretical terrain of many indigenous Fijian studies. My research has also adopted this research framework to help guide the method. In doing so, the *vanua* has been utilised as a theoretical lens when researching and analysing in-depth discussions held with nurses and patients regarding their description of ideal nursing care for people living with diabetes and associated conditions. I now outline the methods used when conducting this research.

My research used *iTaukei* patients' and nurses' experiences to explore the ideal nursing care that patients living with diabetes hope to receive, and the nurses who care for them want to deliver. I used *veitalanoa*[61] as a data collection method with participants within an indigenous research paradigm. Due to the nature of this study, it was important for me to make sure the methods of data collection were relevant to the context, and to gain a deep understanding would require more than one approach to acquire information. As such, the research embraced more than one data collection strategy, which also fits well with the concept of triangulation. Data collection as applied is deemed closest to the Western equivalent of a focus group discussion (Chilisa, 2012) and, in collecting data through storytelling, this aligns with narrative research (Kovach, 2010).

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[61] *Veitalanoa* – a formal account of *Talanoa,* a conversational method. *Veitalanoa* is used as a data collection strategy in this research and discussed in Stage 4 of the Fijian Vanua Research.

The participants were familiar with the *veitalanoa* method as the oral tradition is considered a source of knowledge for the *iTaukei* (Tuwere, 2002). These *veitalanoa* sessions provided the perfect opportunity for participants to discuss relevant conversational topics, making it possible to identify the data themes and subthemes. To fully understand and put in context participants' responses, researchers must address the need to engage with indigenous ontologies and epistemologies within an indigenous setting (Martin & Mirraboopa, 2003; Sommerville & Turner, 2020).

Ethical Approvals

I received full ethical approval to conduct the study from the Massey University Human Ethics Committee and the Fiji National Health Research and Ethics Committee. I also obtained authority to do village visits from the Ministry of *iTaukei* Affairs (see Appendix One). I observed the eight principles of the Fijian *Vanua* Research, the nine village and *vanua* protocols, and other requirements from the Ministry of *iTaukei* Affairs during the entire data collection period. Most of the requirements of the Pacific research guidelines and protocols (Meo-Sewabu et al., 2017) were included. The conditions ensured participation was safeguarded in the best interests of the *iTaukei* people through observing the indigenous cultural protocol of entry.

The Fijian *Vanua* Research (FVR) Design and Framework

The FVR design represents *iTaukei* participants' worldviews, decolonises the framings of Western research methodologies and methods, and rearranges its processes to ensure the cultural appropriateness of its approach while collecting data within an *iTaukei* community (Nabobo-Baba, 2008). Over the years, indigenous, transformative, liberation, feminist, and critical methodologies have sought to strengthen the decolonising process (Barnes, 2018).

The FVR, a descriptive qualitative approach by Nabobo-Baba, was developed from similar principles used by the Tongan *Kakala* and borrowed from critical theory and Kaupapa Māori theory to illustrate a decolonised indigenous Fijian methodology (Sanga & Reynolds, 2017). I used the *veitalanoa* methodology - a conversational method - to gather data and conduct the analysis.

Qualitative research is about meaning and meaning-making and viewing research as context-bound, positioned, and situated (Braun & Clarke, 2014) that fits into narrative practice (Holstein & Gubrium, 2020). Narratives allow new meanings and diverse ways of knowing to emerge and, when used in indigenous settings, pays due respect to indigenous knowledge (Hamdan, 2009). Qualitative researchers are committed to discovery using multiple ways of understanding a particular phenomenon to answer the research question (Speziale et al., 2011). One of the unique attributes of qualitative research is the flexibility of design (Roller & Lavrakas, 2015). Indigenous methods flow from tribal knowledge, so having some underpinning cultural values makes them different and distinctive (Kovach, 2010).

There are specific protocols to follow before conducting research within an indigenous Fijian setting (Nabobo-Baba, 2008). A detailed explanation of how I conducted the research is offered later in this chapter – in the data gathering and validating section. The *Vanua* research framework has inspired many researchers (Sanga & Reynolds, 2017); however, few have used the FVR as a research design to inform methods and analysis. My research uses *Vanua* research as an indigenous *iTaukei* research design, advising its methodology and designing its analysis. The approach to use the *Vanua* as a research design decolonises the academy in many ways (U. Nabobo-Baba, personal communication, September 9, 2018) as outlined in the Fijian *Vanua* Research process.

Conducting research in the **vanua**

People researching in the *vanua* must follow specific protocols and procedures and use the appropriate cultural framing (U. Nabobo-Baba, personal communication, September 9, 2018). The Fijian *Vanua* Research (FVR) guards the interest of the *iTaukei* in a traditional *iTaukei* context and has eight principles that guide the conduct of research in an indigenous setting (U. Nabobo-Baba, personal communication, September 9, 2018). There were close similarities between the eight principles of the FVR comparative to the village research and visitation requirements as outlined by the Ministry of *iTaukei* Affairs (see Appendix One).

The FVR principles

1) Research on indigenous Fijians needs to benefit people, especially the researched community.

2) Research should focus on indigenous peoples' needs and must take into account indigenous cultural values, protocols, knowledge processes, and philosophies, especially those related to knowledge access, legitimation, procedures of ethics, indigenous Fijian sanctions, and clan limits or boundaries, all of which influence knowledge and related issues.

3) Researcher fluency in the Fijian language and/or dialect of the researched community is fundamental. This recognises the importance of language in understanding, critiquing, and verifying indigenous concepts and documenting aspects of their lives appropriately.

4) In team research situations, indigenous persons must be the principal researcher(s).

5) Respect and reciprocity: researchers need to acknowledge and affirm existing elders and *vanua* structures and protocols. In terms of reciprocity, researchers must

show appreciation to the people for their love, support, time, resources, and their freely given knowledge. Fijian gifting is appropriate here.

6) Researchers need to ensure as much as possible that local people in the research setting are coopted as members of the research team.

7) Researchers need to build accountability into their research procedures through meaningful reporting and meaningful feedback to the relevant people and community.

8) *Vanua* chiefs, as well as village chiefs and elders at all levels, must give permission to all researches conducted in the *vanua*.

Language used during data collection

Language considerations are fundamental to research processes, and participants' dialectal choices must be respected (Redman-MacLaren et al., 2019). The patient participants conversed in their provincial dialects and the common *iTaukei* (*Bau*) language in this research. In some instances, the patient participants communicated using cross-language, alternating between their provincial, common *iTaukei* and the English language. Cross-language is pertinent in partnership with indigenous people to retain data meanings (Redman-MacLaren et al., 2019). The data collected from the nurse participants were in the English language.

I discussed the analytic approach with two of my key informants. I was informed that to enable a powerful impact on improving nursing care for people living with diabetes in Fiji and the cultural safety of the research environment, having people speak in their language and then translating their responses to English was deemed the best. Despite English being the language of communication in Fiji and many other vernacular uses being prohibited in parliament, *iTaukei* people still communicate in their traditional dialect. Through advisements, I learnt that good and to-the-point translation was important. For language clarity, the recorder playback sessions helped the translation and captured the true meaning of the data, hence retaining its nuances.

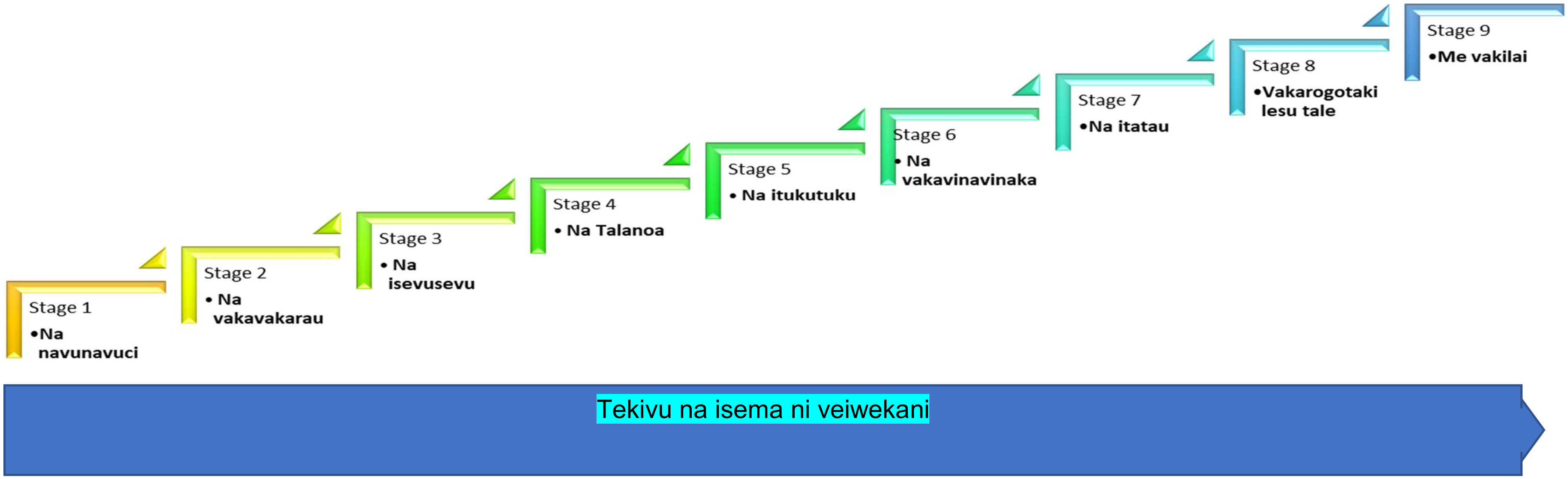
Since most patient participants communicated in their provincial dialect, an identifier for an indigenous person, I noted the possibility of limitations in their anonymity. In addition, identifying patient participants can stigmatise the type of nursing care that patient participants receive, which could possibly affect their care. For this reason, I presented the data in the English language except for some data excerpts presented in the common indigenous Fijian (*Bau*) dialect.

The Fijian* Vanua *Research Process

This section describes the method used in this research. Researchers like Stewart-Withers et al. (2017) have used the FVR, which consists of nine stages as shown in Figure 8. The result, *Tekivu na isema ni veiwekani*, which is the formation of a lifelong connection, entrenches itself from the first stage, *Na navunavuci*, during the birthing of ideas to conduct the research. The embedment illustrates the importance of relationships in an *iTaukei* research environment. Within such an indigenous paradigm, research is a ceremony that connects relationships (Chilisa, 2020; Wilson, 2001).

Figure 8

Steps of the Fijian Vanua *Research*



Note: This information was adapted from Nabobo-Baba (2008) p. 146-148.

Stage 1: *Na navunavuci* (The Conception)

The first stage of the *Vanua* research included contemplating my study topic and reviewing what I was to expect. As such, I adjusted my research topic to reflect nursing care, which remains a passion despite my not practising for more than five years. I planned the research direction, the aims, and the objectives and set the thesis timeframe. I planned the entry, both the *iTaukei* and the Ministry of Health protocols of access and its processes to ensure coverage of all cultural and ethical considerations. I considered the main discussion questions, which stemmed from the primary research questions that guided the study and how they were presented and translated to avoid any misunderstanding. I read through some case study literature and was open to other designs, both methodological and exemplary, to gain an understanding of the research design that best fit this study. I engaged in discussions relating to the *Talanoa* method and reviewed research articles that employed the FVR as a research design and *Talanoa* as a methodology and strategy. I concluded the *veitalanoa* method would best fit my research.

I planned the sample size and the recruitment processes and considered selecting participants that best represented the study population. I identified the case boundaries and geographical location, and years of experiences from both types of participants (see Tables 3 & 4). I mapped some possible problems, adverse events, space issues, and personnel matters and labelled them as vital signs of things that were likely to obstruct the conduct of the study. I developed alternate plans as responses should they occur.

I plotted the investigation process, reconsidering issues to the already identified structure of the research. I started anticipating the participants' responses, and my positionality of being an insider helped. I began drawing sketches of what the report might look like but was still open to many “yet to know” concepts of the multiple realities in the participants' stories. I mapped out the finer details to ensure the research flowed as planned. I sketched plans for recording, transcribing, translating, and disseminating results, allocating attention to different viewpoints and possibilities.

Stage 2: *Na vakavakarau* (Preparation and Planning)

With respect to preparation and planning, I developed a research budget that included gifting my participants and noted the special *iTaukei* cultural protocol of engaging with a sick *iTaukei* person. The budget included the participants' meals since the timings of the *veitalanoa* sessions were to happen during at least one full meal and one snack meal period, for I was engaging with people living with diabetes and who were on treatment and need to eat regularly. Also, the budget included the cultural protocol requirements of presenting the *isevusevu* to every *vanua* identified as connected with the research venue.

In an *iTaukei* community, the host must be informed in advance of the time to meet. It is a tradition to present the *isevusevu* when visiting for the first time. The *isevusevu* is the ceremonial offering of *kava* (Piper methysticum) and paired by a formal speech by the guest to the host or vice versa and conducted in respect of recognition and acceptance of another (Ravuvu, 1983). It is custom and correct to be accompanied by other persons to perform the *isevusevu* (Nabobo-Baba, 2006b). The *isevusevu* (often presented by a male) begins with the presenter clapping his hands together to seek the attention of those who are present. The speech must state the reason for the presentation based on *iTaukei* cultural practice (Nabobo-Baba, 2006b). Part of the speech will include thanking the host for their acceptance and seeking forgiveness for possible breaches of custom and protocol should this occur during the visit.

The presentation of the *isevusevu* is, in essence, the base of the *vakaturaga* (set of customary values linked to caring) ethos and is used in all *iTaukei* lifespan activities. During the *isevusevu*, the visitor sits by the door upon entry and awaits instructions to move further inside the house. The recipient of the *isevusevu* (host - mainly the chief or the head of the household) usually is seated on the upper level of the sitting area while the visitors have the lower end. The *isevusevu* itself acts as security, protecting the visitor. Not presenting the *isevusevu* can perpetuate a breakdown in values, and, for the Fijian context, this affects the *vakaturaga* ethos. It is also noteworthy to realise that culture is not static, and it is appropriate to check first whether participants practise *isevusevu* as some do not due to religious beliefs (Nabobo-Baba, 2006b). Subsequently, after *isevusevu* and, if accepted by the host, the visitor gains entry rights and receives hospitality privileges. Visitors are often directed to the highest place in the house and summoned further inward, away from the door.

It is customary for visitors to introduce themselves to the hosts and, generally, after the *isevusevu* while sharing food and drinks. Conversations will somehow try to identify connections between the visitor and the host. For the *iTaukei* visitor, this process recognises traditional associations and can take up to two or more hours. It is usual practice for *iTaukei* to talk about who they are in a contextual manner that includes fish and plant totems, the meaning of their names, the title of their houses, and genetic information (Nabobo-Baba, 2006b). Establishing traditional connections is an essential step that secures the researcher’s place and links to the participant’s home.

The ethical approval (See Appendix 1) from Massey University and approval notes from the Fijian Ministry of Health and the health facility were the primary documents that were most important in the process. In terms of organisational approval processes, having gained full ethics approval via the Massey University Human Ethics Committee, I also sought permission from the provincial offices through the Ministry of *iTaukei* Affairs and received full support for village field research and visits. The Provincial Administrators were informed of the data collection strategies for the patient-participants. I also received much-needed and timely assistance from the New Zealand Ministry of Foreign Affairs and Trade [MFAT] research grant that facilitated half of my research expenses.

I made appointments with and met potential key informants during the preliminary visit and drew the initial plan of action, including my role. The Fijian Chief Nurse and Midwifery Officer [CNMO] were informed of the fieldwork process. Discussions included the communication protocols, persons to contact, and email correspondence regarding the research. I communicated with two divisional Directors of Nursing [DONs] to discuss the research process and confirmed the research sites and potential participants. The subdivisional nursing managers and the medical officers confirmed the research venues, dates, and times. The nurses took time to respond to the flyers, which were up on health facility noticeboards. I reorganised the data collection timetable around participants' characteristics and interferences that might happen in the field, like family, village, and community events, to ensure participants' availability.

I arranged preliminary access to the research sites, negotiated plans of action, and organised regular access with help from the DON West and Central divisions. I presented the ethical underpinnings of the research and entered into a formal agreement as to the researcher (self) and the Ministry of Health (host). The Ministry of Health required a full research report for validation purposes before the publication of results. I discussed the participant recruitment processes and suitable venues and periods for data collection. Also, I refined access rules for participants on issues of anonymity and the patients' general wellbeing. I negotiated with the Directors of Nursing for suitable timing and data collection venues to organise the nurse participants' *veitalanoa* group sessions. I received names and contacts of the key people to liaise with at the four research areas. I discussed the data collection technique that led to revision and documentation of the plan of action, roles, boundaries, and issues.

My absence from the village warranted a presentation of my *isevusevu* to announce my arrival and present my *boka* (presentation of goods) to make up for the missed village activities. The performance of the *isevusevu* and *boka* was presented to an uncle (my father's elder brother), who was interested in discussing my studies.

The Ministry of *iTaukei* Affairs approval served as a pass to engage with the Provincial Administrators and officers. Through email exchanges, I organised meeting dates, times, and venues. I met two Provincial Administrators and their teams at the corresponding provincial offices. Received openly, I presented the traditional protocol of entry through the *isevusevu* and had fruitful discussions regarding village visits. I was reminded of the requirement to report results upon completion.

Key Informant Interviews

In the search for an appropriate method and strategy to collect information from *iTaukei* in Fiji, I realised the need to discuss my research approach with the Fijian *Vanua* Research Framework author, Professor Unaisi Nabobo-Baba. Professor Nabobo-Baba helped sort some complexities in the data collection approach and discussed the importance of using the *Vanua* research method with the appropriate cultural framing:

> We must use the *talanoa* methodology with the appropriate cultural framing. The *vanua* research framing allows the researcher to do the proper entry within an indigenous paradigm like the Kaupapa Māori. So, not only is proper entry important, the indigenous insider researcher has to negotiate multiple entries, and, as it is, it is the accountability of the researcher that is sometimes harder or higher because these are our people and because we cannot afford to do the glitches that other people do. In the indigenous *Vanua* Research Framework, *talanoa* is the methodology; the framing is the *vanua* research. Our people expect us to understand our protocols … that concerns asking for information … where knowledge is a gift.
>
> With indigenous Fijians, they are very good at safeguarding their information on what they want to say. If they don't like you already, they just edit everything they say in so many ways, and this leads to

> Fijian silences - the taxonomy of silences. One of its categories suggests that people are happy they are talking; however, they can also be treated into silences, but there is no difficulty if protocols are followed properly. It is framed within the *Vanua* framework and the *Vanua* postcolonial radical paradigm, also with the poststructural paradigm because with indigeneity, frameworks are very poststructural as we are contesting the established structure of knowledge acquisition within the University level. We are saying yes, we have ethnography, but we also have our ways. As an ethnographer, in this case, we will go and access the knowledge we want through our protocols … and that begins with the *isevusevu*, or with a cup of tea, or it begins with respectful asking. We don't use the 'I' (interview) or 'Q' (question) word. While testing this in the field, … found that people very quickly become suspicious that you are interrogating them. It is not very helpful … the very important aspect of the 'T' (*talanoa*) word is you're seeking their help so you can gain some knowledge … it must be put in that way, asking people for help to gain some knowledge. (U. Nabobo-Baba, personal communication, September 9, 2018).

The discussion with Professor Nabobo-Baba confirmed the study design and the appropriateness of ensuring the proper framing of the research. I mapped the research design and recruitment, selection, and sample protocols, which are discussed below.

Recruitment, Selection, and Sample

Participants were recruited from their responses to the flyers (see Appendix 4) that were posted on MOH noticeboards, emailed, and hand-delivered to health centres and hospitals from the chosen medical areas. There are four divisions within the MOH in Fiji, namely the Central, Eastern, Northern, and Western. I recruited participants from the Central, Eastern, and Western divisions. The nurse unit managers and the

Directors of Nursing assisted in the recruitment and selection processes by ensuring participants met the selection criteria (Appendix 5). The participants voluntarily participated in the research.

Table 2

Summary of Data Collection Strategy

Participant type	Location	Data Collection strategies
Nurses	Central & Eastern Health Services	*Veitalanoa* group
Nurses	Central Health Services	*Veitalanoa* one to one
Nurses	Central Health Services	Field observations
Nurses	Western Health Services	*Veitalanoa* group
Nurses	Western Health Services	*Veitalanoa* one to one
Patients – Male	Western Health Services	*Veitalanoa* group
Patients – Male	Western Health Services	*Veitalanoa* one to one
Patients – Male	Western Health Services	Field observations
Patients – Female	Western Health Services	*Veitalanoa* group
Patients – Female	Western Health Services	*Veitalanoa* one to one
Patients – Female	Western Health Services	Field observations

The participant recruitment process ensured representation from the medical area. The selection method safeguarded participants' culture. They partook in a sex-specific *veitalanoa* group as it is culturally inappropriate for an *iTaukei* to discuss personal health issues in the presence of others, in particular to people of the opposite sex (see Table 2). The recruitment captured twelve patient participants and eleven nurse participants. I used several specific characteristics to recruit participants. The patient participants had been living with diabetes and accessing medical services in Fiji regarding their illness for more than three years. The nurses had more than three years of nursing experience with people living with diabetes. All participants were *iTaukei* adults who are responsible for providing individual consent.

Table 3

Summary of Nurse Participants' Details

Participant	Years of experience in nursing diabetic patients
Pita	More than five years
Rosi	More than five years
Litia	More than five years
Loma	More than ten years
Lisi	More than ten years
Ana	More than twenty years
Vika	More than twenty years
Vere	More than ten years
Nunia	More than ten years
Selai	More than five years
Lusi	More than five years

Table 4

Summary of Patient Participants' Details

Participant	**Years of experience in accessing healthcare services due to diabetes**	**Type of experience** *Surgery, wound dressing, clinic*
Jone	More than ten years	*Surgery, wound dressing, clinic*
Laisa	More than ten years	*Surgery, wound dressing, clinic*
Jese	More than ten years	*Surgery, wound dressing, clinic*
Jale	More than five years	*Surgery, wound dressing, clinic*
Juta	More than five years	*Surgery, wound dressing, clinic*
Peci	More than five years	Clinic only—attends the dual clinic[62]
Jope	More than five years	*Surgery, wound dressing, clinic*
Jeke	More than five years	*Surgery, wound dressing, clinic*
Mere	More than five years	Clinic only—attends the dual clinic
Leba	More than five years	Clinic only—attends the dual clinic
Kesa	More than three years	Clinic only—attends the dual clinic
Sera	More than three years	Clinic only

Stage 3: *Na icurucuru* (Entry)

I presented my *isevusevu* to the *Vanua*, which is the research area, through the provincial administrators. The *isevusevu* confirms the relationship between the researcher and the researched and marks the beginning of a new relationship that has no end. Through rapport, love, and trust, the *isevusevu* milieu creates warmth where people communicate freely (Vaka et al., 2016). However, for the *iTaukei*, the freedom

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[62] Dual clinic – clinic follow up for patients who have diabetes and hypertension

to freely speak depends on many factors. For example, I approached the head of one subdivisional medical area to introduce myself in person as we had e-meetings while organising the research logistics. I discussed my research intent and the processes, including the research design. The approval from the Ministry of Health served as evidence of support to conduct the research.

The *veitalanoa* session for male patient-participants happened at the conference room of one of the subdivisional hospitals. The *veitalanoa* session for female patient-participants occurred in a village setting. I arrived at the village two days before the data collection day and presented my *isevusevu*, formally announced my research, and negotiated my entry to the village chief. The presentation of a separate *isevusevu* happened before the conduct of the *veitalanoa* group in support of research participants and their relatives who were not from the host village. The female patient-participants travelled from neighbouring communities to the *veitalanoa* group venue. I drew an emergency protocol with the charge nurses of the two subdivisional hospitals should patient-participants need to use them during data collection for both *veitalanoa* group venues. I arranged stand-by transport for the female patient-participants.

Agreement

Despite their familiarity with the Western ethical conventions of signing papers, the patient participants hesitated when asked to sign the consent forms (Appendix 2). A female participant asked another younger participant to sign for her. Jese spoke on behalf of the male patient participants and said:

> *… we have already consented, our presence here today shows our willingness to participate in the discussions, so do not worry, we are happy you are here to listen to what we have been through in the hope that it will change how we are served. We do not need to be signing papers.*

Such comments challenged my role as a researcher, having been immersed in both worlds and needing to suspend any prejudgements about the ethical protocol of obtaining written consent versus verbal consent. Researchers need to respect participants' perspectives of consent (Rivera et al., 2007).

Data Gathering and Validating Strategies

Indigenous researchers worldwide have used their cultural ways to gather information about their context through strategies, such as storytelling, yarning, and remembering. For example, Nabobo-Baba (2006a) used *talanoa* in her indigenous Fijian research about her maternal links. Kovach (2010) referred to *talanoa* as the conversational method. For this research, I provided a way forward to use *talanoa* in a formal and interactive setup. I noted that it was not appropriate to inform participants that they were to engage in a simple data collection method. Therefore, I replaced "*talanoataka"* with "*veitalanoataka*", which means engaging in a formal discussion. Details of *veitalanoa* as a solemn approach to the *talanoa* method appear later in the fourth stage of the Fijian *Vanua* Research.

My research engaged three data collection strategies - *veitalanoa* group, *veitalanoa* one to one, and field observations (see Table 2). The group and one-to-one *veitalanoa* were digitally audio-recorded with permission. An audio recorder is not culturally friendly as participants were anxiously aware that they were being recorded. Overcoming their uneasiness was necessary, and the proper layout of an introduction indicated that they would listen to a playback and determine omissions to their input.

I now discuss the fourth stage of the FVR - the definitions and comparison of the general *talanoa* to the adopted *veitalanoa* as a method of data collection. Next, I will discuss the data collection approaches: the *veitalanoa* group, the *veitalanoa* one to one, and my field observations with participants.

Stage 4: *Na veitalanoa* (Multilogue)

Veitalanoa is a method of collecting information and is derived from the concept of *talanoa*. *Talanoa* is an appropriate research ethnographic indigenous method in the Pacific (Farrelly & Nabobo-Baba, 2012; Meo-Sewabu & Koro, 2013; Otsuka, 2006; Stewart-Withers et al., 2017; Suaalii-Sauni & Fulu-Aiolupotea, 2014; Tunufa'i, 2016; Vaioleti, 2013; Vaka et al., 2016). *Talanoa* is a face-to-face conversation method between two or more people (Vudiniabola, 2011), and its uses vary from a casual discussion to more meaningful ones (Vaioleti, 2006). The *talanoa* method is usually a common oral tradition amongst Pacific Islanders.

Pacific people relate *talanoa* to subject matter consisting of phrases that include what they have, know, saw, or heard, drawing themselves to construct knowledge about discussion topics from their experiences and knowledge (Vaka et al., 2016). It is a way of discussing a topic or storytelling without boundaries (Kingi-Uluave & Olo-Whanga, 2010; Vaka et al., 2016). Storytelling is a common cultural practice across the Pacific that equates to the Western concept of therapeutic conversation (Kingi-Uluave & Olo-Whanga, 2010). The *talanoa* research methodology aims to bind values and is ethically considerate of the Pacific people's behaviours and secures a “methodological and operational space(s) in a Pacific research paradigm” (Sanga & Reynolds, 2017, p. 200).

Talanoa is defined as to chat and to tell stories and is a method of teaching for oral cultures. It is also a relational means of having mindful critical oratory (Tecun et al., 2018). Pacific people use *talanoa* to introduce and discuss health issues and solutions to complex health and social matters (Vaka et al., 2016). The word *tala* in Fijian has many meanings, depending on its pronunciation. While *tala* means to clear away, replant, transplant, and to load or unload, it also means to send, inform, or command. Vaioleti (2006) offers a similar definition of *tala*, meaning to inform, tell, relate, command, ask, or apply. The word *noa* means “yesterday” but is not used separately from *na* (Nainoca, 2011). In another translation, Tecun et al. (2018) define *noa* as equilibrium, which connects a gap in information.

Talanoa, in its more explicit meaning, is a culturally appropriate way of talking, including why, where, how, and with whom people are conversing, and it entirely depends on many factors. Some factors are social status, customs, rituals, language, personality, and profession of the convenor and participants (Vaka et al., 2016). Therefore, *talanoa* in this study relates to yesterday's experience - a reasonable way of a patient's experience of receiving health care. The outcome of *talanoa* depends heavily on its context and determines the effects of overly casual to solemn conversations. Talanoa symbolises respect and humility and ensures traditional cultural protocols are respected during the research (Stewart-Withers et al., 2017).

Usually, *talanoa* participants will sit and talk with no request for commitments, preconditions, or predetermined agendas, unless it is a *veitalanoa*, meaning something that needs solemn discussion (Meo-Sewabu et al., 2017). The *talanoa* method is a suitable communication mechanism where one listens to the other participant (Te Pou O Te Whakaaro Nui, 2010). *Talanoa* allows participants to participate how they wish to and feel comfortable, identify connections within the group, promote consensus around a topic, and uncover rich data (Vaka et al., 2016). *Talanoa* bridges the gap between a researcher and participants, which is one of the critical strengths of the method (Tunufa'i, 2016). The *talanoa* methodology offers the inclusion of the researcher in the research process (Nabobo-Baba, 2008). It also must be noted that *talanoa* involves sharing personal experiences and feelings; therefore, researchers might find it hard to access personal experiences and emotions (Farrelly & Nabobo-Baba, 2012).

In an *iTaukei* indigenous cultural context, *talanoa* can involve formal and informal conversations (Nabobo-Baba, 2006). In the Fijian research context, *talanoa* requires an in-depth cultural and emotional exchange between participants and researchers that consists of cultural protocols (Farrelly & Nabobo-Baba, 2012). Among indigenous

Fijians, *talanoa* is a casual conversation style involving two or more persons who share a common interest. A disadvantage of *talanoa* as a method for information gathering is its overly casual manner that researchers may face difficulties in exercising control over the narratives during research. *Talanoa* can be a one-way method of delivering information so that someone tells their story while the audience listens (Meo-Sewabu et al., 2017). My personal childhood experiences relate to stories narrated by an older woman to children who surround the narrator just before bedtime. Knowing that *talanoa* is not an interactive communication style, I decided to add a formal tone to the data collection method using *veitalanoa*.

Veitalanoa is the exchange of anecdotes (Goldsmith, 1989) and is a more formal method of *talanoa*; "*vei*" adds a reciprocal or mutual meaning to *talanoa*, making it the least casual approach that is guided by the Fijian *Vanua* Research Design (FVRD; Meo-Sewabu, 2016). The *veitalanoa* session is the process or the act of having a *talanoa* method (Ramacake, 2010). In using *veitalanoa* as a method, facts are made known (Goldsmith, 1989). Other *iTaukei* researchers have used the concept of *veitalanoa yaga* and *veivosaki yaga* (specific divisions of *talanoa;* Tagicakiverata & Nilan, 2018; Tiko et al., 2016). *Yaga* means useful, valuable, or necessary. I believe that a proper introduction to the research should set the grounds for appropriate communication.

Further, in a health-care setting, the patients' and nurses' exchange of narratives is always useful for both parties, hence the omission of "*yaga"*. For this reason, I used the *veitalanoa* method in both the group and individual interviews. The *veitalanoa* group adopted the discussion styles of the focus group discussion strategies, while the *veitalanoa* one-to-one sessions adopted techniques from the interview method. The intention of the *veitalanoa* focus group was to gather a collective response to the question while fishing for data from participants' personal experiences (U. Nabobo-Baba, personal communication, September 9, 2018). Interviews in an indigenous Fijian research context are seen and understood as a formal way of collecting information (Nabobo-Baba, 2008).

The conduct of the veitalanoa *group*

There were two *veitalanoa* groups for the patient participants and two for the nurse participants (see Table 2). Data collection from the *veitalanoa* group happened at the MOH facility and a village hall within the research area. I introduced myself as my story, which included my nursing experiences. Introducing oneself to another indigenous person provides information about the cultural location to establish connections and relations (Martin & Mirraboopa, 2003; Singh & Major, 2017). The introduction of Pacific peoples includes family lineages that connect relations with the land and the people (Vaka et al., 2016). For the *iTaukei*, the introduction of people provides personal information, such as plant and animal totems*, iTokatoka*[63], *Mataqali*, *Yasana,* and confederacy, including *vasu* and other tribal connection details.

An introduction typically extends to (if they are married) their spouses' tribal information. These networks and relationships with other people, the universe, and the environment are valuable (Chilisa, 2020). In providing my details, I claimed and declared my genealogy and my position as a researcher. The purpose was to locate my presence as an *iTaukei* and to formulate the type of relations that exist before presenting myself as a researcher.

I presented the research and its processes. The participants received a copy of the information sheet (Appendix 3) and the *veitalanoa* group consent form. I saw it fitting to inform the approval from the Ministry of *iTaukei* Affairs and the Ministry of Health, for participants felt at ease knowing that they also have the authority to speak and to do so freely. Participants were asked to provide their written consent, which was well received by the nurse participants but not by the patient-participants.

I thanked the participants for their willingness to participate. The session proceeded with a prayer as most *iTaukei* are Christians, and meetings are deemed incomplete

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[63] *iTokatoka* – enlarged family unit or group, normally descendants from male relations

without prayer (Tiko et al., 2016) to seek supernatural interventions and guidance in deliberations. Such practices are similar to the *Te Vaka Atafaga* and *Te Pae Mahutonga* models, where spirituality is a significant component of an individual being. I introduced the ethical considerations of the research. I presented the *veitalanoa* programme, and the participants introduced themselves. They quickly “identified their place” with others in a way introducing a “safe to talk” and accepting environment that put the participants at ease as they identified their traditional relationships with others. For the *iTaukei*, introducing oneself is part of the greeting and knowing the other person better - in this case, the participants’ demographic and medical information for the patient participants and nursing experiences for the nurse participants.

The conduct of a proper introduction situated the data collection platform at the same level through our tribal connections - the indigenous researcher and the indigenous participants. The process of a good *iTaukei* introduction helped alleviate anxieties of being in the research environment and allowed participants to speak freely. Due to the intricacy of social interaction shared with people from other tribes through my tribal association with the patient participants, the *Naita*, *Mataqali* and my *Kai* carefully chose appropriate words during the *veitalanoa.* However, the presence of the *Tauvu* neutralised the research environment as they encouraged participants through probes. The research area included participants who were also *Maseki* and *Koicalevu* to each other. Most participants freely shared their medical, family, and social histories.

Food is considered a vital tradition in the conduct of meetings and discussions. It fosters excellent and productive ideas and deliberations. As discussed above in Stage 2 of the Fijian *Vanua* Research, the patient participants' medical status and treatment require they receive meals on time; therefore, I ensured they received food and drinks. Also, I carefully considered the omission of their totems from the menu as it would create the need to present a traditional formal apology. Researchers must ensure that interventions do not interfere with such connectedness (Chilisa, 2020).

An established understanding to use the *veitalanoa* in the *iTaukei* context was shared and agreed upon with the research participants. During the discussions, I noted that the *veitalanoa* session sparked intense discussion, meaning that one topic often led to many others, including some indirectly related issues. Interestingly, the experience has been noted by researchers like Nabobo-Baba (2006a) and Meo-Sewabu (2015), who used the traditional conversational method. For this research, an essential factor in my insider/outsider position relies upon excellent facilitation and extraction, and to note important points only during data collection to enable the *veitalanoa* method as a successful method of collecting information. However, in an indigenous Fijian setting, researchers must note that not every *iTaukei* person can freely talk.

It is likely for Pacific people to attend the *veitalanoa* and only contribute cues in nonverbal means to encourage speakers to continue to talk until they are satisfied (Vaka et al., 2016). Participants who could not freely express themselves in the *veitalanoa* group but felt they needed to tell their stories in a private space wrote their contact details in the space provided on their consent forms. The consent form was the best place for participants to indicate their interest to communicate their stories further to maintain confidentiality and anonymity. I collected the consent forms at the end of the *veitalanoa* session because all participants consented verbally, and obtaining written consent before the *veitalanoa* group would create worry and may act as a barrier to their "true" responses. Researchers like Tiko et al. (2016) experienced the same during their fieldwork.

Data interpretations were part of the *veitalanoa* process, which proved to be a daunting task as discussions evolved very fast and covered many issues within little time into the conversation. I spent much time verifying the information through recorder playback and redirecting the *veitalanoa* to the research questions through impromptu questioning. In most cases, participants' stories were interrupted by another because they felt for and had similar experiences with the participant. Similar experiences have been noted by Vaka et al. (2016), who realised that most stories have similarities when shared by *talanoa* participants, which lead participants to present "personal experiences about life, culture, professional and other ways of knowing" (p. 538). The participants had a chance to go over the recorded data and had the opportunity to omit any part of the recording they considered irrelevant or not to be published. To validate data from the patient's *veitalanoa* group, I conducted *veitalanoa* one to one and had field observations.

The conduct of the* veitalanoa *one to one

Collectively, I conducted six *veitalanoa* one to one: two for the patient participants and four for the nurse participants (see Table 2). The *veitalanoa* one-to-one process occurred in an informal but engaging way. Similar to the face-to-face interview guidelines and protocols, I made sure not to disturb the natural context at the patients' natural settings (Speziale et al., 2011). As an “outsider” to the participant, my role as a researcher was to assume an “emic” perspective. For this reason, I allocated adequate time for building a trusting relationship with participants through the proper entry protocol. Such introductions and orientations assisted in eliminating the distractions created by my presence as an outsider in the participants' natural settings. The *veitalanoa* one-to-one method provided personal experiences that could not be openly shared.

I contacted the patient participants and arranged to meet at their homes, and presented the *isevusevu* and *veisiko* items. It is a protocol for an *iTaukei* who is visiting to take visitation gifts, and it is customary for *iTaukei* people to visit the sick (Nabobo-Baba, 2006b). Gifts are commonly in the form of food and are a socially meaningful task of caring and nurturing for sick or needy people amongst the *iTaukei* (Vudiniabola, 2011).

It was not possible to talk to the patient-participants alone because close family members were always around. The family members, who I now call the “significant others”, remained quiet at the beginning of the *veitalanoa* one-to-one session. However, they engaged when the patient-participants took time to remember significant events of their nursing care experiences and the type of care they hoped to receive. It would be culturally inappropriate to tell someone to be quiet or leave the discussion or meeting venue, so I continued the *veitalanoa* one-to-one session with the patient-participants and their significant others. At the patient participants' homes, I received a meal and a continuously filled cup of tea until my departure. Again, this reciprocal event was in appreciation of my visitation, and it would be culturally insolent to refuse such offers. I considered the data to be saturated after two patient participants' *veitalanoa* one-to-one sessions because no new information appeared.

I met the nurses at their clinics during their lunch breaks. Their discussion points were well prepared and written in their notebooks; hence, their one-to-one *veitalanoa* sessions were shorter than the patient-participants. I followed up with the nurses in their clinics to clarify information. After four *veitalanoa* one-to-one sessions with the nurses, data saturation was achieved with no new information appearing.

The field observations

The field observations offered additional data to further the understanding of the research questions that guided the research. Field notes documented what I heard, saw, and experienced, which became part of the data analysis alongside the *veitalanoa* groups and *veitalanoa* one-to-one sessions. Other observations not captured during the interview are added in the field notes to validate participants' stories (Speziale et al., 2011). I observed participants in their natural settings, and I conducted my field observations on the same day as the *veitalanoa* one-to-one sessions. Repeated visitations to the participants' natural environments will be assumed to intrude into their personal space and further stigmatise the visit. Frequent visits may cause suspicion about people's health. I identified three relevant and related factors that needed closer observations for both the patient participants and nurse participants: the environment and setting, the support available for the participants, and their daily activities.

The field observations for the patient participants' environment included how they lived and carried out their daily activities. I observed the home set-up in how it supported their health conditions. I noted the type of existing family support available for the patients, their diet, their preparedness to attend follow-up clinics, medications, wound care, and family and community activities' participation. The observation included support from home when the patient travelled to their follow-up clinic and the steps involved. The processes constituted their entry to the clinic, triage, waiting time, consultations with the doctor, the nursing care they received, getting through to the pharmacy, appointment booking by the special out-patient department [SOPD] nurse, and their transportation back to their communities.

The observations for the nurse participants happened at their workplaces while they attended to patients. I observed the nurse participants' work environments, spaces, and settings, including the general layout of the work areas and the waiting rooms. I noted the types of support available for the nurses that helped them assist patients, including the availability of wheelchairs, waiting rooms for patients, the types of equipment, linen supplies, surgical supplies, and domestic and pharmaceutical supplies. Also, I looked at the human resource issues, paying attention to the number and level of staffing available. I observed the process of getting a patient through the clinic, looking at the time factor, the process, and the patient education involved, including coaching on medications, clinic days, and the need for physical fitness and proper diet.

Stage 5: *Na itukutuku* (Reporting/Analysing/Writing)

To capture the true meaning and for translation purposes, I discussed the data with research participants after a break from the *veitalanoa* group and obtained their recommendations into what they hoped to receive or deliver. I transcribed the audio recordings verbatim and duplicated each record,and labelled and kept them in separate data files according to the venue and participants' code and field note observations.

Reporting

The reporting stage involved communicating back to the participants all conversations that happened in the research environment and is a process of confirming the data, ensuring true meaning and understanding. I replayed the recorder, paused, and sought clarifications from the participants, ensuring I did not miss the essence of their story. I penned notes and subthemes that appeared from the *veitalanoa*, which indicated the beginning of the analytic stage.

Listening and Recalling

I discovered that listening and recalling was a time-consuming process. I listened to the participants' *veitalanoa* many times to be able to recollect their stories. I visualised the research environment and allocated pseudonyms to the participants' voices. I noted issues of concern and the dynamic aspects of the data. Once familiarised, I began translating and transcribing the recordings as they appeared in the provincial and main *iTaukei* (*Bauan*) dialect while some were in the English language, followed by the English translation of the data. I picked relevant pieces of information that were related to the discussion themes. There were some loosely associated items that helped in the understanding of the subthemes, and I moved these into other conversations.

Familiarity with the data

I began reading and rereading the data, noting down initial ideas, which was an exploratory phase. Specific analytic categories were already predetermined by the participants, whose discussions formed into themes and subthemes. I reread the data, looking for keywords and trends before mapping and naming themes in the data that later helped outlined the analysis. Each participant's story had a distinctive and unique feature, which I respectfully included.

Analysing and Writing

Qualitative data analysis is about telling stories and interpreting and creating; it is a product of deep and prolonged data immersion, thoughtfulness, and reflection, and is something that is active and generative (Braun & Clarke, 2012, 2019). A variety of frameworks guide qualitative research data analysis, although no one frame is the most relevant or appropriate (Liamputtong, 2013). Key points that appear as the patients' and nurses' descriptions of nursing care were drawn separately and reviewed under various possible interpretations by going over the transcribed texts.

The *veitalanoa* group covered topics that became themes, meaning that data analysis began when participants discussed an experience. Other participants related their experiences to the central theme. Still, other conversations that developed from the main discussion topic formed the subthemes. It is normal during a *veitalanoa* process that people would all contribute to an issue before they move on to another topic. However, in a simple *talanoa*, many highlights can likely arise from one single cause. The *veitalanoa* one to one helped interpret the *veitalanoa* group texts. Interpretations were in the form of describing what happened, why I was seeing and hearing the data, the meaning of what I was hearing and seeing, and describing the impact of the data. I noted that in this way, thematic analysis of the data would expand and diversify, and need a lot of sorting (Braun & Clarke, 2020). The data were presented in their translated meanings and identified as *veitalanoa* data analysis. The latter confirms that *veitalanoa* as the method of data collection is both the methodology and the method.

The discussions that happened around themes were translated verbatim just as they occurred in the research environment. I matched them to the data from the *veitalanoa* one to one and my field observation notes, and ensured I retained the nuances of the data. I shared the transcriptions with my primary Supervisor, who helped with data interpretation and guided the analysis and discussions. Themes were cross-checked, ensuring prominence and validity. I drew tentative conclusions and organised the main points that led to the formulation of the final report. I included allonyms for participants after the translated direct quotes.

The analytic process consumed more time than the *veitalanoa* session as discussions with the participants required more clarifications, arriving at twenty-two subthemes. Within the constraints of their culture, some patient participants requested that aspects of information they had shared should be withheld, and that it was only for me to know and not to be published as they did not want to fracture their relationship with the nurses. Nabobo-Baba (2006a) related to similar experiences while researching in a Fijian village. The participants agreed that I could share with the Fijian Chief Nurse but not their demographic information. However, the Chief Nurse was aware of the research venues and could quickly identify the origins of the data. Not writing about "the other stories" is an acknowledgement of the researched community as arbitrators of quality, which is validity (Chilisa, 2020).

The *Veitalanoa* Analysis

Involving research participants through cultural forms of processing and producing knowledge is an exciting area. The researched community is engaged in analysis and validating research studies, which births indigenous validity (Chilisa, 2020). The concept of indigenous reality speaks to the question of whether people feel the relevance of the research to their issues and challenges (Chilisa, 2020). As emphasised by my key informants, the analysis approach must reflect the order of how I understood the research data, the verification and interpretation processes, and the *veitalanoa*. Empowered by the FVR, my research automatically fitted into a thematic analysis where participants identified the main point of experience (now recognised as a theme) and discussed their different experiences that formed into subthemes.

The *veitalanoa* analysis began during the data collection process while clarifying what I heard during the *veitalanoa* sessions and observed during my field observations. The participants narrated the explicit and conscious meanings of the data during the first stage of the analysis. Chilisa (2020) identified this stage as the external narrative. The *veitalanoa* analysis referenced Braun and Clarke’s (2006, 2019) analysis processes, which identified strategies for thematic data analysis that involved listening, recalling, and translation, and familiarisation of the data.

The *veitalanoa* analysis steps

As mentioned in the previous paragraph, the *veitalanoa* analysis used Braun and Clarke’s (2006, 2019) thematic analysis stages, added another two steps, and rearranged the processes. The *veitalanoa* analysis has eight steps, documented here in the order of how the process transpired during my research from the data collection stage to the formulation of the final report.

Step 1. Becoming familiar with the data through playback of audio recording, and verifying and clarifying participants’ responses

This step is part of the data collection phase, actively involving the research participants, where the researcher clarifies with participants the meaning of the data. I see this stage as the exploratory approach because specific analytic categories were not predetermined. Participants then added to the data or asked for its removal, explaining in detail what they meant and whether they wanted (or did not want) their stories to be communicated. In doing so, participants indicated here what was meant to be recorded and written in the hope that it would help other people who faced similar experiences. I recorded the verification process and took notes. I thanked the participants and bid them farewell.

Step 2. Listening, writing, and transcribing

This step is the solo effort of the researcher, away from participants. While waiting for the next *veitalanoa* sessions, I replayed the recordings and noted key issues that needed attention. I played the recordings and transcribed all narrations verbatim. One specific characteristic of my research was that data was in the indigenous language. Therefore, the second step involved listening to the recordings and writing the data as they appeared in different vernacular forms according to the participants' provincial languages.

My research used the two-step transcribing method. After their *veitalanoa* group, participants had a meal break before I verified their *talanoa*. The verification process included a translation from participants' provincial dialects to the common Bauan dialect and their *talanoa,* which was clarified during tape playback to illuminate the true meaning of their *talanoa*. Transcribing the data into English required a two-stage process to verify its meaning at the end of the *veitalanoa* from the provincial language to the national indigenous one and then, later, to the English language.

Step 3. Reading and rereading the data and rearranging themes

This step involved reading and rereading the data, looking for keywords, trends, and ideas that later helped shape the analysis. Each participant's *talanoa* had a distinctive and unique feature, which I respected. It is easier to use this step with a single case in a single *veitalanoa* group. For multiple *veitalanoa* groups, this task seemed time consuming and required extra effort to decide on joining similar themes or separating them. For example, a participant said, *Ni ratou sa lewa ga mai, au sa vakamuria ga, sega tale niu qai tarogi iratou*- (since they have decided, I remained quiet). This type of "powerful" data extract became a theme in the discussions that followed. Other participants quickly related similar experiences to that of the first participant. If they did not have similar experiences, they shared possible reasons from their experiences to add to the discussion. From another *veitalanoa* group, a male participant said, *E ratou tarogi au–vakacava? O vakadonuya mo sele se sega? Ke sega, mo sa na suka ivale* (They asked, are you consenting for surgery or not? If not, then prepare to go home). I drew similar *talanoa* from a female participant in a separate *veitalanoa* group who said: *Era vaqarai ira na wekaqu me ra mai tovolea me ra veisautaka na lomaqu me'u vakadonuya me sa musu na yavaqu. Ni'u sega ni vakadonuya, au biubiu mai valenibula me'u mai qaravi au ga ivale* (They looked for my relatives to convince me to give in to their amputation plans. I did not consent, signed out from the hospital, and attended to my wound at home). The data excerpt was translated from a provincial dialect to the common Fijian language.

I realised that thematic analysis required more involvement in my interpretation of the data. The analysis included identifying and describing both implicit (unspoken but understood) and explicit (clear and obvious) ideas that formed into themes within the data. I obtained an initial and thorough understanding of each *veitalanoa* before looking at commonalities. The process is similar to Braun and Clarke's (2006) second phase on coding by identifying interesting data characteristics in an organised manner across the entire data set and collating data related to each code.

Step 4. Forming subthemes

The fourth step ensured the researcher identified and compared the frequencies of participants' stories, checked their cooccurrences, and labelled them as subthemes. As discussed in the conduct of a *veitalanoa*, a key point in the method is the researcher's vigilance in "watching" the discussions, ensuring they do not go beyond the research topic. As much as it could be a daunting task, cultural sensitivity and competency are carefully considered in manoeuvring the *veitalanoa* to the research focus. In an *iTaukei* context, it is considered rude to stop anyone who is actively participating and redirect their conversation. Sometimes, while letting the discussion flow, the researcher may become actively involved in the discussion and diplomatically "steer" the *veitalanoa* back to its focus. Therefore, the fourth step makes way for other associated themes related to the main *veitalanoa* point of discussion, producing subthemes. Finally, I identified the main themes, which were separated from the subthemes in the data sets.

Step 5. Reviewing themes and subthemes

This step is similar to Braun and Clarke’s (2006) fourth stage where themes were checked, and it was ensured that each subtheme fitted in the main theme. The process enabled the generation of a thematic map of the analysis.

Step 6. Defining and naming themes

Similar to Braun and Clarke’s (2006) fifth stage, this step involves continuous analysis to refine the specifics of each theme. This step checked and ensured the presence of common characteristics that made up the themes that appeared in each participant’s *talanoa*. This step ensured the overall story of the analysis was presented, generating clear definitions and a title for each theme.

Step 7. Trimming the data

As discussed above in Step 4, when using an indigenous data collection method, researchers will always find “other” pieces of information in the data. While the participants in the first stage may remove some data, there were other pieces of information in the data sets. Therefore, while it is normally within the jurisdiction of the researcher to remove these pieces of information while analysing the data, therefore, very little of the extra information were added to participant’s stories.

Step 8. Producing the report

This stage referenced Braun and Clarke’s (2006) sixth stage, which is the final opportunity for analysis. The step involved the selection of rich, convincing data excerpts and the final analysis of selected excerpts. Each participant’s *talanoa* is different, even though many were related. This step also relates the analysis to the research question and literature, which “produces a scholarly report of the analysis” (Braun & Clarke, 2006, p. 35).

Generally, in thematic analysis, there is a concern with the reliability of the data because more interpretation goes into the definition of data items, creating complexities of meaning within a textual data set (Braun & Clarke, 2006, 2012). However, as a lone researcher, these complexities became less pronounced. Overall, the *veitalanoa* analysis was part of the data collection process that happened during the research process. For this reason, it must not be considered as a particular research activity, fitting into the fifth stage *(Na itukutuku)* of the Fijian *Vanua* research process. I started the analysis during the process of orientating myself to participants’ responses while replaying the audiotape for verification purposes.

Stage 6: *Na vakavinavinaka* (Gifting)

Gifting is a shared behaviour and is a to-be-repeated event as research marks the beginning of a relationship between the participants and the researcher (Nabobo-Baba, 2008). Gifting, as used by indigenous Fijian researchers and scholars like Nabobo-Baba (2006a), Nainoca (2011), Vudiniabola (2011), and Meo-Sewabu, (2014), is a reciprocal tradition among the *iTaukei*. After each *veitalanoa* group, I thanked the participants for their attendance and gifted them with money to reimburse transportation costs and their time. Relatives who accompanied patient participants to the *veitalanoa* group were separately gifted. All the *veitalanoa* group sessions included meals due to the data collection timing and because patient participants were on antidiabetes treatment. The *veitalanoa* one-to-one nurse participants received lunch money to compensate for their lunch hours, while the *veitalanoa* one-to-one patient participants received *veisiko* items, formally presented with the *isevusevu*.

The women from the host village prepared food for the female patient participants, and they received monetary gifts as tokens of appreciation. This reciprocal practice is similar to the *Tivaevae* model of health, which highlights using reciprocity. Furthermore, even though there was no emergency with the patient participants during the data collection, I gifted the driver of the vehicle that was on standby for emergency transport. I carefully considered my decision to use monetary tokens of appreciation. Money allows the gifted person some freedom to fulfil their immediate needs, whether it be food, shoes, or medicine. However, the traditional protocol of *veisiko* to the home of the sick remains, and I observed its reverence for the *veitalanoa* one-to-one patient-participants.

Stage 7: *Na itatau* (Departure)

From an insider's perspective, *itatau* is momentary (Nabobo-Baba, 2008). I thanked and farewelled the participants after each stage of my data collection. Before leaving Fiji, I returned to my village and presented the *itatau* as the traditional protocol of farewell as it was time to say goodbye. *iTatau*, similar to the conduct of the *isevusevu*, included the presentation of *waka* and paired speeches. I received well wishes for the rest of my academic journey and requests to return for the implementation of my findings. Often, researchers receive reminders about the lifelong relationship forged during the research process, meaning there is no closure (Nabobo-Baba, 2008). It was a sad moment to bid farewell to an aged uncle. I also visited the Fijian Chief Nurse and bid her farewell.

Stage 8: *Taleva lesu* (Reporting back)

Taleva lesu is a necessary *iTaukei* protocol that honours the fostered relationship and means referring back, reflecting, presenting, and informing chiefs and research participants of completion (Nabobo-Baba, 2008). Initially, I had several plans for communicating my research and its findings. My intention to meet with the Fijian Ministry of Health nurses did not materialise due to the measles outbreak in December 2019. The outbreak engaged the nurses who worked hard to contain measles through awareness and vaccinations. However, I presented a brief report to the Fijian Chief Nurse in January 2020. I sent a copy of the research report to the Ministry of Health research committee. The secretariat acknowledged receiving the information. There was no response from the health research committee on my findings. The COVID-19 pandemic prevented the dissemination of results back to the stakeholders in the research.

Stage 9: *Me vakilai* (Transformative processes)

Me vakilai refers to the transformative process brought about as a result of research reports and may happen during or immediately after the research (Nabobo-Baba, 2008). I competed in the Three Minute Thesis (3MT) competition and received a judge's commendation. It was an excellent platform to communicate my research to a nonspecialist audience. I made a video of it, which is available online. Also, I made a one-minute video on living with diabetes in Fiji. I am currently working with Diabetes Fiji on the translation of the pamphlets, which were in English, into a simple *iTaukei* language. I also presented the findings from this research at several face-to-face and online conference and workshop sessions. The COVID-19 travel restrictions halted my plans to communicate findings to the provincial administration personnel. However, this process will occur after my study in 2021.

Chapter Conclusion

The chapter offered an in-depth discussion of all the planning and thought that went into the design and carrying out of the fieldwork. I discussed the research approach, framed by the Fijian *Vanua* Research Framework (FVRF), that helped design my study. My position as an indigenous researcher, among the many roles I have within an indigenous community, suggested that some caution might be needed in terms of how I was going to approach the data collection process. The FVRF's nine strategies provided a culturally appropriate and fitting design that resulted in the formation of a lifelong connection with my research participants. For the participants, the *veitalanoa* process became therapy (research as therapy) that created a platform for information, awareness of disease management, the acceptance they were not alone, and feelings of being empowered to ask about their health conditions. The research process confirmed my researcher role as an agent of change in participants' lives.

The study identified steps of an indigenous data analysis - the Fijian *veitalanoa* data analysis - which referenced Braun and Clarke's (2006) thematic analysis stages and is the first to be written with a detailed outline of its process. The diversity in findings created a need to carefully consider the many issues my thesis needed to deal with. Due to the complexities caused by the COVID-19 pandemic, communication of the research findings to various stakeholders in Fiji did not happen, a task that will be completed after my return to Fiji due to its protocol requirements. However, where possible, I have been communicating my findings online to research symposiums.

Chapter Seven: Patients' *Talanoa*

Chapter Seven documents the patients' experiences of receiving nursing care from a health-care facility and highlights some challenging moments in their life journey as people living with diabetes and associated conditions in Fiji. The participants willingly shared their socioeconomic dynamics and health details during the introduction phase of the data collection. As per the *vanua* cultural protocol of establishing relationships and concepts of caring through *veikilai*, the participants introduced themselves in the formal *iTaukei* way and included detailed information about themselves, their tribes, and their connections to the land. This kind of introduction set them apart as individuals in the Western world. The release of such information would breach anonymity and confidentiality issues, for it is easier to identify people through their tribal links in Fiji. I have included limited information and moved their details to the Appendices section of this thesis.

The *iTaukei* patient participants described their nursing care experiences as provided by a generalised nursing population, both *iTaukei* and non-*iTaukei* nurses. These findings are specifically from the patients' experiences of care delivered in the Fijian government Ministry of Health facilities. The *veitalanoa* sessions generated three main themes and sixteen subthemes (see Figure 9), which I present in the participants' own words, supported heavily by my field observations. The main themes are cultural barriers to care, expecting safe and trustful care, and the need for education and health promotion.

Figure 9

Summary of Patient Participant Responses

Cultural barriers of care

- Accepting care without complaint
- Depending on nurses for support
- Expecting respect for the elderly
- Cultural resistance
- Fear of amputation

Expecting safe and trustful care

- Nothing about me without me
- I have a life outside the clinic
- Treat my body with respect
- Dealing with limb pain
- My care needs teamwork
- I need trustful care

Need health education and health promotion

- No one tells me the plan of my care
- Paperwork limits quality conversation
- How do I take care of myself?
- I need to be educated in my language
- How do I manage in my community?

I draw on data from the individual *veitalanoa* sessions, field notes, and personal communication with the Fijian Chief Nurse, with whom I discussed the emerging data to back up the analytic items. The patient participants all felt it necessary to share their *veitalanoa* on the course of their journey relating to the *veitalanoa* theme. They laughed, cried, and made jokes about what they had been through - the last aspect was done in the way of enlightening others' experiences that relate to their caring values. Their journey allowed me to see things from the patients' perspective, a harrowing experience as a nurse whose undergraduate training focused solely on managing patients' biomedical problems.

Cultural barriers of care

Patients do not leave their culture outside the door of the consulting room. Culture influences every aspect of their expectations, communication, and responses to what is happening. Patients are culturally bound and have certain expectations about their treatment (Jaworski et al., 2017). Still, the *iTaukei* patients' cultural mores of *veidokai*, *veivakaturagataki* and *veivakaliuci, vakarokoroko,* value hierarchy, status, and relationships, which relate to *vanua* concepts, mean they will not challenge any healthcare professional who breaches their expectations. As a result, patients were submissive and seemingly accepting of the decisions made for and about them. However, in the safety of the research environment, patients expressed their concerns and articulated some worries as consumers of clinical services. As shown in Figure 9, there are five subthemes under the heading of "Cultural barriers of care": 1) Accepting care without complaint, 2) Depending on nurses for support, 3) Expecting respect for the elderly, 4) Cultural resistance, and 5) Fear of amputation.

Accepting care without complaint

The *iTaukei* value of *veidokai* symbolises behavioural acts of accepting whatever comes their way from another person of status—in this case, the healthcare professional. This implies that culturally compliant *iTaukei* patients are unlikely to question, challenge, or take control of their illnesses; therefore, they become uninvolved in their care. Even in instances when there was room for discussion, patients felt compelled to agree to amputation plans:

> The nurses and the doctors just decided on the amputation. They did not explain anything about my illness or the consequences of the disease to me. I did not ask the nurse or the doctor during my stay at the hospital. You know … we do not ask, as it is not the way of *iTaukei* culture. They decided quickly to amputate my leg. They just said they were going to amputate it. They did not ask how I would feel about

> the amputation. They said that it was for the best. They did not give me time to think about their decision. I trusted them … I wanted to ask about their decision to amputate my leg, but since they have decided, I remained quiet. (Jone)

Jone received a below-knee amputation (BKA) of his right leg, and his left foot was freshly bandaged from a forefoot amputation. He chronicled his experiences of several hospital admissions and related how he fell victim to the *iTaukei* cultural principles of respect for authority, which value hierarchy and status. The observance and compliance with such values positions health-care professionals as more important to patients, thus creating a gap in the professional and patient relationship. Patients have been orientated to "receive anything in good faith and never refuse" due to their cultural values, which subjects them to one-way decision-making regarding their health:

> I stepped on a nail, and my foot became infected. When I arrived at the main hospital, they said that I had lost function in my leg. I asked out of despair for them to be considerate to recheck my foot, and they responded, saying there was nothing else they could do because it was "dead"… I did not consent to the amputation, and they came the next day, expecting a decision to agree to an amputation. I begged them to recheck my wound, but their response was, 'What is it - are you consenting for surgery or not? If not, then prepare to go home.' No other discussions of how it affects my leg or my life - they want a positive response to their amputation plan. Now, it feels like there is no other way but just to give in. How could you explain that the foot was dead when it was still in use? (Jope)

Jope received a BKA of his right leg. After the *veitalanoa* group, he sought clarification on information he received from health-care professionals during his admission that had continued to bother him. One was about his supposedly "dead foot" that was amputated while he was still using it. Jope's health-care experience clarified issues of the language used at the health-care facility and patients' responses to health-care professionals' information. The data confirms that the *iTaukei* cultural principles affect patients’ behaviours and responses to health-care professionals during an illness event.

For most participants, their cultural protocol of *veidokai* was a barrier to their communication and need for information. Such barriers disempowered patients from communicating their opinions with and requests to health-care professionals. Most participants agreed with the sentiments shared by Jone and Jope. For example, another participant, Jale, mentioned that he only had a blister on the tip of his big toe but received a forefoot amputation. The patients’ experiences highlighted the lack of partnership during their care, and they felt trapped between the health-care system and their cultural values. Therefore, the patients willingly accepted medical decisions made for them.

Depending on nurses for support

Patients had high regard for nurses, not only for their professional role but also for their continuity of presence with them. Despite this, the patients did not feel actively supported by the nurses when surgeons decided on their amputations. The patients had not voiced their concerns until doing so in the relative safety of the research environment:

> I want nurses to decide on the plan of care for my wound … the doctor just came once and ordered an amputation … the nurses are in the ward all the time throughout the day in different shifts … that is why I am saying for nurses to say something about my wound at least … they told me that my leg was looking much better during dressing changes, but they did not say the same to the doctor when they wanted to amputate my leg. They should have told the doctor that my wound was getting better, so I could have more time, and with the help of the antibiotics, it would heal faster … no, they did not say

> anything and they did not even allow the medicine to work … that is why I end up like this … (Jone)

Jone was emotional while sharing his experience. During the *veitalanoa* group, he paused and took time to gather the strength to continue. The discussion moved to another topic when Jone was quiet for more than a minute. He narrated his experiences of the many hospital admissions, amputations, follow-up clinics, and encounters with health-care professionals that lacked patient advocacy. In another *veitalanoa* group, a participant, Laisa, felt that all health-care professionals who attended to her agreed to the amputation plan:

> It is sad because the nurses went along with what the doctor said. When I did not agree to their amputation plan, the nurses started looking around for my relatives, asking them to convince me to consent to the amputation. I felt everyone was against me, and I was fighting a losing battle. (Laisa)

Laisa's experience made it difficult for patients to trust nurses. All participants agreed that they had hoped that the nurses would advocate for them during their care. When the opposite happened, patients faced difficulties in coping with decisions made for them. In Jone's experience, his wound was healing, but he received a limb amputation because the surgeon ordered it to happen - a decision that was never challenged by the patient or the nurse. Patients' *vakarokoroko* (respect) for the health-care professional overrode their thoughts about the consequences of amputation for them, meaning they experienced care far from the *iTaukei* cultural value of being *veikauwaitaki* (concern for others).

Patients arrived at the hospital to seek assistance for their illness but encountered an amputation plan. They felt helpless and not supported. One participant, Jeke, hoped the nurses would explore patients' feelings regarding their health. His request for a wound debridement instead of an amputation was refused. He wanted to try the antibiotics and have more time for his wound to heal. This request was denied because the surgeons wanted an easier way of managing his health-care condition. Despite this, Jeke refused the BKA but received an amputation of his forefoot.

Most participants reported being quiet and accepting, even when the nursing care they received was not acceptable. Seemingly busy doctors made decisions without giving patients enough time to think and make choices, and nurses who were similarly culturally bound did not intervene or challenge the doctors' decisions. Patients passively accepted decisions made for them, which contributed to tyranny in a very patriarchal health-care setting, affecting their care. From the data, there was an apparent lack of patient advocacy, which is a crucial nursing role in nursing care settings. Because of their cultural mores and the nurses' lack of support, patients were silent and silenced in an environment where they are the most critical health-care services’ customers.

In these examples and more, patients were aware of other options available to treat their medical conditions. However, they were denied requests for more time to receive nonsurgical interventions, leaving them feeling unsupported, pressured, and threatened by health-care professionals. Patients felt that there were predetermined plans to amputate, and they experienced hopelessness in bargaining for more options. The lack of psychological preparation for the scheduled surgery created doubt, decreased morale and led to unnecessary fears and unhappy patients (Cheng et al., 2018; Levett & Grimmett, 2019).

Expecting respect for the elderly

In an *iTaukei* setting, social manners towards older adults include values that encompass caring through respectful relationships, as noted in Chapter Four. The older participants expected to be respected. Instead, they reported uncomfortable experiences that were far from the expected standard of professional nursing care. One participant, Juta, felt emotional, cried, shook his head, and was quiet for some time. His response changed the *veitalanoa* group environment. With a much lower tone after being quiet for some time, he continued despite being emotional. He highlighted the improperness of one of his conversations with a young nurse:

> I felt not respected because the nurse made a joke out of my experiences … the nurses' response was worrying. I felt threatened … (feeling emotional, shakes his head and whispered) we do not talk to our elders that way. That was a very young nurse, young enough to be a granddaughter. (Juta)

On his review clinic day, Juta's wife accompanied him. She was Juta's primary support person, responsible for his daily care and activities. She packed Juta's lunch, water, clinic attendance card, and medications in her handbag. Juta was appreciative of his wife's support. Juta wore closed shoes and was very well dressed but limped when he got up to walk. Juta's general physical presentation reflected the "*kena irairai*" component of Meo-Sewabu's (2015) *Tanoa* model, in obscuring his missing forefoot.

As noted in Chapter Four, respect is a cultural value for the *iTaukei*, where, as a person ages, they receive more respect and politeness, known as *vakarokoroko* and *veidokai*. Juta's narrative noted expectations of older *iTaukei* patients when they receive nursing care from young nurses. Most of the participants reported similar experiences and feelings. The patients' experiences showed a lack of cultural understanding by the nurses towards elderly *iTaukei* patients, who expected to be respected for their age despite their medical status as a patient. Another participant said:

> These are the very young doctors and nurses, the ones making the decisions to amputate legs. I have seen that they lack the respect that their older colleagues provide. The more aged professionals are respectful and considerate. The younger ones are far from it. I hope they change their attitudes, at least to older patients like me. (Mere)

Respect is both a professional value in nursing and indispensable to patients' rights (Koskenniemi et al., 2019). Despite respect for age being one of the central principles of the *iTaukei* culture, patients consistently revealed that they found no such reverence to be present. The data excerpts captured patients' concerns over the lack of respect they received from younger health-care professionals. Despite feeling threatened and not respected, patients did not refuse or question the improper nursing care due to their cultural mores.

Most of the participants shared the same sentiments as Mere. While communication with patients typically occurred within a formal setting, the nurses used therapeutic humour to help patients who were facing difficult situations. However, older patients reported having experienced inappropriate humour by younger nurses that made them feel threatened. The nurses' unknowingly displayed unprofessional behaviours to the patients. Some nurses are aware of the significance of therapeutic humour, but the nurses did not know that their efforts to help lighten patients' moods left them shocked when they received age-inappropriate jokes from younger nurses, whom patients assumed were two generations younger than them. These data emphasised patients' expectations of age-appropriate nursing care to the aged population.

The patients' experiences confirmed that no one really knows what goes unspoken and unreported, and this contributes to the declining standards of acceptable practice. This implies that despite knowing the deficits in their care, the patients did not criticise the health-care professionals and accepted their experiences graciously. This research environment enabled a therapeutic atmosphere for patients who felt empowered by other participants' shared experiences.

Cultural resistance

Indigenous people have their systems of healing for any ailment. The patient participants reported using alternative therapies but withheld information on such practices from the health-care professional. However, the patients openly shared their experiences within the research environment:

> The doctors and nurses were very fast to say that I have diabetes. They should first check and investigate … to understand how things are at home. They should understand the *iTaukei* ways. In the past, *iTaukei* people did not have diabetes. It was known to be common among people from other ethnic backgrounds. We have our ways of tackling high blood sugar levels with our herbal medicines. The nurses told me not to take my herbal medicine. It is sad because that is how I manage my illness. I cannot go against the nurses, but, within me, I know the benefits of herbal medicine. I understand they want me just to take the tablets, but I know its effects. I was sick … realised that I need to offer my apology to the *vanua*, through the chief. Now I'm well and taking herbal medicines. I do not tell the nurses because they will not agree. It is best to be quiet about some things to avoid bad relations, especially when all is good because we are traditionally related. (Jope)

Jope, like most patient participants, used ethnomedicine, which is a combination of alternative therapies known through traditional practices of healing by the *iTaukei*. Another participant shared a possible cause of his raised blood sugar level (which would not be seen as medically credible) and said that amputation rates within his community had created fear. Despite their worrisome experiences while receiving nursing care at the hospital level, patient-participants maintained their relationships with community nurses:

> I still go to the clinic, and they say that my blood sugar level is under control now. It was some time ago that they say I have diabetes. To me, I know that diabetes is just a rise in blood sugar level because we have eaten a lot of sweets. I take my herbal medicines and do the right thing and carry out tasks to the best of my ability … so I am all good. I am worried about the number of people being amputated, and I just pray that God will keep me healthy. People go to the hospital

> because they are sick, and next thing we hear is they are amputated. That is scary. I think the nurse knows that I take herbal medicines … has not said anything about it, so I keep it that way. (Peci)

Another participant, Laisa, said she was happy about her decision to sign herself out of hospital care due to amputation plans by the health-care professionals. She mentioned her spiritual faith, determination, and strong will, and said that ethnomedicine had contributed to her healed foot. Despite the delayed wound healing period, Laisa still had her foot.

The patients were aware of the advantages of alternative therapies, which helped manage their illness. However, they kept information about their uses of other treatment methods from the nurses to maintain their relationship; the importance of maintaining this relationship is a significant cultural concept. Therefore, nurses did not fully capture the patients' ways of managing their diseases, failing to consider cultural, social, and emotional factors that contribute to illness and healing, which creates a gap in nursing care. During the *veitalanoa*, all patient participants continued to attend follow-up clinics. The patients’ behaviours towards their conditions and how they received biomedicine meant they continually acknowledged nursing care despite not agreeing with what they received.

The data showed that patients take back some of their agency around traditional knowledge and practices, limiting full disclosure about managing diseases and general health statuses. However, pertaining to experiences of nonparticipation in their care, some patients preferred to keep how they managed their diseases from the nurses. Reasons such as avoiding bad relations and embarrassment surfaced; further, relating to the nurses’ stories, patients avoided full disclosure of such information to maintain their traditional relationships with the nurses.

Fear of amputation

In other instances, patients have developed a fear of receiving an amputation due to their awareness of the extent of the problem and their having heard other patients' experiences of undesirable events. For this reason, patients dreaded seeking help for their illness. Among the *iTaukei* epistemologies, information is passed from either authority or learned through observations:

> There is a problem with us - the *iTaukei*; we get scared and are afraid of the hospital because we cannot trust those that work at the hospital - both doctors and nurses. The thought of having an amputation arises as soon as they inform people about having diabetes. People often ask about my experiences. There are so many people with amputations, and that adds to the fear of seeking medical help. (Jeke)

In another example, Jale wondered why health-care professionals made rushed decisions to amputate a limb. According to the *veitalanoa* group, this problem was apparent in the lack of time to monitor their health status. They all noted the increasing number of people living with a disability due to amputation. The participants shared how their amputated statuses had become a barrier to how some community members approached healthcare:

> They think that my leg was a piece of wood or what? It is common knowledge in my community that the main hospital is like a butcher. Any person transferred to the divisional hospital will return without a limb ... this is by seeing other patients. My brother-in-law had an amputation. Fear is the main reason why people seek alternative treatment instead of going to the hospital because no one returns without having an amputation. So, I walked out to save my leg. (Laisa)

Patients' health-seeking behaviours are affected by conversations with and the influence of significant others. Drawing on experience and observation, patients have preconceived ideas, lack of trust in health-care services, and mentally link the health-care facilities with a fear of amputation. This means that patients were aware of what was happening around them but still followed advice from others. In situations where people could make their own decisions, they still took other factors into consideration. Such belief practices and knowledge affected individuals' health-seeking behaviours.

The medicalised environment prevailed over cultural requirements, and patients felt caught in a system that reduced their sense of value, autonomy, or participation. In the freedom of the research environment, patients also described care from nurses that were far below their expectations. When reading patient participants' comments, it is worth noting that nurses were aware of the deficits in their care due to inadequate practice environments. However, it is difficult to explain such deficiencies entirely as patients commented on inappropriate humour and lack of respect, particularly for their advanced age. Once again, despite direct contradiction to their cultural expectations, patients largely accepted what occurred with polite passivity.

Expecting safe and trustful care

People typically have some sense of what to expect when they arrive at a health-care facility for medical assistance. Any deviations from the expected results caused a loss of trust in the system, especially when they encountered a negative outcome. Henderson (1964) theorised a unique function of nursing to assist the individual in performing activities that contribute to health or recovery (or to peaceful death). The role includes establishing a trusting relationship between the nurse and the patient, making trust a moral obligation (Ozaras & Abban, 2018) and a vital determinant of satisfactory patient outcomes in a professional care relationship. Trust is a significant component of a therapeutic relationship in a health-care environment. Trust has two dimensions—institutional and interpersonal (Ozaras & Abban, 2018). The data shows patients' dissatisfaction with the treatment they received from health-care professionals, which led to their lack of interpersonal and institutional trust. Their lack of trust, as shown in Figure 9, consisted of six subthemes under the heading

“Expecting safe and trustful care”: 1) Nothing about me without me, 2) I have a life outside the clinic, 3) Treat my body with respect, 4) Dealing with limb pain, 5) My care needs teamwork, and 6) I need trustworthy care.

Nothing about me without me

Patients received amputations without considering their socioeconomic status or the suitability of their living conditions for managing after an amputation. “Nothing about me without me” is about medical decisions made without patients’ involvement. The theme encapsulates the need for a more patient-centred health-care system where patients did not need to tolerate rapid decisions to amputate:

> They referred me to the main hospital for a specialist consultation … for the surgical team to see my wound. At the main hospital, there were no discussions about the type of care I would receive. I expected them to ask about my leg, but nothing close to that happened. The conversation regarding my wound was only made in the operating theatre when they said to me … 'your leg is about to be amputated'. Now, I know that patients who present themselves late to the hospital go straight into an amputation. (Jone)

Another participant, Juta, was emotional during the *veitalanoa* group and told his story with much wretchedness in his voice. Still, he offered some rationale behind the surgeons' decisions:

> I had a well-established job ... I've lost that now that I have an amputated leg. My whole education and job knowledge have gone to waste. I worked very hard for that. My family suffered after my amputation. At the hospital, I felt like being a burden to the doctors and nurses. So, their best option was to amputate to help speed up the care given. But they should have thought of how it will affect my life … I know their primary concerns were about my health. (Juta)

Another participant, Laisa, refused to agree with the amputation plan. This means that if she were silent or requested more time to think about the amputation plan, she would still receive the amputation. During the *veitalanoa* group, she proudly showed her foot to all the female patient-participants. Laisa empowered other female participants and encouraged them with her story. Her steady persistence and faith meant she did not have an amputation. I admired her strength as an *iTaukei* woman.

The patients identified several flaws in the health-care system. They were not prepared for the surgery when it happened. Health professionals made decisions for patients without considering the impact of amputations on them and their ability to earn a living. While patients were left to assume possible explanations for the surgeons' rushed verdicts to amputate, there was no consideration of how such decisions would affect their quality of life. A participant lost his job, the primary source of income for his family. Amputations are known to be one of the most debilitating outcomes for employed patients (Journeay et al., 2018). Rushed decisions to amputate a limb from a patient living with diabetes have many negative consequences for patients. Losing a body part is a multifaceted experience, and patients need time to grasp the idea and prepare for disability (Levett & Grimmett, 2019).

I have a life outside the clinic

Longer waiting times at the clinics inconvenience patients in many ways. Patients hope to receive nursing care from a well-organised clinic to avoid long hours of waiting. Laisa explained her responsibilities at home and how the discussions around the amputation plan affected her:

> They did not think of my role as a mother and wife … who will take care of my responsibilities? Who will fetch food for my family? When they decided on the amputation, the only thing that I thought about was my role at home. It was just a stingray wound, and they wanted to cut it. It was not my first stingray wound. They tried to send me to

> the divisional hospital. It is common knowledge that every patient transferred to the main hospital returns with an amputation, so I refused ... they brought my niece, who is a nurse, to try and persuade me, but I still refused … today, I still have my foot. After three months, my wound healed completely. I am sharing this as an example because all they think of is amputating limbs. If we become weak and succumb to their decisions, we will fall. We must be confident, trustful, and have faith; then we will not be tempted to be amputated … because of our belief and *mana*. (Laisa)

Women's roles do not change in the event of illness unless they are fully incapacitated. However, when they are unable to carry out their roles, other female carers assisted in *solesolevaki* or helping people in need. Women who experienced the hassles of waiting times at the clinic were generally more disadvantaged than men due to their domestic responsibilities:

> Waiting time is a big hassle at the health centre. It has been that way for many years, and nothing has changed. No one has thought of a better way to resolve the waiting time. We must take numbers and wait, measure our blood glucose and blood pressure, and wait for about two hours to see the doctor. They attend to the outpatients first. By the time we finish, the bus service is no longer available. (Mere)

During one of his trips for a medical review, Juta waited for more than an hour before the nurse called him for blood pressure and glucose assessment. He waited for another hour before the doctor's consultation. After his review, which lasted less than five minutes, Juta attended to some other business in town and did some shopping before returning home. Although Juta did not seem to mind the whole day outing, his wife, who accompanied him to the review clinic, was worried about her chores. One female participant said:

> Longer waiting time at the clinic makes me tired and sick. I would wait around two hours of waiting and less than five minutes of

> consultations. There is always a problem with the bus service, so, most times, we wait for any transport to hitch in. Some women walked for more than eight kilometres because there was no transport. By the time we reached home, it was late, and we were tired. I did not have any more energy to do some housework. (Kesa)

Some patients received certain remittances on bus fares due to their medical conditions, while others are still awaiting assistance. From their health-care experiences, patients knew that there was room for improvement in the health-care delivery system. They would wait for a long time to be reviewed at the follow-up clinic, and women, in particular, would be especially concerned about arriving home feeling very tired and unable to manage their multiple domestic responsibilities. The patriarchal setup within *iTaukei* communities places significant pressure on women, making them more prone to the complications of diabetes and other illnesses. Female patients were entirely responsible for the day-to-day care of family members despite their medical condition and associated symptomatology. Thus, for the women, spending long periods waiting in clinic settings added considerable stress.

Treat my body with respect

If nurses treated medical issues as disgusting rather than more neutrally as problems, then patients' wellbeing and outcomes suffered. Patients felt intimidated, insulted, and concerned about the nurses openly displaying inappropriate behaviours during their treatment. It was not acceptable for patients to have feelings that discouraged their health-seeking behaviour or made them reluctant to accept health-care advice:

> The nursing services at the health centre were poor, especially from one group of nurses - those of Indian descent. I could see they were disgusted during the change of my wound dressing. It is like they did not know how to clean wounds; they dressed my wound carelessly and did not attend to it well. They rubbed wet swabs on it and closed

> it again … they wanted to fast-track their work. They often stand as far back as they can and provided arms-length nursing care like they are seeing this type of wound for the first time. I prefer to be attended by an *iTaukei* nurse. I only realised that I had an injury when it started to smell, and that was when I went straight to the health centre. I did not feel anything when I stepped on that nail. They should also understand that I did not intend to have a smelly foot. (Jese)

Patients also reported times during treatment and care when nurses acted in inappropriate ways, for example, showing disgust when viewing their wound. Unfortunately, patients' relatives witnessed such behaviours. Jese received daily wound dressings at a health-care facility and had an amputation when his toe did not heal. He was discharged from the hospital one week after his surgery and received a daily wound dressing change from a nearby health centre until his wound completely healed. During fieldwork, Jese was attending the dual clinic and was compliant with his medications.

Jese arrived at the *veitalanoa* group venue with his nephew, Netani, his primary carer. Netani willingly took care of Jese without financial reimbursement. As discussed in Chapter Four, Natani's involvement in Jese's care encompasses most of the *iTaukei* caring and sharing values. Netani joined the *veitalanoa* group when Jese was too emotional to continue. He stood and demonstrated to the group how the nurses attended to Jese's wound. All participants agreed with Netani's explanation. Another participant, Laisa, demonstrated how nurses would open her bandages, quickly rub swabs on her wound, and rush to close her dressing due to the smell of her wound. Hard to heal and malodorous diabetes-related foot ulcers is an increasing global health issue (Ousey & Roberts, 2016). Laisa considered the nurses acted in a very unwelcoming manner that made her feel they wanted to send her off quickly. In this way, patients like Laisa missed out on health education and proper nursing care.

Following Netani's explanation, all participants looked my way for comments. Feeling very uncomfortable, I fought hard against my own emotions and looked at the recorder on the table, my head slightly bowed. I, for once, did not know how to respond. Patients who have been regularly accessing health-care services develop expectations about how they should be treated. This led to criticism when the care they received was not up to the expected standard. In this case, the patient (and others) criticised the nurses' wound dressing techniques. Patients also referenced a preference for an ethnic group of nurses, suggesting they felt safer in that cultural context. Further, patients' intentions to be nursed by a specific ethnic group of nurses is worrying when the application of care should be the same for all types of patients by all nurses (Ringdal et al., 2017). In these examples, patients knew that the care they received was not the best, yet they had not said anything until the relative safety of this research environment.

Dealing with limb pain

Patients living with diabetes-related amputations are likely to experience phantom limb pains. When voicing their experiences, some patients received scathing insults, which again was not according to their cultural values and concepts of the *vanua*. Therefore, they felt ridiculed when the nurses treated their concerns as harmless banter. They remained quiet and did not have any control of their treatment options. In one circumstance, Jale received unpleasant responses to his experiences of pain:

> I just had to try and deal with the pain because I was at the hospital. Those injections are painful. I asked the nurse to push the medicine slowly because there was swelling around my arm. My missing foot was painful … don't know how is that possible. The nurse joked about my experiences and said that the medicine would be flushed faster … that I am a man and should be strong. I told the nurse that I was not an animal to receive such treatment. The nurses' response was worrying; however, I did not respond. That was not an *iTaukei* nurse, so they do not know the *iTaukei* custom. (Jale)

Most of the patient participants shared the same sentiments as Jale in their experience of pain. For example, Laisa said that the nurses were more worried about the amputation plan than her pain symptoms. She was also labelled a complainer. Therefore, she kept quiet and did not respond to what was being said about her. Laisa had one fundamental request - to receive nursing care without judgement.

These findings showed that patients' perspectives on receiving patient-centred care within the context of pain management are lost. They felt insulted, stressed and were left to justify their need for pain relief. They were concerned about the nurses judging them for being weak and complaining. They sensed that they were being stigmatised due to their reports of pain. In one instance, the nurse’s inappropriate use of humour upset and unsettled the patient. Derogatory statements towards patients made in a professional nurse-patient relationship are unacceptable, beyond professional expectations, and give rise to complaints (Grissinger, 2017).

Health outcomes are poorer when health-care professionals do not respect patients’ feelings (Grissinger, 2017). The lack of adequate pain and wound management caused patients to leave the health-care environment and resort to ethnomedicine, which reversed the biomedicine influence on community health, as shown in Figure 5. Properly communicating by sharing additional information, asking follow-up questions, and taking the time to ensure an accurate understanding of the patient’s experiences may improve the situation (Haverfield et al., 2018).

My care needs teamwork

The patients noted the vital role of teamwork in their experiences of safe and trustworthy nursing care. Teamwork is an essential component of effective patient management. Its absence leads to chaos, and patients described how the lack of teamwork negatively affected them. Jone described his health-care experiences that lacked effective teamwork and resulted in his foot being amputated. He expressed how he suffered unnecessarily due to acts of professional insubordination:

> I want to experience nursing care that involves the whole team and follows through from what the Consultant says ... a case of insubordination. The Consultant checked my wound and ordered a wound debridement and monitoring in the ward. They (the junior doctors) met me at the operating theatre and suggested the amputation. They say it would be easier to amputate while the nurse, who witnessed the Consultants' orders, did not say anything. After the amputation, the nurse came over to me and said they were supposed to debride my wound only like the Consultant ordered, but it was too late. When the Consultant realised that I received an amputation, he gave the junior doctors a good telling off - my wife, the other doctors, and nurses were there, including students. I am glad the Consultant told him off - that should be a lesson to everyone who was there, including the nurses. (Jone)

Jone was loud during the discussion. He proudly stated he felt more “special” when the Consultant scolded the junior doctors for their acts of insubordination. Jone received a wrongful limb amputation instead of having a wound debridement. Jone later said that he did not trust the nurses and junior doctors. He did not seek a legal opinion regarding his case. In this example, patients knew that the care they received was not as planned; they had received the wrong treatment with a poor outcome and did not benefit from the care delivery despite being at the centre of the treatment process. From his hospital bed, the patient silently observed and experienced an act of insubordination by other health-care professionals within the same team. The lack of respect for authority resulted in an amputation and his lack of trust in the health-care system. The silent compliance by the nurses breaches all codes of ethical practice but strongly reflects the social order in *iTaukei* society where medical professional hierarchies are in place that contributed to the nurses’ silence.

I need trustworthy care

Patients feel it necessary to have a trustworthy health-care system. Health-care professionals like nurses are important components of health-care systems. Nurses form meaningful relations with patients, and their connection positively impacts patients’ health through their trust in nursing care.

Trust is an essential component of a therapeutic relationship, and patients want to believe in the reliability and capability of health-care professionals; this belief often strengthens as a result of patients having specific clinical experiences (Leslie & Lonneman, 2016). Patients who are at the receiving end of care need care to be delivered by experienced professionals with relevant years of clinical experience, knowledge, and passion relating to their work. Patients reported a justifiable lack of trust in the health-care system, which they wrongly assumed would take care of their health-care needs:

> During admission, my experience was that they (surgeons and nurses) told me that amputation was the best alternative … need to do an analysis and check … does not grow back once they amputate … not like a tree branch … doctors and nurses need to be competent. Competency assessments to include successful wound management without amputation. They do not allow our wounds to heal but amputate limbs. Our family suffer, the community suffers, and it affects everybody in every way. The high amputation rate indicates proper assessment, including getting a second or third opinion. (Jope)

All participants agreed with Jope’s sentiment on health-care professionals' competency and the value of receiving several medical opinions. Another participant, Jese, said he felt helpless when he asked for reconsideration of the decision to amputate his foot. Another participant, Jone, said that he did not trust the health-care providers because it was common to see people admitted to surgical wards with diabetes-related limb amputations. However, another participant, Mere, expressed her contentment with the way she was supported:

> In our community, we have a good relationship with the nurses. We are supported more by the Village Health Worker. She visits us at home, and we have meetings. One officer from Diabetes Fiji came from Suva to visit us. The people in the village always look forward to accommodating people or organisations that come to address us. Everyone in the village would know if there was a meeting for people with NCDs and they would call out and announce for everyone to hear. I am getting used to being labelled with NCD now; before, it was hard. I used to be ashamed because my *tabu* would hear. (Mere)

Patients identified the weaknesses in the system and among the health professionals in the management of their care. They were victims to organisational arrangements, which led to increased rates of amputations. It is worth noting with regard to patient participants' comments that the nurses were fully aware of their care deficits due to the inadequate practice environments. For example, most of the nurses' time was spent on attending to patients' wound dressings, and people living with diabetes experienced delayed wound healing, meaning more extended hospital stays for patients needing wound care. Once again, despite knowing that theirs was not the best available care, patients accepted the health-care professionals' decisions. Regardless of their satisfaction in the relationships with nurses, the stigma associated with the NCD label shamed patients who live in traditional *iTaukei* village settings where relationships have deep and respectful meanings.

Patients need health education and health promotion

People seeking medical attention are always in need of information and advice regarding their health. Communicating health information to patients helps raise awareness and assists in health promotion strategies in disease management

(Thomas et al., 2016). Patients' need for information on diagnosis and treatment methods was recurrent, and they become engaged in their care when they had information regarding their medical condition and treatment options. As shown in Figure 9, there are five subthemes under the heading of “Patients need health education and health promotion”: 1) No one tells me the plan for my care, 2) Paperwork limits quality conversation, 3) How do I take care of myself?, 4) I need to be educated in my language, and 5) How do I manage my health condition in my community? These subthemes showed how nurses played an essential role in communicating vital information to people who needed it and conveying nursing care to patients verbally, or through actions, demonstrations, or touch. Communication of necessary health information to patients influenced their satisfaction, affecting health outcomes, as noted by Schillinger et al. (2004).

No one tells me the plan for my care

One hallmark of nursing care is when nurses can anticipate and respond to patients' many care needs, one of which is patients receiving updated information regarding their medical condition and treatment methods. Patients have the right to be informed to enable better cooperation, improved mental status, and preparation for the next medical intervention. The following data excerpts show that patients missed some vital information from health-care professionals. During the research, I noted that *iTaukei* patients continued to receive interventions while waiting to be informed:

> I waited for them to tell me anything about my care. The doctors and nurses should know what I need, at least start with some conversation about my wound and how they plan to manage ... How can I know? Should they wait for me to ask? They took blood for tests, and the results are only known to the doctors and the nurses. Until now, I do not know. They are the ones with the best knowledge in dealing with patients, so they should keep me informed. They were too busy … but these are some things that should come naturally as part of their job. They never told me … (Jone)

All participants agreed with Jone’s account of not receiving enough information about their care. Despite having had many encounters with health-care professionals, the patients said they had knowledge gaps about their health conditions. Another participant, Mere, said that doctors and nurses always decided on her care, and they assumed everything was good with her even though she was feeling changes in her eyesight. Mere also noted how health-care professionals were always rushing to clear the clinic and, at times, missed their meal breaks. She felt empowered during the *veitalanoa* group to seek more information regarding her status. Another participant, Jeke, said he received important information at a later stage of his diagnosis:

> Initially, I did not receive all the information that I needed to know. After the amputation, an intern doctor then explained everything, but it was too late. I wish I knew that vital information before I got sick. In the ward, the doctor came, said something, and went. The nurses were there all the time, and they should explain what I needed to know. The doctors just come and go … are too busy, but they should at least tell me ... what is going on in my body, the causes of diabetes, how can I improve … need discussion of my results, so it can be my guide to improve my health. The problem is because we do not know. We assume they are telling us everything. So, we just receive whatever little information and never ask for clarifications. (Jeke)

Most participants said they also experienced what Jeke went through. Therefore, the timely release of important information to patients was not practised, which did not mitigate any potential harm to patients. The transparency that was too little and too late reduced the health-care system’s reliability and affected patients negatively. Patients had hoped that the nurses would provide them with more information. This was not surprising as nurses spend far more time with patients than doctors.

These patients' stories (and many more) indicated a gap in patient care delivery and the lack of relevant health information relating to their care. Patients waited to be informed and relied on information from other patients. In instances when patients received information, its timing was inconvenient. The lack of attendance or attention by other health-care professionals caused busy nurses to be blamed for inadequate care. Meeting patient information needs helps satisfy patients' expectations, which should support clinical decision-making and lead to increased quality of patient care (Clarke et al., 2016). Patients have a right to information that assists their mental wellbeing. When they did not receive this information, they felt forced to explore other sources of information and treatment methods.

Another participant, Jale, shared how he felt left out of a system he believed was supposed to support him. As his condition changed, new interventions and care became necessary. In Fiji's practice settings, it is usually the nurses' role to provide additional information and change patients' support plans as part of the nursing process following a medical change of plan. The role includes fully informing patients as to what they can expect. This work is exacerbated in an environment where doctors' communication is scant and directive rather than collaborative. However, this important nursing role became impossible when nurses worked in busy practice environments, causing some patients to report that they were unaware of information updates relating to their care until hearing the responses of other patients in the research environment. This helped explain Jale's attempt to justify why nurses "forgot to explain changes" in his status.

Other participants were concerned about their lack of information regarding care updates. One example arose in the discussion of folder colours according to the PEN model, which designated patients' overall health status. While waiting at the health centres for their appointments, patients listened to other patients' stories to gather information on diabetes management. Most patients learned of new updates in their care from other patients while waiting at the clinic. These acts of sharing individual experiences related to their cultural values to help other people with their disease and other symptomatic conditions. There were also some discrepancies in the way patients were managed and informed. Field observations noted that not all foot clinic nurses had undergone training on foot care, which was later confirmed by the Fijian Chief Nurse. One medical division was taking the lead role in foot care while routine wound care was provided to patients living with diabetes-related foot infections in other medical areas.

Another participant shared how the insufficient provider–patient communication led to his inadequate knowledge about new medications. Jese said the physician who changed his medication said, “You need another tablet” but did not provide reasons for prescribing the new tablet or advice on how to take medications and the possible side effects. Later, Jese read some information on the internet when he started experiencing side effects and was angry because he “was not prepared”. Jese’s experience, which was also shared by most participants, was a contributing factor in their not accepting medication prescriptions.

Some patients received updates during the research environment from other participants, leaving them concerned and disappointed. Patients preferred having background knowledge about their condition along with an understanding of the diagnosis (Clarke et al., 2016). The lack of information contributed to delays in patients' readiness to self-manage their health issues. The provision of insufficient information made patients seek other sources, such as the internet, to fill in knowledge gaps.

Paperwork limits quality conversation

Patients noted their lack of involvement in a face-to-face discussion regarding their medical conditions as health professionals spent a substantial amount of time on paperwork. As consumers of health care, patients are typically observant, even though they may not entirely understand the clinical and technical issues of nursing care (Davis et al., 2013):

> Healthcare professionals should always talk to us, and they should not be writing all the time. They only say yes, okay, and nothing else … they are so used to just writing. What is wrong with talking to us, for them to ask about life, food intake, and other issues? These days,

> they do not speak much because they only know their books. I do not know what information they were writing about me and the types of reports they are writing, but one thing I know is they spend less time with patients. Before, the doctors and nurses used to tell me to be careful about the consumption of some type of food. Nowadays, they are so used to writing and filling in books so they can report that they are performing, but they do not do the actual job - it is not well done. I am not hesitant in saying this because my experiences in the earlier days were with professionals who always discuss and provide information about the disease. These days, they do not … we cannot compare the standard of nursing care to what we have now. (Jeke)

My field observation journal documented how seven people crowded out a small and busy consulting room and confirmed Jeke's experience. I observed how the busy Nurse Practitioner (NP) spent less than a minute talking to the patient but spent a much longer period writing the patient's information. After entering the patient's details, the NP wished the patient well. The observation noted that when the patient stood to leave, the NP realised that the patient was without a prescription. The NP and the patient, who were both aware of the researcher's presence, looked at the researcher. The NP commented critically on the need to duplicate data entries while the patient smiled. One participant said:

> They have a systematic way of enquiring about my health status. It is the same during every clinic. They would start with greetings, say everything is okay, and to continue the same care. They spend a lot of time writing, and I am sitting idle, waiting for them to complete their paperwork. I wonder what they are writing about me. A nurse once told me that they have some reports to submit. The nurse herself was complaining about the amount of paperwork they must fill. (Leba)

Leba's example, which was agreed to by most participants, showed that deskwork has edged out quality face-to-face time with patients. Paperwork has taken much of the nurses' time, meaning less time is used to communicate important information relating to patient care. In this way, patients fell victim to organisational demands for effective reporting, which created a gap in vital health information communication. The gap left patients in a position to seek other sources of information, most of which were misleading and contributed to adverse outcomes. Patients observe and experience the skill in care delivery and inconsistencies in care, minor errors, and disasters (Davis et al., 2013).

How do I take care of myself?

For health-care plans to succeed, their affordability must be assessed and carefully planned, and consideration must be given to their impact on organisational objectives. Communicating a cost-effective care plan is a critical component of patient-centred care (Saini et al., 2017). Care plans must match patients' ability to access and afford care, warranting proper preparations and understanding from patients' perspectives. In a country where living costs are high, the option to live healthily has now become an expensive alternative in Fiji. Participants noted the difficulties they faced while trying to live healthily:

> Sometimes, there is a mismatch between what is available at home and what the nurses are asking me to eat. It is the nurses that provide education on the right types of food to eat and the exercises that I should do. You know … life in Fiji is hard … high costs of food against its quantity and quality. I resort to cheaper and unhealthy ones. I cannot plant my vegetables or go fishing because of my amputated leg. (Jale)

All participants agreed with Jale’s sentiments. One participant, Jope, raised the issue of the availability of allied health-care professionals and said that he had never consulted a dietician or a physiotherapist. There was a need to empower people who have diabetes or are at risk of diabetes with knowledge and other resources to help them control their condition (Royal College of Nursing, 2014). One patient participant said:

> I pay my fare to the clinic, and some others have free bus cards. We must wait until we reach sixty-five years to receive free bus fares and is one of the reasons people do not attend clinics, particularly the younger ones. Maybe they (government) are waiting for us to die (laughs) … they do not realise that younger people also have NCDs … the bus service is pathetic, as they are not consistent. They follow different routes and confuse us. (Peci)

The high costs of living contributed to noncompliance with medical advice and made patients resort to cheaper and unhealthy food choices. The data showed that patients must bear the burden of out-of-pocket payments to access health-care services and, sometimes, miss review clinics due to affordability issues. Patients' inability to pay health-care-related costs contributed to worsened patient outcomes, which increased costs to the Ministry of Health and affected the country's socio-economic development. It is important to note that the patient participants did not communicate their concerns with any health-care professional but freely did so without hesitation during the research process.

I need to be educated in my language

Patients required the dissemination of information about their medical problems and treatments in an appropriate medium. One such medium was using languages that patients could understand. Patients expressed concern at the difficulties they faced when medical professionals used obscure language and medical jargon, “the hard to understand language”, to communicate important health information to them. In this way, patients were lost in the non-translation of the message and did not ask for clarification, while health professionals assumed that the patients understood them. There were two examples of this happening:

> They did not know some of the Fijian words to describe parts of the body and what the progress of the disease was ... they used words that I did not understand. Another issue was that they could not explain to my level of understanding. I do not blame them, but they should make it their business to know how to communicate these things. I feel sorry for myself and other patients … we must go along with what they are saying because they do not know how to say some things clearly. (Laisa)
>
> I also heard some new words … the nurse assumed I knew … maybe she was pretending to (laughs). However, I did not know what she was trying to say … and another thing - she mentioned a complicated English word. I think it was something to do with my wound dressing because she was pointing to my wound … that bit I understood. (Jeke)

Where patients received some information regarding their care, communication was in languages *iTaukei* patients did not understand. Medical terminologies created helplessness among patients with low health literacy, which is common among the elderly and patients who have low educational attainment (Schillinger et al., 2004). The patients comfortably voiced their concerns about being inappropriately informed about their medical conditions and treatments during the *veitalanoa* group yet admitted to infrequently or never asking questions of health-care professionals. The lack of clarity in health information led to worsened patient outcomes through increased chances of disease complications.

How do I manage my health condition in my community?

Management of long-term conditions requires a careful balance between health and social care. Most health outcomes derive from the social determinants of health rather than clinical treatment (Braveman & Gottlieb, 2014). Participants identified the lack of involvement by other government ministries regarding their care. They anticipated receiving nursing care that connected well with other government departments to support their need for a healthy lifestyle. Other government departments identified by the patients were:

- Ministry of Agriculture to provide seeds for village gardens and an individual family garden for all patients diagnosed with NCDs.
- Ministry of Transport to provide busses that someone with an amputation can access. Patients need proper timetabling of buses to suit clinic dates, and have printed bus timetables, subsidised bus fares for people who need to attend clinics, and suitable means of available transportation to nearby clinics for people with amputations.
- Ministry of Social Welfare to assist people who live with a disability and need to attend regular clinics.
-

The female participants all hoped to have a community vegetable garden that could help them eat healthily. People living in communities normally require support to achieve major projects such as this, which need support from other government ministries. Mere said they normally received seeds from the Ministry of Agriculture. However, there was a lack of consistent assessment of the damage caused to their farms by unfavourable weather conditions. Personal observations confirmed the expensive prices of locally grown vegetables in supermarkets. Some patients were recipients of the Ministry of Social Welfare scheme in Poverty Reduction, which assisted people with monthly monetary support and food vouchers. Other participants had this to say:

> The Health Ministry should take the lead role in communicating our needs to other government ministries. They are not coordinating very well. To help people living with diabetes, they must communicate well with each other. Otherwise, there would be problems. (Juta)

> Some receive free food vouchers and money from the government. We were told by the nurse last year that we can receive assistance through medical reports. We are still waiting for this. So, when we have the money to travel, then we can attend clinic … it can also

> motivate those who do not attend clinics due to financial constraints ... also avoid disease complications. (Laisa)

Most participants agreed with Juta and Laisa. They identified the discrepancies in the current assistance by other government ministries. They also noted the variations in the type of support they received. All participants also shared the lack of involvement of their families in their care. They said that their families, who in a typical village setting lived close by, lacked knowledge of their illness. Juta chronicled the importance of family support, which greatly assisted his care and hoped the nurse had involved his wife from the beginning of his diagnosis. Another participant, Leba, hoped her family was involved and said she started sharing medical information with them. During a *veitalanoa* individual interview, another participant, Jeke, disclosed having ED[64] issues and that he did not know how to handle them. Jeke also wished that his wife had received some educational sessions on his issues. He was referred to the counsellor and medical officer for assistance, but explained:

> It will be good for us (the nurse, my wife and I) to talk and discuss the difficulties … together … some ideas to take care of issues. It will help … other patients go through the same problems that I have, and that help is available, which can only come from someone who understands the disease better. I do not want to go through criticisms because of my issues at home. (Jeke)

In areas where government assistance was provided, patients received inconsistent and delayed support from the other government ministries towards their care. This made them unable to continue eating healthily and attend their follow-up clinics regularly, and this led to more complications of the disease. These complications included end-stage kidney disease, blindness, and limb amputations that contributed to a sicker population in Fiji (Morgan, 2015; Snowdon et al., 2013).

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[64] ED – erectile dysfunction

Even though family members were directly involved in the care of patients, nurses did not inform them of the planning and management of the patient at home. The support from family was an effective factor for patients' recovery; therefore, they needed to be informed to enable more significant involvement in the care of patients. Families not being involved or advised about the care of another sick family member had detrimental effects on the wellbeing of the patient (Aweko et al., 2018). It led to a lack of support for the person in need, which affected compliance with health advice (Rintala et al., 2013). Interestingly, despite patients experiencing gaps in the health-care services, they did not express their concerns until they were in the research environment.

Chapter Conclusion

This chapter considered patient participants' views on what constituted best practice and ideal nursing care for patients living with diabetes and associated conditions. Overarchingly, this data showed that the patients were more concerned about their overall experience of care and treatment than their nursing care per se. In the process, discussions by the patient participants formed into three main themes to support their experiences. The first was the cultural barriers to care, which patients identified within their cultural values and perceptions of the *vanua*, the degree of their dependence on nurses for support, and their expectations of respect for age. The theme also identified how patients approach health care using their cultural knowledge and become resistant to Western medicine approaches. Patients also expressed how knowledge of the high incidence of amputations in Fiji among the *iTaukei* population had caused fear among them, which has become a factor that prevented them from seeking health-care services due to fear of having an amputation once they were diagnosed with diabetes.

The second theme centred on how patients expected safe and trustworthy care that involved inclusiveness in all discussions and decisions about their care. Patients said that their health plan should consider their other activities of daily living, apart from accessing health-care services. Therefore, they requested considerate nursing care that also focused on their lives outside the clinic, particularly for women with their domestic responsibilities. Patients with diabetes-related foot infections asked to be treated with respect, particularly in relation to worsened infections and delayed wound healing processes. Patients also wished for nursing care that was reassuring when they experienced pain as a result of surgery. The patient participants experienced incidences of insubordination and received inappropriate care, which had lifelong consequences affecting their quality of life.

The third theme related to patients' need for health education and health promotion. Patients received treatment without being informed of their care plans and were suddenly confronted with harsh decisions that affected their health. Also, the patients noted the length of time during consultations that health-care professionals used on desk duties; this time was at the expense of face-to-face conversations that involved health education and information. Patients were, therefore, underprioritised because of organisational requirements for effective reporting of activities, and, consequently, they did not feel well prepared on how to self-care. Patients also identified an important need to be able to engage with health-care professionals using conversational languages they could understand.

Chapter Eight: Nurses' *Talanoa*

Similar to the patient participants' *veitalanoa* in the previous chapter, Chapter Eight documents the experiences of the eleven nurse participants who have provided care to patients living with diabetes and associated conditions in Fiji. The nurse participants responded by sharing their work history and experiences of delivering nursing care. In their description of the ideal nursing care they hoped to deliver, the nurses reported the difficulties they continuously encountered.

The *iTaukei* nurse participants described their nursing care experiences with *iTaukei* patients while practising as licensed practitioners with the Fiji Nursing Council. These findings are specifically from the nurses' experiences of providing care while employed by the Fijian Government in any of its Ministry of Health facilities. The *veitalanoa* documented three main themes and sixteen subthemes (see Figure 10), which I present in the participants' own words. The main themes are barriers to care, substandard care, and education to support practice. In order to elaborate on the themes, I draw on data from the *veitalanoa* group, individual *veitalanoa*, my field notes, and personal communication with the Fijian Chief Nurse with whom I discussed the emerging data.

Figure 10

Summary of Themes and Subthemes from Nurse Participants

Barriers to care

- Impact of cultural practices
- High patient volumes
- The lack of space
- The lack of time
- The lack of equipment
- The lack of teaching resources
- Increased workload
- Work overload
- Lack of autonomy

Substandard care

- Poor relationship
- Lack of time to conduct health awareness
- Ignoring stigma
- Following orders despite own clinical judgement

Education to support practice

- Postregistration education
- Training for Village Health Workers
- Education on complementary therapies

Barriers to care

Nurses face many challenges at work that prevent them from providing nursing care in the way they know is needed. These challenges become barriers to effective implementation of nursing care to patients who have diabetes and associated conditions. In relating their experiences, the nurses discussed the avenues they utilised to help meet the patients' nursing needs.

As shown in Figure 10, there are nine subthemes under the heading of "Barriers to care": 1) Cultural practices, 2) High patient volumes, 3) The lack of space, 4) The lack of time, 5) The lack of equipment, 6) The lack of teaching resources, 7) Increase workload due to patients' preferences, 8) Work overload performing other tasks, and 9) Lack of autonomy. Overall, the data from the nurse participants revealed multiple examples of nurses working in less than optimal conditions due to some organisational characteristics that were key barriers to patient care.

Impact of cultural practices

As outlined in Chapter Seven, cultural practices and beliefs have a significant impact on how patients respond to their diagnoses. Such beliefs and practices conflict with the nursing goals for such patients. The nurses expressed difficulty in dealing with patients who denied their diseases, refused or complied poorly with treatment, and blamed other factors for being sick. Such patient behaviours prevented nurses from drawing up workable nursing care plans for patients living with diabetes. One nurse participant explains:

> One problem that patients have is denial … nurses need to be very patient when dealing with them … know which person they can involve, to help provide insight into their disease. Patients are fast in denying that they have diabetes, and quickly respond by denying having a family history … some think that diabetes is associated with witchcraft or curse … not compliant with medical advice. Time should be committed to patients who are still in denial. Most *iTaukei* continue to smoke, drink *kava* and alcohol, and do not care about their physical activities and diet, which affects their blood glucose level. (Vere)

All participants shared the same sentiments as Vere. They added that *iTaukei* patients arrived at the health-care facility only after they had exhausted all traditional means of healing. The patients often presented very late, when their foot infections had not improved, thus resulting in amputations. Despite having counselling during the initial assessment phase, patients still used traditional therapies. Another participant said that patients with foot infections preferred to have their wound dressings changed at home despite being advised against it and, therefore, they ended up with an amputation. A few participants reported the difficulties they faced because people were temporarily living (*veivakavaletaki*) with relatives in towns and cities, and the nurses were not aware of their patients' whereabouts.

Some zone nurses in the *veitalanoa* group highlighted the difficulties they encountered during home visits when patients would visit (*veisiko/veigadivi*) their relatives in other places. Therefore, the nurses felt there was little they could do but to wait for patients to return when they were generally in a worsened state. One participant, Lisi, said that some *iTaukei* patients feared receiving an amputation, which drove them to seek other sources of healing. Due to this fear, patients either died from untreated sepsis or they had to have limb amputations due to the extent of their foot sepsis. Lisi further added that despite being advised on diabetes and its complications, patients still lived unhealthily, specifically the men, who did not listen to their wives. In another example, Vika wanted to be able to deliver nursing care to honest patients. She said:

> Some patients would take their medications and herbal therapies a few days before review days, and this makes their capillary blood glucose (CBG) readings healthy. It affects their folder colour codes (PEN model), which also affect their treatment and advice. Some patients ended up with hypoglycaemic attacks, but their HbA1c reveals normal results. They play around with their medications. During home visits, I come across a high number of patients who are noncompliant to their medications. There are many leftover medications. I try and inform them the process involved in ordering their medicine … and the mentality is that medications are free. If people start paying for their health care, they might be responsible. The free services add to their problems and cause more complications … I mean the free health service and the handouts from the Social Welfare Ministry. (Vika)

All participants agreed with Vika's argument that most *iTaukei* patients did not take diabetes seriously, which, interestingly, they took to mean they did not care. In one example, Lusi noted how it was common for *iTaukei* patients to say that everyone would die one day. Dealing with patients who were in the denial stage of accepting their disease is a universal issue for nurses that prevented appropriate clinical decision-making. Patients' denial of having the disease contributed to their developing complications of the disease, including amputations. The data showed that fear of receiving an amputation and denial of the disease also forced people who faced difficulties in managing their symptoms to opt for alternative therapies. Patients who used alternative therapies made the work of nurses harder, and nurses faced a significant challenge in managing patients who alternate between prescribed medications and herbal treatments.

High patient volumes

The nursing workforce have not been able to provide a safe nursing staffing level according to their work demands. Nurses must deal continuously with high volumes of patients and are concerned about patient safety and adverse patient outcomes in their practice environments:

> There are too many patients to see in such a short time. We do not have the time to properly care for them, so we always must rush to attend to all of them. There is no quality nursing care. (Loma)

In Fiji, on a normal clinic day, patients and some relatives usually crowd around the clinic area and, on most occasions, along the corridor. Passing through can be a difficult process due to the type of patients waiting in line for consultation. For example, patients with missing lower limbs were normally in a wheelchair or had prosthetic limbs, so walking past them must be done with care. In one observation, I witnessed the crowded consulting room that had seven people in it at once, and patients with their relatives crowded the corridor. One nurse noted:

> If I am doing the maternal child health clinic (MCH) and have a new diabetes-related foot case coming in, I leave MCH and attend to the new patient. The number of patients with diabetes is increasing now … wanting a quick review, and some arrive very early. The *iTaukei* typically arrive late, and, by the time I attend to them, I am exhausted from stating information repeatedly. We also need more nurses to help with the workload. (Rosi)

The nurses reported they hurriedly attended to patients so they could accommodate the high volumes of patients within a set clinic period. I personally observed that some patients arrived four hours early at the clinic for their appointments. The clinic was organised on a first come, first serve basis, and offered blanket clinic appointments. Patients were triaged and waited for the doctor or the Nurse Practitioner for consultation. There was no water fountain in the clinic and no canteen near the health centre, except for two bean carts selling Indian sweets across the road. Another man around 60 years old was selling snacks at the health-care facility entrance.

Review clinics for people living with diabetes operated during a certain period of the day. The nurses reported not being able to deliver holistic nursing care due to the high volume of patients. For this reason, nurses missed some critical aspects of nursing care. Missed nursing care negatively impacts patient management (Blair & Smith, 2012; Bordage, 1999; Simpson et al., 2016). The high volume of patients affected nursing staffing, which resulted in shortages of nursing staff to share the workload, and this contributed to unsafe nursing practices. Conversations with the Fijian Chief Nurse confirmed awareness of the problems within the nurses' working environment. According to the Chief Nurse, the Minister of Health was aware of the inadequate practice environments and the challenges nurses faced in terms of the facilities and other infrastructure issues. All the nurse participants agreed on this point, and this was further confirmed by my field observations that nurses struggled to address the high volume of patients needing to be seen within a short timeframe. The nurses were exhausted, which significantly impacted patient care.

The lack of space

The lack of space and resources further prevented nurses from carrying out their roles in the way they knew was needed. The nurses acknowledged the profound effects of working in a confined and crowded environment. They identified several working conditions they believed were not conducive to safe nursing practice:

> I want to work in a well-managed and organised clinic. Here, patients arrive any time, and it is stressful to see everyone crowding around in the passage. It is like everyone is staring and monitoring what I do around the clinic … there is no privacy. It is hard for patients to remove their pants in a space that is not private … challenged with the lack of space to conduct proper assessments. We still conduct foot assessments according to the business plan for our coverage. Sometimes, I educate my patients outside … under the tree. We do not let our patients go away … otherwise, we will not catch them … we only follow up the home-based cases in their homes. (Rosi)

Nurses experienced occupational stress, which negatively impacted patient care. As documented during my fieldwork, I witnessed the lack of adequate lighting and ventilation in a corridor. The data showed that nurses worked in relatively congested and overcrowded environments and battled with a high volume of patients and insufficient resources. I observed the Nurse Practitioner reviewing a patient. She was very loud, and all the other patients could hear her discussion with the patient because the consulting room did not have a door. A nurse added:

> When we have a double clinic, patients are usually squashed up in one room, usually more than five people … concern for privacy for the patients and working conditions for the nurses. We are trying to cope … share the clinic with the other department … I use the couch when it is free; otherwise, patients sit up using a footrest. The clinic is always overcrowded; patients stand … wait for a very long time for review.

> The lack of space, knowledge, and resources is troubling because we can miss some essential details. (Litia)

In another fieldwork observation, there were patients with relatives in the consulting room, waiting for their turn, and a nurse who was also with another patient, providing follow-up dates in the same room. There was no couch or door. Some patients and relatives pushed their way through to check what was going on inside. Such practice environments prevented patients from discussing their health-care needs and, compounded with their cultural values and the *vanua* protocol of establishing relationships, *iTaukei* patients could not openly discuss their health issues.

Nurses were not able to provide the full level of care due to unpredictable work conditions and, therefore, resorted to delivering a rudimentary level of care. It was clear from listening and observing that the circumstances meant that nurses provided only very basic care and missed many opportunities for more careful assessment, health teaching, and in-depth responses to presenting problems. As such, this was inadequate care that was further compromised by the lack of essential resources.

The lack of time

The participants mentioned that the clinic schedule for people living with diabetes was on a three-monthly schedule. They were concerned at how easy it would be for a person to develop complications, like foot infections, and still be waiting for their clinic schedule. For this reason, the nurses discussed the need to educate patients about their condition to prevent delayed presentation:

> It is hard to SNAP[65] patients, and it is a tough job to gain their trust and confidence … it takes time to know them well. I have mentioned this to the doctor. I investigate contributing factors, asking personal

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[65] SNAP – identification of NCD risk factors: Smoking, Nutrition, Alcohol, and Physical Activity

> questions. Sometimes, stressed patients become emotional and cry, and other patients are listening to our conversations ... they need to be in a room, have a one-to-one talk with nurses, and talk about the cause of their problem. I provide comfort, and with the other patients looking … some nosy patients will ask, why is she crying? ... and I will tell them … no, it is just some of the issues we are discussing … that is the problem when we do not have any space, which is beyond our control. (Rosi)

SNAP assists nurses in identifying risks and demonstrating how to advise patients on smoking, nutrition, alcohol, and physical activity. There were two additions to the SNAP component: stress management and spirituality. In another observation, Rosi was conducting a foot assessment on one of her patients. She had to stop and move her patient from the examination couch to the bench in the same room because someone else needed to use the examination couch. Other patients were waiting for a foot assessment. The examination couch and the room were another nurse's workspace.

As noted during discussions with the Fijian Chief Nurse, the Ministry of Health was aware of the challenges nurses face at work. The hardworking nurses improvised to meet patients' needs. It should be noted that the Ministry of Health could not control most of the challenges faced by the nurses, especially with the clinic infrastructure and set-up; this was because of financial constraints, the high volume of patients, and other cultural factors. Communications with the Chief Nurse also confirmed that the nursing department had submitted their reports to the Minister of Health. The responsibility now lies with the Minister, who is also looking at ways to resolve these issues. Until change occurs, nurses will continue to be challenged by the lack of time.

Patient education is a particular task that is influenced by many factors; hence, it needs a careful approach. Selai said she does not have the time to teach her patients:

> It is all about education … nurses need to explain to the patients to help them understand … the problem is who has the time to do it since we need to clear off the many numbers of patients. Most patients have complications already, and this takes more time teaching them. (Selai)

All participants shared Selai’s sentiments—the importance of providing education to patients living with diabetes, and the fact that they did not have time to educate their patients. Some nurses explained how they were sacrificing meal breaks to educate other nurses on managing diabetes-related foot infections. There were discussions of simplifying education to match patients’ level of understanding and educating in a variety of languages. She shared how she allowed relatives to observe the change of wound dressing procedure while she used that period to educate patients and their relatives. However, she reported that most relatives feared patients’ wounds. Another participant, Litia, suggested that due to the high number of diabetes-related foot infections, there was a need to have two nurses during clinic days.

Nurses knew the importance of a competent patient education plan and wanted to implement it; however, they lacked the time to educate other nurses, patients, and their families. The nurses encountered staff shortages and lacked time to fulfil their job demands and the complexity of patients’ educational needs. The specially trained foot care nurses were overwhelmed by patients’ need to be informed; therefore, they had trained other nurses to meet the work demand. The lack of time to attend to patients’ educational needs prevented nurses from delivering appropriate and adequate information about diabetes (Drincic et al., 2017). The lack of awareness contributed to noncompliance of medical advice, worsening the patients’ health statuses by increasing the chances of disease complications that further stressed health budgets (Fernandes et al., 2016; WHO, 2016).

The lack of equipment

In addition to crowded conditions, nurses frequently deal with insufficient healthcare facility resourcing, forcing them to provide nursing care that falls below acceptable standards. Two examples of this are:

> We do not have consistent sterile dressing supplies therefore do not use sterile dressings. We prepare our dressing supplies … Gilchrist, swabs … and they do not go through autoclaving … still waiting for our autoclaving machine … the dressing trays are not sterile. We only dip and soak dressing trays and forceps in hot water and savlon for a few minutes, and they are ready to be used … is always an issue to transport trays to the main hospital. So, we use the unsterile ones … only one dressing tray on many patients, mostly on those with minor dressings ... no minor dressing packs. (Loma)

> There is no couch, and it is uncomfortable for the patient and the nurse to conduct a foot assessment on a patient who is sitting up. (Rosi)

In one fieldwork observation, there was only one dressing tray opened and used on three patients who required minor wound dressings. Also noted was the absence of minor dressing packs. Discussions with the Fijian Chief Nurse confirmed she had received complaints from some nurses regarding their working conditions. Some nurses were more comfortable talking to her than to their supervisors. The Chief Nurse did not turn anyone away but had followed up the complaints. Other nurses lodged their objections to the Fiji Nursing Association (FNA).

Proper wound care is an essential aspect of care for people with diabetes. Faced with shortages of health-care facility resources, nurses provided inappropriate care due to lack of sterile equipment, which may lead to cross-infection and delayed wound healing. Unhealed wounds exposed the patients to many risks, including further wound debridement or limb amputation. These stories and my observations showed that wound healing was compromised, and infections were more likely to happen. Infections occur in the absence of the proper treatment of wounds (Corsi-Vasquez & Ostrosky-Zeichner, 2020; Kent et al., 2018). Failure to manage wounds led to an increased risk of amputation (Hessels et al., 2019), not to mention personal suffering and prolonged hospitalisation.

The lack of teaching resources

The nurses shared how patients living with diabetes and associated conditions must understand health-care instructions and adhere to them. However, the nurses lacked educational tools that assisted them in enabling this understanding. One nurse participant explained:

> Now it is worse, and we are receiving more *iTaukei* mothers. They are not compliant with health advice. It goes back to our awareness and education, but it also depends on their understanding of how well they understand the health message … mainly from our rural mothers. We should be showing them pictures that support our talks, some images that show the disease complications … because patients do not take things seriously. It will be useful to have videos that patients can watch while they wait in the clinic. (Ana)

All participants agreed with Ana’s sentiments on educating patients, stating that the Ministry of Health should provide teaching materials and educational videos to support their role as educators. Where there were educational materials available, participants said they ran out, and orders for more resources arrived late. There were also discussions about how people only saw diabetes as a word and were not aware of its complex consequences. Vika explains:

> The community need to see the consequences of diabetes through its complications. It is frustrating to see the lack of attention directed to

> the associated conditions of diabetes … the posters we have presented a healthy person running, planting, and has portions of fresh and healthy food. The complications of the disease need to be in posters or bigger canvases for people to see. We need to have banners that have complications of the disease, so when people look at them, they understand them straight away, especially the not-so-well educated. (Vika)

There were also suggestions that the Ministry of Health should have better plans for public awareness. One participant, Selai, highlighted how the language used in pamphlets had become a barrier to patients' understanding; all brochures were in English except for the one on diabetes retinopathy. Another participant, Lisi, mentioned that people were not aware of the pathophysiology of diabetes and suggested that educational charts be supplied and pasted in patients' dining areas within their home.

The nurses knew that patients could benefit from health education materials, and they also knew that patients needed information and better-informed care. However, the patients' need for information was not met due to lack of educational resources to support nurses in their patient-educator role. Educational pamphlets could change patients' perception, knowledge, and understanding about diabetes, and help patients comply with medical advice. The lack of supportive educational materials to assist the nurses did not fulfil the information need of patients, which contributed to undesirable long-term health consequences (Horner et al., 2000). The nurses felt disempowered and were frustrated with the current management of patients living with diabetes.

Increased workload due to patients' preferences

Patients have shown that they notice differences in care at different centres. Nurses described with concern that some patients visited medical centres other than those designated according to their residential addresses to access care that they perceived was better:

> I want to deliver the type of nursing care that is consistent in all facilities. Some patients prefer the nursing care that I provide despite belonging to another medical area … not a good picture for nursing when patients behave this way … disturbs the medical supplies, adding workload to staffs even though I do not mind … unfair to other patients. Despite sending these other patients to their clinic after attending to them, they still return the next day to the clinic … I told a patient with fore-foot amputation that she belongs to another area. I attended to her and discussed her case with her area nurse. Next day, the patient was back in the clinic, and when questioned, stated that she did not like the other nurse's approach … not treated the way I attended to her wound. Her area nurse is not *iTaukei*. (Rosi)

Patients' preference for nursing care provided by some nurses has put pressure on resources in certain practice environments. In an observation, Rosi was attending to one of her patients when a woman in her 30s greeted her from the window. Rosi jokingly asked the purpose of her visit to the health centre. The woman, a postoperative forefoot amputee from another medical area, said to Rosi "*No one is like you*". Rosi responded by saying *"Do not pull my leg"* and attended to her after she attended to all her patients. Rosi had been attending to her wound for several weeks. Another nurse added:

> Nurses must speak the same language, know, and be involved in wound care … I feel that all nurses should know how to take care of the patients' wound. Sometimes, after hours, the nurses send wound pictures to me through the phone on messenger, and I advise them on the dressing. We encourage patients to come in the morning as patients know the difference in the care they receive from other nurses. I have another colleague, who is a senior nurse. She knows

> what to do, but she does not do any foot assessment. Maybe she has her reasons. I end up doing all the work and feel so tired. (Litia)

The nurses' stories and my field experience indicated a lack of consistency in the way nurses practise that determined patients' health and help-seeking behaviour. The nurses described how some patients had developed personal preferences for nurses and their services. They travelled away from their designated medical areas to other areas, affecting resources and increasing workloads for some nurses. Displaying hospitality without barriers and receiving and treating patients openly despite their allocated medical area are cultural values possessed by most *iTaukei* nurses.

Compensating for allied health roles

The nurses knew that to provide a holistic approach to people living with diabetes and associated conditions, efforts should concentrate on ensuring a consistent supply of multidisciplinary health professionals, including dietitians, physiotherapists, and more nurses to attend to patients' needs. One nurse said:

> I am the foot care nurse[66] and am responsible for all diabetes cases. I have a zone to cover but look after all patients with diabetes from other zones as well. I need to see them in their first clinic. I do not receive extra pay for extra work. The dietician is mostly on sick leave … I fill in and use diet charts to educate patients to avoid worsened conditions. I try to educate patients with the little knowledge I have about diet. I also encourage patients to return for clarifications if unsure, especially the patients with foot ulcers or infections. The patients must receive advice on nutrition, physical fitness activities, and medications. Generally, I encourage patients to come to the

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[66] Foot care nurse – nurses who have training in diabetic foot care. They are responsible for all patients with diabetes and needing foot care. They assess, diagnose, dress patients' wounds (if any), and recommend pharmacological interventions.

> clinic, so I can assess and refer them if needed … something that needs fast-tracking to save their limb. Most patients cannot cut their nails due to nephropathy effects on their eyesight, so I cut their nails. The foot care assessment form helps in managing the patient. With the foot assessment, I do toenail removal and advise the high risks cases; otherwise, I encourage patients with lesions or infections to return for wound care. (Rosi)

Rosi, like other participants, filled in for the dieticians, physiotherapists, and the doctors in their absence to continue the routine care and fulfil objectives of patients' visits. Litia added:

> We have only one dietician, and she looks after the whole centre and the birthing unit, she is always at the antenatal clinic. It is a lucky day for the patients if the dietician is available to come across to the centre. We also have an allocated physiotherapist from the main hospital who is hardly here. Sometimes, I teach the nurses again, and this is an added responsibility to my workload. (Litia)

Some nurses attended a training programme on diabetes-related foot care for primary care nurses. The programme was facilitated by Diabetes Fiji with collaborative efforts from the Ministry of Health, FNU[67], WDF[68] and other relevant stakeholders. They identified themselves as foot nurses. The foot nurses were responsible for conducting foot assessments and risk clarification and providing advice and education to patients living with diabetes on self-foot-care. They also managed diabetes-related foot problems and conducted primary and preventative programmes for diabetes-related foot care. It is of great interest that they then described themselves as foot nurses, thus contradicting all of nursings' notions of holism.

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[67] FNU – Fiji National University College of Health and Nursing

[68] WDF – World Diabetes Federation, which operates in partnership with Diabetes Fiji

The nurses were spending a substantial amount of time troubleshooting recurring operational problems that had been interrupting care and creating risks. The nurses were multitasking and ensuring the continuity of care. Their stories showed that they acted as healthcare intermediaries and worked flexibly to blur their jurisdictional boundaries with those of others to ensure that care continued. Such situations were common. Nurses had always ensured patient safety by filling in for other health-care professionals. These added tasks changed the scope of nursing practice and took nurses away from primary nursing care, which created considerable role ambiguity within nursing.

Lack of autonomy

From their observations and information during shift clinics, the nurses knew that more people were overly dependent on government assistance through social welfare support. Their overreliance on the government has discouraged young people from engaging in farming practices to produce freshly grown food; this has resulted in lower levels of physical activity and unhealthy eating habits among young people. One nurse noted:

> Most villagers receive the social welfare support … most patients buy processed foods like noodles and tinned food … so more young people have diabetes … young, healthy men are recipients of the social welfare … do not plant their food, contributing to increased physical inactivity … they know that there will be food for them from the welfare scheme every month. (Selai)

Some nurses explored available avenues to disseminate health information to patients who were in the denial stage of accepting their diseases. They used their traditional relationships to help manage their challenges with patients who needed to live healthily and comply with advice:

> Not many people will attend health meetings. People will only participate in meetings if there is feasting, grog, and dancing, so I target their village meetings to create a general awareness of diabetes and other health issues. Sometimes I express my disappointment towards the patients in a friendly way using the shared traditional connections as they are the *tauvu.* That has since become the secret weapon. They listen and do not talk back as expected in a *tauvu* way of conversing, and I guess it is because I am wearing the uniform, and they identify the status with authority. Using the traditional relationship is one way to get through to handling non-compliant patients. In that context, nurses can say all the good and the bad things and mean good. Therefore, patients apologise and promise to comply. (Lisi)

Nurses understood that the care provided in the clinic was just one component of the overall care needed to prevent diabetes and reduce complications from established diabetes. They spoke with concern about the context of patients' lives and the failure of a national response to the diabetes crisis. They acknowledged the nursing commitment to a holistic rather than a biomedical approach to care delivery.

Fresh food

The nurses discussed the link between eating healthily and patients’ medical statuses. They collectively agreed with Vere’s contribution to the discussion:

> Most patients think that medications are magic, that will help manage their issues, and they tend to forget the lifestyle factors that affect their prognosis. Most patients do not change their eating habits. The costs of vegetables are high, and I wish the patients receive some assistance like seeds to plant their own … so we can be sure they follow diet plans. Some communities are NCD friendly, have support

> groups that have gardens to supply their vegetable needs. The projects are mostly student-initiated during medical or nursing students' group attachments to the community. (Vere)

Transport

The nurses practised beyond their duty of care to ensure patients' wellbeing. Nunia shared her experience and noted occurrences similar to the other nurses in the *veitalanoa* group:

> Sometimes, we provide patients with an overnight bed at the hospital even though they are not for admissions - for their blood tests and medications the next day. If we have extra beds, we allow them to sleep, especially those who live very far away. We do some things like this to make sure they receive what they need. We go out of our way to assist them, give their fares back home, their food, and other things. (Nunia)

From personal observation and experience, the steep bus steps made travelling difficult for a person with an amputation. Such inadequacies in public transport are risky for people living with amputation because of susceptibility to falls, injuries, and reopened wounds. People living with such risks usually require assistance in getting on and off public transport, and the degree of risk escalates if there is a lack of proper footwear. The nurses shared their experiences helping patients identify proper shoes for comfortable travel and to avoid ulcers and blisters. Litia added:

> Follow-up of patients is essential to avoid more complications. Some patients face financial problems that affect their clinic attendance. If I have transport, I visit them at home. I have a patient who had a forefoot amputation and struggles to come to the clinic every day for dressing change. Sloughs were building up around her wound. She needed special transport because the bus steps are steep, and she is worried about her foot. So, I arranged for her social welfare

> assistance … she is regular to the clinic. Other patients still await their support. At times, we end up giving their fare to get them to return for change of dressing. I teach dressing change to patients in the clinic, and, when conducting home visits, I teach the relatives. In the community, there is the village health worker, who also can assist with the wound dressing. We provide advice to patients on their diet, physical fitness, medications, and daily activities. (Litia)

In these examples, nurses were concerned with patients' dietary, transportation, and footwear needs and helped patients in every possible way. The data excerpts indicated that compassionate and committed nurses work extra hard to accommodate patients' needs, and the nursing workforce has much potential to grow as a profession in Fiji. Another example is shoe care:

> I educate patients on the type of shoes they should wear. Sometimes, patients come to the clinic, not knowing they are not wearing any shoes. I always reminded them to wear shoes, the types, the kind of shoes they should buy, and the time for a change. Some of them do not know their shoe sizes. I encourage patients to wear proper footwear, which is very important. We tell patients to buy massage shoes with soles, which help because they take care of numbness and burning sensations … we need to reach out to footwear manufacturers to make shoes with massage soles so patients can buy as it helps patients who experience loss of sensations and numbness … to stimulate nerve endings. Also, there is a need for arch support shoes to support their bones and weight. There is a need for footwear fitting clinics in every town so people can buy proper shoes. (Rosi)

Nurses practised in environments with high patient volumes and inadequate resources, which led to improper nursing care. High patient volumes contributed to nurses having less time to attend to patients' needs, which led to missed nursing care and caused poorer patient outcomes (Hessels et al., 2019; Yu et al., 2019). The nurses' inability to meet public health-care service expectations contributed to their sense of hopelessness that was compounded when some patients travelled to other healthcare facilities to seek better care. Nurses strategised to deal with adversity and reduce the effects of job demands, and, in this way, nurses have developed resilience while trying their best to deliver nursing care.

Substandard Care

Nursing education prepares nurses in environments that ensure they are ready for practice with conceptualised competencies that are holistic and context-dependent (Flott & Linden, 2016; Lavoie et al., 2018). Nurse educators play a crucial role in the formation and nurturing of nurses by providing guidance and challenges that inform students about the details of the layered, complex practice of nursing (Trede et al., 2016). However, the reality of nurses' experiences in their actual clinical areas did not allow for standard best practice as taught in nursing schools. As shown in Figure 10, there are four subthemes under the heading of "Substandard Care": 1) Poor relationship, 2) Lack of time to conduct health awareness, 3) Ignoring stigma, and 4) Following orders despite own clinical judgement.

Poor relationship

To provide holistic care to patients, nurses need to invest time to know them and understand their cultural, family, socioeconomic, and community statuses. For *iTaukei* nurses and patients, this is part of their cultural value by identifying their connection to the *vanua*, which establishes trust. Patients trust nurses for their treatment and disease management, making trust a vital component in the nurse-patient professional relationship (Ozaras & Abaan, 2018). However, the data showed that nurses did not have enough time to establish a trusting relationship with patients:

> Unless nurses know the person, patients will not freely talk, limiting the amount of information gathered from them. There are so many forms to fill … requires many patient details and takes time. Gaining patients' trust is essential in nursing … our approaches, communication style … especially for the *iTaukei*. It is a lot easier to establish rapport with the patient first before asking about their illness. It takes time to have a complete introduction … nurses must introduce themselves first, where they are from, and so this will allow patients to respond equally. Patients use prayers, herbal and cultural therapies, so knowing them will help in nursing interventions. However, we do not have enough time. (Lisi)

Lisi sacrificed her personal time to know her patients. Despite having a high volume of patients and little time, Lisi spent more time on new patients. She shared how traditional relationships helped her nursing work using the social concepts of the *vanua* to establish a professional relationship with *iTaukei* patients. Lisi mentioned how she identified space and place within the *vanua* she worked in, which confirmed her grounding and formed a traditional relationship with the patients, establishing the professional nurse-patient connection. However, Lisi's story was different from other nurses, who mentioned that they did not have time to establish their traditional relationship with patients. The lack of time prevented nurses from identifying their relationship with patients from other *vanua*. Most participants were amazed at Lisi's experience and mentioned they wanted to provide the type of nursing care that understood the patient, identified cultural relations, and developed awareness of patients' financial statuses and their community standings. In this way, the nurses felt they could motivate patients to make healthy choices.

Another participant, Vika, said that patients could only entrust their nursing need to nurses if they felt comfortable in the relationship. Vika added that patients typically had many domestic issues that affected their care and that nurses must establish trust and build rapport with them to arrive at workable solutions. All nurse participants agreed that establishing a trustworthy relationship with patients required time, which they lacked. The nurses reported hurriedly clearing all patients. Vere explained:

> I want to provide nursing care that has no space in between the patient and the nurse, meaning communication without barriers, but this is hard because of our culture ... some things are taboo. The initial foot care assessment requires much information … steps to follow in SNAP column. Nurses cannot assess patients right away … must first know the patient as a person, and that takes time, which is what we do not have because of the number of patients we have to see. (Vere)

The nurses identified the need to spend more time with patients to establish trust and develop rapport. They also wanted to communicate better and identify patients' nursing needs. The nurses understood the *iTaukei* sociocultural values of caring and recognised the importance of proper *veikilai* processes in developing therapeutic relationships with *iTaukei* patients. However, the conduct of *veikilai* is a lengthy process, and nurses battle between the requirements of the *iTaukei* culture to know their patients well and the lack of time they have. Therefore, they were not able to establish trustworthy relationships with their patients.

The nurses' inability to develop trusting nurse-patient relationships further contributed to their having limited patient information, which affected nursing intervention (Nieuwboer et al., 2017). The lack of such information also prevented specific plans for individual patients, thus negatively affecting nursing care quality (Leslie & Lonneman, 2016; Ozaras & Abaan, 2018). The lack of staff, the high number of patients, and the increased workload for nurses contributed to nurses' shortage of time to establish trustful relationships with patients. The many tasks and responsibilities that nurses perform concurrently, the diversity of different patients' needs, and the *iTaukei* cultural protocol of introduction contributed to the delivery of substandard nursing care.

Lack of time to conduct health awareness

The increased prevalence of diabetes and its impact on nurses' workload has prompted nurses to consider it necessary to educate the public regarding the disease. Health education programmes are intended to help communities improve their health through cumulative knowledge and increasing their confidence in their own ability to self-care (Paterick et al., 2017). All nurse participants expressed a desire for more time to provide public health education and awareness-raising regarding diabetes and its complications. Selai explains:

> Diabetes is now no longer the disease for the old or a specific ethnic group, and the information should go out to the public that younger people are getting the disease and receive amputation. The Ministry should mobilise health teams to preach about diabetes in public places, with sound systems so people can hear. We will need more staff as of now; we do not even have the time to teach our patients at the clinic. (Selai)

Vika highlighted the need for diabetes education from the primary school level. She noted how schools in Fiji had adopted the healthy food canteen policy, which was a government strategy to avoiding obesity among school children. From personal observations, I was concerned about how, just a few metres from the school, there was another government strategy in poverty alleviation (to promote small businesses): a sweets cart with all types of Indian sweets with very high sugar content. Vika suggested that the school health team spend some time raising the awareness of students, teachers, and parents about diabetes. However, such awareness programmes require more staff and more time. Ana further stated:

> There is a lack of knowledge. As healthcare providers, nurses in these roles should have more time to provide awareness to the community so people will know more about diabetes … there are already many people in public with the disease and are in the denial stage. Statistics must accompany teachings, particularly to the *iTaukei*, as we the

> *iTaukei* have a different mindset. If someone has diabetes, the family and community should be informed and made aware of the problem so they can help each other out. (Ana)

The nurses understood the impact of disseminating information about diabetes, and they indicated the need for public awareness; however, they did not have the time to deliver this information themselves. They said that without the dissemination of information to the public, people would remain ignorant about the disease. As mentioned, the nurses' lack of time to attend to patients' needs negatively affected both nurses and patients. The nurses were stressed because they could not carry out nursing care diligently, and the patients did not receive the adequate nursing care they needed. The lack of knowledge on diabetes had detrimental effects on patients because they presented themselves late for medical attention.

Addressing stigma

People living with chronic conditions were most likely to live with stigma related to their disease, which has significant effects on patients' mental health (Schabert et al., 2013). For this reason, patients living with diabetes experienced shame due to the perceived causes of diabetes. Selai (nurse participant) said that people living with diabetes were often treated differently by other people. She added that diabetes-related amputations were associated with being cursed and that most criticisms were from people in the patients' own communities. Such reproach made it hard for people living with diabetes-related amputations to live normally. Selai also highlighted the need to reverse such a mentality and that nurses needed more time to raise awareness about diabetes in communities to prevent stigma. Nunia and Lusi added to this as follows:

> Patients who have diabetes suffer from stigma, and this also contributes to why those identified from the shift clinics as "at risk" do not come for follow-up care at the health centres. They call it the

> “generational curse” or “generational disease” and patients believe that it is their share of curse from their ancestors. It takes much time to sit with patients and explain the pathophysiology of the disease, and the general public also needs to be informed. Nevertheless, who has the time to do that? I am already struggling to complete my work here. Maybe it would help if we have many nurses. (Nunia)
>
> Most people think they are *cursed* when they have diabetes … and so others feel about them differently and see them as cursed in society. That itself is a stigma, so patients don’t attend clinic. I always try and break that barrier … one is that of the limited information people have about diabetes. It is not an easy task because to break it, I need to be consistent, but I do not have time. I have other work to do. The problem is to empower and provide insight to the patient, their families, and relatives, and the community or general public. (Lusi)

The nurses reported that stigma was one of the factors preventing new cases of diabetes from receiving appropriate medical attention. They expressed the need and their desire to create awareness and address the stigma surrounding patients living with diabetes and associated conditions. The lack of nurses’ time to address stigma challenges patients’ needs for balanced mental health. The psychological impact of living with a stigmatised condition is significant and may be a barrier to optimal self-care, affecting mental and physical health (Schabert et al., 2013; Shiu et al., 2003).

Following orders despite own clinical judgement

Nurses make clinical judgements and decisions according to their knowledge. To apply their knowledge, they must have the freedom and authority to make decisions (Skår, 2010). Some nurses had considered how they might shape services differently away from a medically led model of care. Delivering home-based and community-based care allowed some flexibility in nursing care delivery and advantaged nurses and patients. Some nurses preferred to provide nursing services to people in their communities instead of waiting for patients to arrive at the clinic. Rosi explains:

> My work attachment only focused on diabetic foot, not other problems of the feet. However, the doctors have been sending all the foot cases and patients with nonhealing ulcers to the clinic. I review the wound every two weeks, and, for delayed healing, I usually change the dressing to another type as there are different types of dressings. Even the doctors depend on what I think and enquire on the suitable type of dressing for patients' wound because of the way I categorise wounds. So, we discuss the type of dressings that patients need. I also do culture and sensitivity tests and recommend treatment (medications) to the doctor, who writes the prescription. In this way, nurses can be running their foot clinics and foot care programmes for people living with diabetes and foot conditions. (Rosi)

Rosi's story indicated that “foot care nurses” were responsible for all patients with diabetes-related foot problems. However, the scope of their practice has extended to include a general cohort of people with foot problems. Additionally, nurses had other responsibilities for people living with diabetes and diabetes-related foot infections. Generally, the foot care nurses made independent judgements in the management of diabetes-related wounds. The nurse-led clinics fostered faster and efficient services for patients as they saved waiting time for consultations with the doctors. Such clinics enable nurses to attend to patients' needs and improve patient care (Daly et al., 2017). However, the nurses still depended on the doctors to prescribe medications and decide on other treatment options. Again, time is an issue as Vere explains:

> I always plan to conduct awareness, targeting people during village meetings, mostly at night. It is the only time I can meet with the people who have diabetes ... they have other activities during the day. I still have to work my regular hours and overtime in the evening, conducting shift clinics. I do not receive any pay for working extra hours, but it is replaced with time off later. When I take time off, I have unfinished work … so I will wait until I can take it with my leave. I feel

> sorry for the patients because they look forward to meeting me. We are short-staffed and feel tired when we work during the day and do evening shift clinics. It would be better to have some nurses work during the day and be explicitly doing shift clinics. (Vere)

All participants agreed with Vere's sentiments of providing shift clinics to people in their communities. Another participant, Lisi, shared how nurses were usually tired from planning many activities to be done within limited timeframes; therefore, they worked overtime to fulfil their care plans. Lisi stated how their plans to carry out community outreach programmes were hindered by organisational issues, such as transport and staff shortages. Lisi added that such issues contributed to the high number of people living with diabetes-related lesions, which often resulted in amputations.

The nurses had identified flexible and innovative ways to serve, inform, save amputations, and meet community nursing needs. In situations where they conducted community shift clinics, nurses reported double workloads, which contributed to high levels of stress and frustration. They reported working extra hours in an unsafe practice environment that created the potential for adverse effects on patients. Transportation and human resources were among other factors that negatively affected nurses' initiatives to conduct flexible community shift clinics.

Education to support practice

Health education significantly benefits people and improves public health, which further promotes health equity (Hahn & Truman, 2015). Due to the evolving global trends of diseases, nurses need to be lifelong learners to provide the appropriate level of care for patients. Nurses are professionals who, based in the sciences of nursing practice, education, and behaviour change, should use knowledge and skills in education theory to plan, implement, and evaluate continuing education activities in nonacademic settings (Curran, 2014). Nurses use a wide range of appropriate theoretical and adequate clinical expertise that blends with experience. Without knowledge, there can be no concept of caring in nursing as its primary purpose is achieved through theories and clinical skills (McHugh & Lake, 2010). The need for increased education to support their nursing practice was a theme that emerged in nurse participants' stories on specialised nursing education and diabetes research. As shown in Figure 9, there are three sub-themes under the heading of "Education to support practice": 1) Postregistration education, 2) Training for Village Health Workers, and 3) Education on complementary therapies.

Postregistration education

Participants noted that many aspects of care required by patients fell outside their knowledge or skill range. In most instances, they showed significant innovation in attempting to meet the unmet patient needs. Nurses expressed their concerns over the needs patients clearly had. They acknowledged that they lacked adequate knowledge about the disease and felt they had disadvantaged the patients by not knowing what to do when confronted with challenging cases:

> Now there are many newly diagnosed patients with diabetes and foot problems. To avoid amputations, we need specialised and qualified personnel. Not all nurses have enough knowledge about diabetes ... need for further education and attachments to the Diabetes Hub.[69] There should be a specialised nurse training programme specifically for diabetes, so nurses can be knowledgeable about the type of care they need to apply. (Litia)

All participants agreed with Litia's perspective and shared how their lack of updated knowledge on diabetes had disadvantaged their patients. Epeli said that as a nurse, he wanted patients to know everything about diabetes, its causes, complications, and the importance of diet, medications, physical activities, and the follow-up clinic. Epeli

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[69] Diabetes Hub – a health clinic for patients who have NCDs and mainly diabetes as a primary disease

found it better to deal with patients individually than in groups. He further added that most *iTaukei* patients lacked awareness of the disease, and he often referred them to the doctor due to his limited knowledge. Epeli felt that his lack of knowledge was unfair to the patients, and he looked forward to some formal training on diabetes to upgrade his knowledge. Selai offered another example:

> A male patient shared his erectile dysfunction (ED) problem, so I called his wife to the clinic and had a good discussion with her, informing the complications of diabetes. I feel that all I could offer was to call the wife. Maybe we should not be waiting for patients to tell us, and we should know these things … instead of waiting for families to break down, leaving people uninformed. How do we manage a patient with ED? We did not learn how to handle such cases from the nursing school, so I feel like it was an extra duty. (Selai)

Rosi attended a one-day training session on foot care and felt she needed more formal and specialised training to assist her in foot care. Rosi also hoped that all nurses received training in foot care and detailed information about diabetes to educate patients on the pathophysiology of the disease and the importance of compliance with medical advice. Rosi also admitted that her limited knowledge prevented her from informing patients confidently. Despite this, Rosi learned from her experiences with patients.

The nurses knew their undergraduate nursing training was insufficient to match the work demand, and this meant they felt disempowered. Their lack of proper knowledge to perform diligently and the volume of patient needs had caused them to feel they needed formal and specialised nursing education on diabetes. An upgraded and specialised nursing knowledge about diabetes would lead to a better understanding of its management.

Training for Village Health Workers (VHWs)

The engagement of VHWs is part of the Fiji Ministry of Health initiative to promote healthy living in Fijian communities. They are selected from their communities to be the reference person for the zone (area) nurses. VHWs are under the jurisdiction of the Ministry of Health and receive monthly allowances for their health-related work. Nurses felt the VHWs required upgraded basic health knowledge about diabetes to enable better service delivery at the community level. Lusi and Vika add:

> What we need to do to reduce patients' blood sugar level is simple. The best approach is to involve the VHWs and the village headman. They need to come on board to help prevent diabetes, but they need training. Every village has a health committee, including a VHW. Nurses need to be trained first before teaching others. (Lusi)
>
> There is always a slow improvement rate with the *iTaukei* patients with diabetes. The VHWs are involved in our awareness programmes, but their mindset is that they look after the very sick and the bedridden patients. They need to attend some formal training on diabetes. The nurses can do this, but we must have some postgraduate training. (Vika)

The involvement of VHWs strengthens the support of diabetes management at the community level. The nurses spoke of their need to undergo specialised diabetes education before they could educate the VHWs. Nunia noted the improvement in community health since the formal recognition of VHWs in the workforce compared to previous years. She suggested that since the VHWs were familiar with their communities, they needed to have proper training. The nurse participants all agreed that early intervention led to better management of diabetes and controlled the development of complications. They also agreed on how community support engagement helped them in their work and could be a platform to raise awareness about diabetes, which could result in health-orientated communities.

Education on complementary therapies

The nurse participants provide nursing care to patients who concurrently use herbal treatments; therefore, they expressed their interest in studies to support their experiences. Herbal therapy has been a contentious source of alternative medicine since the advent of biomedicine, and its use has been subject to a growing interest in research (Ekor, 2014). There is debate about the need to provide evidence-based care and the lack of funding opportunities to evaluate complementary therapies (Tabish, 2008). Research investigating the effectiveness of these therapies has yet to reach a consensus (Gharaibeh & Tawalbeh, 2017). Litia is keen to know more:

> I want to provide nursing care that is supported by research on the uses of herbal medicine. Patients are using herbal therapies. Some opt for herbal dressing. One patient, in particular, asked for more time to apply pawpaw extract to his wound, so I gave him time - one week, and asked him to return to the clinic. I was surprised to see his wound nicely granulated and pink, and his CBG[70] reading was within the normal range. It would be good if the Ministry supports research on herbal therapies because I feel defeated when I try to apply what I learnt, but the patient arrived with surprising results. It is not only the pawpaw skin but also the ripe pawpaw fruit; patients are using its flesh and leaves to treat dengue-fever-like symptoms. (Litia)

The Fijian Ministry of Health allocates millions of dollars annually to the purchase of antidiabetic medications and the treatment of disease complications, including kidney, cardiovascular, and eye-related diseases (Fiji Government, 2018b). Despite the impressive advances in medical diagnosis and treatment, most *iTaukei* patients use herbal therapy to self-manage diabetes. The nurses were aware that patients referenced herbal medicines and other traditional therapies through their knowledge of, and relationship with, the *vanua* as the first-aid treatment to treating diabetes.

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[70] CBG – Cappillary Blood Glucose that is a measure in mmols/L of blood to determine glucose blood levels

Nurses who allowed patients' preferences for herbal medicine witnessed wound healing and therefore requested research to support their practice. Lisi is one:

> Nurses know that most *iTaukei* believe in herbal medicine, maybe because they are asymptomatic even though their blood sugar level is high. Patients have CBG readings of more than 20mmols/L but are asymptomatic and do not care. Therefore, when I conduct foot care assessments, most of them are identified as high and acute risk cases, but the problem is, they are asymptomatic. They only come to the clinic when they have active lesions and usually present late. The only thing we do is refer them for wound debridement and specialist care. However, most still prefer and opt for herbal medicines. There should be some kind of awareness of herbal therapies, and we need an upgrade of our knowledge of diabetes. (Lisi)

Continuous professional development is crucial. Innovative ways of managing patients help ease nurses' work; therefore, nurses must remain knowledgeable of new skills to manage patients effectively. In Fiji, the undertrained VHWs remain the link between the community and health-care professionals; however, their knowledge of diabetes is limited, so they need further education. To educate VHWs, the nurses must first receive additional training on diabetes. Research into the effect of herbal remedies on people living with diabetes was something the nurses looked forward to since most *iTaukei* patients alternate between prescribed and traditional therapies, including herbal medicines.

Chapter Conclusion

This chapter documented the nurses' description of the care they wanted to deliver to patients living with diabetes and associated conditions. Three themes and sixteen subthemes emerged from the interview data. Nurses identified the barriers that prevented the implementation of proper nursing care: certain cultural practices; high patient volumes; the lack of space, time, equipment, and teaching resources; increased workload due to patients' preferences; work overload from performing other tasks; and the lack of autonomy in making their own decisions. These have prevented them from delivering the ideal nursing care they know patients needed.

The second theme revealed how nurses could not deliver the most comprehensive and holistic nursing care, which meant they provided substandard nursing care with no time to establish a proper nurse-patient relationship. There was also no time to conduct public awareness campaigns, they often ignored the stigma associated with diabetes that patients endured, and they followed the physicians' orders despite their clinical judgment suggesting alternative approaches.

The third theme centred on the idea that nurses who care for people living with diabetes did not have the proper education to support their practice. The nurses requested formal postbasic qualifications on diabetes to broaden their knowledge of the influences of culture on their patients and train the VHWs. The latter is the critical link between the Ministry of Health and the *iTaukei* people in their communities. Given the extensive use of complementary therapies by the *iTaukei*, nurses asked for further education on the uses and effects of these therapies.

Chapter 9: Discussion, Conclusion and Recommendations

In conducting this study, I set out to understand the experiences of *iTaukei* patients and nurses practising nursing care in the context of a diabetes epidemic within their community and practice environments. Data were collected from patients living with diabetes and associated conditions and nurses who deliver nursing care to people living with the disease.

This chapter begins with an overview of how the main research question has been answered. A summary of both patients' and nurse participants' findings is included, revealing a disconnect between their expressed needs and the structures of health-care services provided by the Fijian Ministry of Health. The main themes that emerged from the data are then considered at a structural and theoretical level, followed by some recommendations that could help improve nursing care delivered to patients living with diabetes and associated conditions.

Summary of Patient Findings

Patients described their experiences of receiving care in an environment that did not offer options, this requiring them to agree to decisions made for them. Their cultural mores of respect for authority, which are part of their *vanua* protocol of relationships, made them accept care without complaint. In the safety of the research environment, patients described their expectation that nurses would advocate for them when treatment decisions were being made. The patients also expected nurses to adhere to their cultural customs of respect for their age, and the experiences of disrespectful behaviours undermined their confidence. Patients' fear of amputation made them continue with their traditional ethnomedicine, which is sourced through their relationship with the *vanua*, despite receiving care from health-care professionals.

Patients did not receive nursing care that met their expectations and were not prepared or involved when decisions were being made regarding their care, which affected their quality of life and relationship with the nurses. Patients felt that their lived context was not accommodated in care planning or care delivery. Patients also considered the nurses lacked professionalism when they showed feelings of disgust towards their malodorous wounds. Patients especially lost trust in nurses when their requests for assistance in their care resulted in the nurses' inappropriate use of humour, which also contradicted their concept of the *vanua*. They observed that as doctors made decisions about them without discussion, the nurses silently accepted this situation. This absence of patient advocacy and teamwork amongst health-care professionals left patients feeling unsafe in an environment where insubordination thrived with negative consequences for patient outcomes, contributing to patients' lack of trust in the health-care system.

Most patients had limited understanding of their care plans, and this affected their ability to provide informed consent and assume their care after discharge. The patients noted that paperwork and the need for reporting took up quality time that could have been used for their care. These converging situations interfered with the formation of relationships according to the *iTaukei* way of knowing. This was also acknowledged by the nurses, who noted there was not enough time to discuss self-management issues with patients. In instances when communication was offered, patients struggled to understand health-care professionals' language in terms of medical terminology as well as English not being the preferred language of communication for many patients. Therefore, patients were frequently unaware of how to manage their condition.

In the context of a diabetes epidemic, the patients' and nurses' experiences of care and practice confirmed that they wanted to receive and provide nursing care without the barriers that exist. Patients who are very aware of the barriers often seek other means of help and care, and delay presentation at clinics. This means that when they do present for care, their needs may be much greater.

Summary of Nurse Findings

Nurses’ concerns closely mirrored the circumstances that patients described. Nurse participants doubted they would be able to change the reality of their practice due to the nature of the practice environment. In addition, the organisational and profession-related barriers contributed to nurses’ inability to establish relationships with their patients. Nurses also described their lack of time to raise awareness of diabetes and empower those with stigma-related experiences. Yet, despite their expressed thoughts about how they can shape healthcare services differently from a medically led model of care, nurses still follow orders and remain passive in a hierarchical system.

The nurses also battled with the lack of adequate working spaces, working equipment, and teaching resources to deliver care according to their nursing education. Nurses encountered many organisational problems, such as when they compensated for the insufficient numbers of other health-care professionals, especially allied health. For example, there are no podiatrists in Fiji, and the nurses fill in as “foot care nurses” to manage the growing concerns of foot-related complications. Therefore, nurses are experiencing high volumes of patient need, which forces them to further compromise the care they can offer. In addition, the absence of adequate staffing to assist the high number of patients contributed to nurses’ lack of time to attend to patients’ needs.

The nurses battled with their lack of knowledge of diabetes-related complications and complexities of disease management and identified their need for increased professional education. They noted the vital role of Village Health Workers, who are their link to the communities, and, due to such complexities of disease management, the nurses highlighted the importance of upgrading training for these workers. Nurses were aware of patients’ connections to the *vanua* and their use of complementary therapies, but they could not make use of that awareness in a helpful manner.

Nurses are the key player in treating patients' nonhealing foot ulcers and other diabetes-related foot conditions. In practice, their views on the progress or otherwise of wounds were never accommodated in clinical decisions made by surgeons. Nurses rarely, if ever, articulated their views about patient wounds, nor were they asked to provide a clinical opinion.

Discussion

The consideration of patient and nurse data in this study offers vital perspectives on the structures and organisation of the Fijian health-care system. There is a considerable disconnect between the cultural needs and practices of *iTaukei* patients and their experiences as patients with diabetes. Having summarised and integrated the patient and nurse data from a *vanua* perspective, it emerges that the operation of the Fijian medical system does not directly accommodate the needs and beliefs of the *iTaukei*. The infrastructure in the Fijian health-care system is both fragile and under pressure, and significantly bio-medicalised, which is at odds with *iTaukei* practices and needs.

I now move to consider the contextual issues that influence the care setting for both patients and nurses in greater depth. I will argue that the infrastructure is fragile and medicalised, and there is a hierarchy of importance, which renders patients and nurses silent. In this context, nurses' skills are underutilised. I will conclude by recognising the degree to which culture has been shown to be a contributing factor - but could also be considered a solution among *iTaukei* in Fiji.

Infrastructure is fragile and medicalised

The nurses' stressful experiences of working in inadequate practice environments and not being able to nurse in the way they know is needed threatened patients' safety.

This is an area that needs more attention from the Fijian health service management. Such attention must include redesigning work environments to resolve the nurses' suboptimal work conditions. Good structural designs create a safe space for nursing practice and prevent errors from occurring (Brambilla et al., 2019; Henriksen et al., 2007). In addition, nurses could not work according to their job description due to the health-care services' inability to cater to the high volume of patients living with diabetes and associated conditions.

The lack of resources has significantly affected patient care in Fiji, contributing to the high rate of amputations. For example, the nonavailability of podiatrist positions has detrimental effects for patients and also negatively impacts nursing care. In addition, patients' issues were not addressed using a holistic approach but managed from a purely biomedical perspective that was insufficient. This means that *iTaukei* patients were not receiving treatment that incorporated a balancing of the *vanua* factors.

Releasing the potential of nursing

To improve health and healthcare, nurses must operate in a satisfying, empowering, and safe environment. It is known that undesirable work environments make adherence to safe nursing practice hard (Aiken et al., 2018). Consistent inability to practice as preferred results in increased stress and higher burnout and trauma among nurses (Kelly & Lefton, 2017; Simpson et al., 2016). The problem usually develops over time (Watts & Thorne-Odem, 2020) and may lead to increased attrition from the workforce.

Despite these conditions, nurses find ways to connect to patients and often experience emotional turmoil while engaging in a professional relationship with patients (Feo et al., 2017). However, the nurses in my research could not engage in such a relationship because they worked in an environment that did not value or provide time for caring in a culturally appropriate manner. In a double bind, nurses as women were expected to use their natural abilities in mothering and domestic skills to support and care for the wider community (Carryer, 2020). As a result, nurses experience potential threats to their welfare. These experiences do not align with the WHO's optimal health and safety definition of a healthy working environment (Burton, 2010).

The nurses faced many challenges, one being the high volume of patients living with diabetes needing hospitalisation against the limited number of beds at the divisional hospital, a tertiary health-care setting, where the operational level is specialised. In addition, gaps in health-care service delivery at primary and secondary health-care settings put pressure on the tertiary level of services for patients with disease complications. As stated in Chapter Eight, the high patient volume caused an overload in nurses' work and created overcrowded health-care facilities, which had to accommodate patients in a restricted timeframe. In the current context, quality nursing care will remain unobtainable as nurses cannot establish relationships with their patients, a significant *iTaukei* cultural value.

In an *iTaukei* context, the nurses share unique traditional relationships with patients. Nurses in any setting are expected to develop therapeutic and supportive relationships with patients (Feo et al., 2017; Kitson et al., 2013). However, this has become a challenging task for several reasons. From the data, the barriers of care (lack of nurses' time, high volume of patients, and inadequate practice environments) prohibited the formation and development of therapeutic relations between nurses and patients. These barriers prevented the formation and establishment of the relationship between the nurses and patients according to the *vanua* relational frame; this affected how *iTaukei* patients develop their trust in nurses who care for them.

Nurses have been the essential multitaskers of the health-care profession (Watts & Thorne-Odem, 2020). The data showed that nurses were highly skilled in managing demands within an inadequately resourced environment. The nurses worked with some degree of flexibility, which was also part of the *iTaukei* cultural values, and compensated for the absence of other service providers to fulfil organisational requirements. Such practices by the nurses made them act as health-care intermediaries who worked compliantly outside their usual boundaries of practice because they wanted to ensure the continuity of care (Allen, 2007). On a day-to-day basis, these other tasks did not allow nurses to focus on more specific professional responsibilities that they believed were the essence of nursing. Such changes to practice suggest considerable role ambiguity in nursing within their practice environment, particularly for *iTaukei* nurses, whose concepts of the *vanua* are part of who they are.

Increased workload and lack of time heavily impacted the nurses' ability to attend to patients' needs, which resulted in rationed care. Such rationing of nursing care has a detrimental impact on patient management (Jones et al., 2019; Kalankova et al., 2020; Moosa & Luyckx, 2021; Simpson et al., 2016; Willis et al., 2017). The nurses' inability to deliver effective care to patients affected their capacity to keep up to date with advised nursing interventions (Nieuwboer et al., 2017). For example, the nurses were not able to discuss care updates with their patients. Lack of information affects care quality by not allowing specific plans for patients, which affected their trust (Leslie & Lonneman, 2016; Ozaras & Abaan, 2018). Therefore, patients in my research lacked confidence in the health-care system, and they sought other treatment alternatives for their ailments. The nurses were very aware of the effects of not spending enough time with patients and tried to cope with the barriers to effective and quality care.

Nurses need to be empowered through a strengthened and supportive health-care system that facilitates and values their knowledge and expertise (Carryer, 2020). The nurses reported how inadequate nurse staffing significantly affected their practice. They were concerned at the level of rationed care, which reduced their ability to identify patient need, thus affecting disease management. Rationed, delayed, unfinished, or missed care essential to patients' safety also has associated consequences for the nurses (Simpson et al., 2016). The nurses needed support to be able to carry out their nursing duties diligently.

People living with diabetes requested empowerment strategies to: follow treatment plans, effectively deal with stigma, and handle misguided advice from within their communities. Knowledge and social networks, including families and culture, influence health-care access due to social norms that increase stigma or encourage the seeking of care (Corrigan et al., 2014). Stigma in health-related issues prevents diagnosis, treatment, and successful patient outcomes, and addressing it has been recognised as a key to quality health-care provision (Nyblade et al., 2019). However, as identified in this project and reported in Chapter Eight, nurses lacked time to carry out vital work, which can reduce stigma. The psychological impact of living with a stigmatised medical condition is substantial and becomes a barrier to ideal self-care, causing distressing psychological and physical health (Schabert et al., 2013; Shiu et al., 2003). It is essential that nurses - as per their fundamental philosophy of care, are able to address the full gamut of patient need. Currently, this cannot be said to be possible in Fiji.

A highly medicalised health-care system

Nurses knew that their decisions had significant implications for patient outcomes. However, they did not always have the freedom and authority to apply their knowledge and make clinical judgments for several reasons. Given the structural obstacles that nurses experienced at work, as discussed in Chapter Eight, patients also had structural silos within which nurses had to carefully support patients to make vital lifestyle changes. For example, *iTaukei* patients referred to the *vanua* as their silos that had sociocultural meanings. Participants also clearly saw and described the inability of the medical system to effectively deal with the NCD burden and, therefore, identified the need for support from other government ministries.

Nurses' proficiency in using their clinical judgement is based on knowledge, experience, reasoning, intuition, clinical thinking, and evidence-based practice skills (Seidi et al., 2014). However, despite their clinical judgement, nurses in my study followed orders from doctors that were not part of the patients' initial care plans, thus breaching ethical standards of conduct. Typically, in an *iTaukei* experience, the nurse and patient succumbed to inferior status and remained quiet as a requirement of their culture.

Family involvement in patient care is beneficial to most patients (Ligita et al., 2020). Amputations have far-reaching effects on patients and their families (Camur et al., 2020). From the study findings, patients did not have time to discuss care options with family members. Patients with amputations relied on families for support, and their experiences caused them anxiety and stress. The patients were suddenly confronted with amputation plans without the inclusion of their family members. From education to consenting to surgeries, the inclusion of family was critical in determining the amount of support the patients received at home. The patients' experiences prevented the delivery of nursing care that is patient-centred.

Women are affected by gendered differences in their experience of care

The *iTaukei* cultural mores discussed in Chapter 4 affect women in many ways. *iTaukei* women are expected to behave in a "womanly" manner (Meo-Sewabu, 2015). Within the *iTaukei* patriarchal society, such traditional assumptions and practices disadvantage women, who are traditional carers and still assume these responsibilities despite being sick. Women who attended clinics highlighted how the long waits at the clinic were stressful, frustrating, and anxiety-inducing.

Even though men are participating in informal caring roles, women have been predominantly the traditional carers, particularly in the context of ill-health (Kenny et al., 2020). In an *iTaukei*, patriarchal setting, women are adversely affected by both the health system and culture due to their gendered roles, as discussed in Chapter Four. Female patients traditionally must help everyone in society, become sick more often, and need support from work and home to manage their diseases (Phyllis, 2021; Sharma et al., 2016). For example, female patients were affected by the long waiting time because they often rushed through their appointments to return to managing their day-to-day responsibilities and the needs of other family members. This means that despite being sick, women still undertook domestic responsibilities, including serving *vanua,* and thus perhaps have greater susceptibility to disease complications.

The women’s rush to have their clinic appointment and go home quickly to attend to their chores was further affected by the lack of adequate public transport scheduling. Most patients heavily depended on public transportation that was likely to simultaneously take everyone to the clinic, meaning patients’ clinic schedules became a whole-day event. Such experiences by women added to their stress and call for effective strategies and interdepartmental assistance to enable an effective health service delivery that meets the travelling patients' needs and avoids long waiting times.

However, in instances when women were not sick, their ability to find employment and continue living their lives was affected by their strong sense of obligation to care for another sick person in their family. I noted that most women still assumed responsibility for their husbands’ clinic appointments, and many women had their amputee husbands’ clinic appointment cards, water bottles, food, and medications in their handbags.

Forty-five per cent of those who received a limb amputation between 2011 and 2018 in Fiji were women (MOH, 2019b). Women being sick or disabled affected their family routines more than when other family members were ill, and such disturbances in family routines significantly contributed to stress among women because it influenced how they self-managed. The burden to maintain a balance between managing their families while controlling their health status increased their risks of having more complications of the disease and other illnesses (Mogre et al., 2019).

Silence

Silence constitutes a significant part of the *iTaukei* psyche. For an *iTauke*i, silence plays an important role in knowing, which is equated to verbalising (Nabobo-Baba, 2013). Therefore, nursing care delivered to an *iTaukei* patient must include contexts of nonverbalised communication contained in silence. The quiet environment of *iTaukei* patients must be fully understood from an *iTaukei* perspective. Hence, it is vital that a good rapport and relationship is established to gain the patient's trust, enabling them to communicate their personal information and needs confidentially. Nurses who care for an *iTaukei* patient must identify such cultural spaces that exist and use them in their role as mediators in their health conditions. Once trust is established, health-care professionals must continually probe *iTaukei* patients' thought processes to enable a good nurse-patient relationship.

Cultural incompetence in misunderstanding the meaning of silence led health professionals to assume that patients accepted care plans that affected clinical decisions. For example, patients' silence misled health-care professionals into believing they were consenting to amputation plans. Health-care professionals merely guessed the meaning of patients' silence and inadequately assessed the strength of the patients' adherence to their cultural values concerning silence.

Patients remained silent and were assumed to have accepted and complied with decisions made about them. They also did not complain about their treatment until the research environment created a safe space in which they felt able to comment. The true meaning of patients' nonresponses was not precisely known, thus affecting the degree of openness in the nurse–patient relationship (Angel & Vatne, 2017). However, the patients' nonassertive state could be understood from their cultural perspectives. In instances when patients' requests for more time were denied, they felt hurt and forced into submitting to authority. In one example, the patient was pushed into silence because they were approached to consent for an amputation plan when they were in the operating theatre. When suddenly confronted with the need to consent to amputation, patients felt lost and were silent.

The patients also felt helpless and not supported by the nurses. Leaving patients in such a position affects their sense of relatedness concerning trust in the staff and their sense of personal autonomy (Lie et al., 2019). Regarding amputation, patients needed time to accept information that they would lose an essential part of their body and discuss it with family members or significant others so as to make sound decisions, including how their lives were about to change forever. The nurse's inclusion of others, such as family, is critical in determining the amount of support the patients will receive after their hospital care. Keeping the family informed enables a trusting relationship between the professionals and patients' families, promoting holistic nursing care delivery that encompasses a patient-centred approach (Rintala et al., 2013). Unfortunately, the patients in this project found such relationships to be absent. Without such support, patients experience stressful emotions (Williksen-Bakker, 2004).

As noted in Chapter Seven, *iTaukei* patients felt compelled to agree with decisions made for them due to their culture of respect for health professionals. However, the environment of a hierarchy of importance makes them submissive to decisions and therefore unable to decide for themselves. Despite their educational preparation, nurses perceive a hidden agenda, which is never made explicit, but they quickly learn that they are in a hierarchy of importance, and their clinical judgements and assessments of patient needs are not valued as part of a clinical team. The order of importance in Fiji's health-care settings was noted by patient participants, who witnessed how it was more pronounced during their hospitalisation.

Health-care professionals must establish appropriate communication patterns to avoid patients feeling misled by a health-care system meant to cater to their needs. My research found such communication patterns to be absent. The practice of silence by the nurses meant that they did not communicate patients' needs to medical or any other staff. Patients felt let down by the nurses who did not advocate for their improved wound status as a reason to delay or withhold amputation. When nurses do not talk, and patients do not ask, the gap widens in communicating patients' information needs and forms of biomedical tyranny flourish. In this process, essential health professionals become silent, and others may take advantage of the patients' vulnerable position to carry out what they think is best without involving patients in life-changing decisions about their bodies. These communication patterns indicate the need to begin health education at the community level to ensure that patients have some sense of their rights and options.

Amputation and stigma as further barriers to accessible best care

At times amputation is a life saving measure for a patient. However, the point of this discussion is; prevention is sadly lacking and for various reasons amputations are often done when it is not a life-saving measure. The doctors' decision to amputate as the easy way out of patients' health problems added more burden to patients and their families. A needless amputation is a significant life change with lasting implications for the patient. The patients rearranged their lives after the amputation, including adjustments to family members' livelihoods. Patients who suddenly met with an amputation plan experienced body-part separation anxiety, which adversely affected body functions and worsened their overall health status (Camur et al., 2020; Singh et al., 2009). Patients' anxiety was exacerbated when health-care professionals teamed up with families and persuaded them to consent to amputation.

Amputations also caused a life-changing impact on patients' socioeconomic status through increased health bills and unemployment. Loss of employment created an urgency to delegate and affected organisational functions when there was no succession planning in place (Pandey & Sharma, 2014). Patients who had been sole breadwinners restructured their daily living activities, like transportation and life at home. Patients who lost work delegated their responsibilities to others and depended on other family members and government support for living expenses. Sudden loss of duties, either at work or at home, meant younger people had to fulfil many roles, with success depending on their readiness to change and take up such responsibilities. These affected the *iTaukei* women, who battled with the dual demands of their health issues and their domestic responsibilities, more than men.

Patients who had been diagnosed with diabetes and were on treatment mentioned they were being singled out and treated differently from other villagers. They were considered as people with *mate sureti*. This negative label means patients invited the disease into themselves and were fully responsible for their ailment. Furthermore, there was no consideration of the environmental and socio-economic contribution to their conditions as, for example, food environments and poverty contribute to NCDs (Torres & Atkinson, 2018). The patient participants expressed their hope that the negative connotation of the disease label would change to a more positively worded one.

A biomedical approach alone is insufficient

Patients received health-care services and advice that was offered with no consideration of the particular contextual factors that influence both the prevalence and experience of diabetes. These include affordability and accessibility of services, food availability and choice, sustainability issues, and culture. In Fiji, the influence of urbanisation, poverty, transport, policies, and health-care structural support are essential factors that are inadequately addressed. In addition, denial of diabetes further compounds the problem.

Culture is always an important factor for health practitioners to consider in working with any population (Dietz et al., 2011; Gopalkrshnan, 2018; Tripp-Reimer et al., 2001). Nurses and patients in my research both highlighted the need to consider the obstacles arising from the predominance of a biomedical culture. In diabetes nursing, the delivery of culturally appropriate care also heavily depends on practitioner competencies in specific cultural knowledge and interventions, the education of patient adaption, and the development of community partnerships (Tripp-Reimer et al., 2001). The nurses recognised such partnerships with patients by acknowledging their traditional relationships with them. Such collaboration becomes part of nurses' socioethical practice (Hunter & Cook, 2020). However, such a partnership cannot be formed due to the lack of time nurses have.

Patients' involvement throughout their care allows autonomy in decision-making that can result in a trusting relationship between patients and health-care professionals (Vahdat et al., 2014). In this way, professionals can guide patients to make informed choices, promoting an environment of healing. Unfortunately, most patients experienced the opposite to their expectations. Negative health-care experiences create doubt, reduce morale, and lead to unnecessary fears and unhappy patients (Cheng et al., 2018; Levett & Grimmett, 2019; Shapiro, 2018).

Patients require health information that is precise and fitting for their medical conditions and their level of health literacy (Nutbeam & Lloyd, 2021). Effective communication between patients and health-care professionals is fundamental in ensuring quality and effective care (O'Leary et al., 2010). However, *iTaukei* patients received medical information from English-speaking nurses; therefore, their understanding of what was being said regarding their care varied according to their knowledge of English. This lack of understanding becomes a risk due to its effects on poor health literacy and equity (Nutbeam & Lloyd, 2021).

In line with the new public management culture, the primacy of attention on patients' individual needs has been shifted to accommodate managerial objectives, which influence the quality of nurse-patient relationships (Smith, 2007; Strandas et al., 2018). In this study, both nurses and patients discussed at length the time nurses spent on filling out reports, which further exacerbated their lack of time to spend with patients. Despite serving many important functions, effective record keeping takes up to 50% of nurses' time (Mutshatshi et al., 2018). The need for effective reporting gives rise to challenges that nurses faced, between the need to focus on patients' needs versus nurses' responsibility for data reporting. This means that nurses are unable to nurse patients fully according to their goals and philosophy of care.

In one example, during my field observation, nurses spent less than a minute conversing with patients in their review clinic; patients themselves confirmed the brevity of this review session. Thus, the need for effective reporting has replaced quality time with patients. Similar concerns have been raised by Tukana (2013), who found that discussions about a patient's condition occurred in less than 25 per cent of consultations, which resulted in little meaningful dialogue between the practitioner and the patient.

The lack of time spent with patients contributed to the insufficient and misguided information provided to them. Patients wanted health-care professionals to enhance their understanding of the disease, yet this process became hard to implement in an overcrowded and resource-deprived setting. The lack of time to provide for patients' educational needs meant that patients could not acquire appropriate and adequate information about diabetes (Drincic et al., 2017). Patients lacked awareness of their health status, which contributed to their noncompliance with medical advice.

Patients relied heavily on information from health-care professionals, and, generally, patients with disease complications needed more information regarding their condition and treatment options. Therefore, the efficacy of health information disseminated to patients became an essential determinant of patient outcomes. In a health-care setting, the success of knowledge transfer heavily relied on the health-care practitioner's ability to simplify information to match the patient's level of understanding. An essential part of disseminating health information is the use of medical language. For example, one patient was confused when professionals used medical jargon, leaving them no option but to resort to the internet for clarification. Mostly unregulated and unspecific, the internet has become a source of false health information for desperate people with health issues. Overreliance on the internet can cause personal and social harm through nurturing false beliefs about medicine, disease, and prevention (Wu & McCormick, 2018) because information found does not necessarily apply to the person searching for answers.

The lack of information on care updates and the differences in information relayed to patients by various health-care professionals created gaps in health-care delivery and affected patient outcomes. Information-deprived patients turned to other sources of information and received conflicting medical information, which led to uncertainties in how they self-managed. The patients' lack of understanding appeared to be the main driver for medication nonadherence. This nonadherence worsened patient outcomes that included limb amputations, resistance to antibiotics, further complications of the disease, and increasing health-care costs.

Patients with diabetes who obtain sufficient health information have decreased anxiety levels, improved outcomes through greater compliance, enhanced self-care, and better disease control (Association of Diabetes Care and Education Specialists, 2021). Empowered patients are most likely to experience minor discomfort, fewer side effects, suffer fewer postoperative complications, and have a quicker recovery (Davis et al., 2013). Patients expected explanations from the nurses about their disease, its prognosis, and management. Failed disease management resulted in the introduction of new treatment options, and when patients suffered adverse effects of new regimes, they discontinued treatment because they were unaware of what to expect. Their discontinuation of treatment further complicated their illnesses. Despite having deep feelings about improper care, they did not comment until they were in the research environment. As already noted, *iTaukei* patients felt trapped in their cultural mores to accept medical decisions without question.

Nurses' skills and potential are wasted due to the hierarchy, culture, and lack of post-registration education

When nurses are empowered, they can holistically manage and have specific plans for patients living with diabetes (Alotaibi et al., 2018; Krall et al., 2016). Nurses in Fiji have been the band-aid strategy for the MOH to respond to organisational demands on human resources and the NCDs crisis. The Nurse Practitioner programme filled the gaps for medical officers while the foot-care programme for nurses took on particular roles supposedly suited to podiatrists. Despite the burden of diabetes on Fiji's health-care system, there is no postgraduate specialised nursing programme on diabetes. Instead, nurses relied on their basic training knowledge, which contributed to the theory-practice gap that nurses reported. The lack of up-to-date knowledge on diabetes and associated conditions prevented nurses from effectively addressing the disease's complications, leaving patients with poor health-care experiences.

Nurses have an active role in safeguarding patients' needs because they spend the most time with patients. Nurses can only provide competent and effective patient care if they integrate knowledge, attitudes, and skills; therefore, they need knowledge updates. Being an educator is a vital nursing role, so nurses must take responsibility to teach patients and make patient education one of their priorities (Bergh et al., 2015; Marcum et al., 2002). Nurses' ability to improve patient experiences lies in their ability to communicate with patients effectively and empathetically.

Nursing education is one of the three focus areas of the State of the World's Nursing 2020 report (WHO, 2020). The WHO is committed to action the three pillars of learning outcomes for nursing students, standards for nursing programmes, and specific requirements for nursing educational institutions (Baker et al., 2021). In this regard, the WHO has actively encouraged addressing the global nursing need, meeting domestic demands, and advancing integrated health and social care models (WHO, 2020). The nurses in my study requested more education to help them deliver the nursing care they hoped to provide. An increase in post-registration nursing programmes and improved structural deployment of nurses at safe staffing levels require investment and political will.

One useful possibility for supporting nurses lies in the further development of the unregulated workforce. Nurses have some support from Village Health Workers (VHW) at a community level of care. As community members, VHWs are better positioned to offer support as they become the interconnecting link between the community and the nurses. To conduct their role effectively, the VHWs need special education and training on diabetes management updates (Orcherton, 2017). Education and training on diabetes management will help create awareness among people in their communities. For the *iTaukei*, this will enable a health-conscious and health-orientated platform, which will also locally support people living with chronic conditions like diabetes.

Culture as both a problem and a solution

Patients' culture and other cultural factors are essential components of health care (Hunter & Cook, 2020). As discussed in Chapter 4, *iTaukei* relate illness to sociocultural aspects as they explore such meanings and set things right with the *vanua* - a step towards positive results of health and wellness. On most occasions, only when symptoms of illness continued after the cultural protocol do *iTaukei* refer to the biomedical system for help. When accessing Western health-care services, patients, as already outlined, hesitated to communicate their needs to professionals and accepted medical decisions about them with polite passivity

To provide holistic care means incorporating culturally appropriate levels of care, and failure to do so lead to patients not being engaged in suggested treatment. In Fiji, nurses need to be culturally sensitive and have knowledge regarding indigenous perspectives of health (Vudiniabola, 2011). Having cultural knowledge is especially important when caring for patients who, due to their cultural ethos, delegated decision-making to the doctors and nurses.

Forging a partnership

Nursing care involves carefully responding to patients' concerns and upholding the ethical principle of nonmaleficence to promote healing in an unfamiliar environment. This includes deep respect for cultural mores as an important component of that care. In order to achieve this, nurses need to feel a much greater level of professional autonomy and freedom to determine their own practice more directly with a clear focus on patient-centered care.

Given that Fiji's current health-care system is not a patient-centred model, patients currently feel disempowered to work in partnership with health professionals to determine the best treatment options. Perhaps the solution lies in medical pluralism, which is the blend of the two systems - Western medicine and ethnomedicine. The two approaches need not clash because they can blend within the context of primary health care (Oliver, 2013). Patients and nurses both acknowledged the benefit of ethnomedicine in managing diabetic wounds, which implies that the two systems may be mutually beneficial. The integration of the two systems suggests using both Western medicine and ethnomedicine through the inclusion of Western medical doctors and traditional healers. Integration of both systems requires an understanding of each system's social and cultural constructions and the complexity of the whole (Oliver, 2013).

The solution may lie in extracting the causative factors for the patient to enable personalised platforms to identify beneficial, healing, and coping strategies. For this, a workable solution for the *iTaukei* living with diabetes and associated conditions is through the provision of *iTaukei* culturally competent nursing care. In this way, patients who use ethnomedicine are understood, monitored, and followed up, and receive continuous education, support, and empowerment. Due to their influence on *iTaukei*, and as deemed essential to the other Pacific frameworks, the church and community could help reaffirm cultural values and realign with the *Vanua*, *Lotu* (spirituality) and *Matanitu* (government) ideals.

Recommendations

Cultural knowledge (specifically iTaukei cultural knowledge) to be recognised as a key component of nursing care in Fiji. To impact the findings of this study, culture needs to be included as a causation pathway in the prevalence of diabetes among the *iTaukei* in Fiji. The effects of culture on the health-care behaviour of an individual need to be better understood.

Post-registration nursing programmes are developed. The nursing fraternity in Fiji requires regular postbasic nursing education in diabetes and related concerns. Therefore, the Fiji Nursing Council will have to approve nurse specialist positions at any health-care facility in Fiji to allow nursing institutions to offer nurse education programmes on diabetes.

Create podiatrist positions within the health-care system. There is no podiatrist, podiatry services, or podiatry training in Fiji. Nurses currently fill the role as an extra responsibility to manage the growing related concerns of foot-related complications due to diabetes and are known as “foot care nurses”. A podiatry qualification may help to reduce amputations and promote quality of life among people living with diabetes.

Refocus on primary health care. In line with strategic directions from the World Health Organization, International Council of Nurses, United Nations General Assembly, and health-related Sustainable Development Goals (SDGs), scaling up primary health care can save lives and increase life expectancy. There is a need to strengthen primary health care from health promotion, prevention, and treatment perspectives in Fiji.

Talanoa *methodology incorporated in Fijian research education system.* From my experiences in the method and methodology in this study, I see the need to include *talanoa* as a research methodology in nursing research education and practice in Fiji. Its promotion can act as a patient advocacy platform on health-care issues where patients feel comfortable sharing their experiences to improve nursing care in Fiji.

These changes will have to go through the FNC before being implemented by nursing institutions.

Strengthen policies related to NCDs and monitor their progress. Torres and Atkinson's (2018) work could be used to consider other influencing factors that contribute to the prevalence of diabetes and associated complications in Fiji. To begin with, suggestions from Bell et al.'s (2020) report on the Fijian government initiative of taxation laws on imported food need implementation to enhance healthy eating and living in Fiji.

iTaukei need to reaffirm their *vanua* values. The *iTaukei* need to be informed not to wait until they are sick to explore their cultural ways and means of wellness. Living healthily through the v*anua*, adhering to *vanua* protocols, maintaining relationships, taking routine herbal medicines, and maintaining balance are a good start.

Reflection on process

For the participants, the *veitalanoa* process became therapy (research as therapy) that created a platform for information, awareness of disease management, and acceptance that they were not alone in their experiences. The patient participants felt empowered to participate in their health care. The research process confirmed my researcher role as an agent of change in participants' lives. Having the patience to listen and capture the *veitalanoa* sessions was challenging, and I waited for as long as they needed to share their experiences of nursing care.

The research environment allowed me to see the two sides of the patient-participants. At the *veitalanoa* group, the patients wore the "patient hat" and shared their experiences of receiving health care. They were well-dressed and had travelled away from their dwelling to the *veitalanoa* group venue. However, the observations and *veitalanoa* one to one happened in their homes and communities, which allowed me as a researcher to see them differently, now as a person and not a patient. I gathered much information from patients in their natural settings, gaining a holistic understanding of their reality while linking and matching what I heard during the *veitalanoa* group to what I was seeing.

Limitations

This study focused only on patients diagnosed, on medical treatment, and registered as people living with diabetes and associated conditions. Those who did not attend medical clinics might have other reasons and explanations for the nursing care they anticipated receiving. The study also captured *veitalanoa* with the *iTaukei* who could travel to the research venue. Perhaps further research could focus on patients who cannot travel away from their homes. The patient participants were all living in and accessing health care services on the main island of Viti Levu. Therefore, the patients who live on smaller islands may have differing experiences that were not captured in this study.

Dissemination and actions to begin helping

Disseminating information and contributing usefully to the research community is included as a requirement of the *Vanua* research design in its ninth stage as outlined in Chapter Six. I planned to present my findings to nurses in Fiji during the Fiji Nursing Association Scientific session, which happened in April 2020. I received confirmation of a successful abstract submission but cancelled my trip due to the COVID-19 travel restrictions. I intend, when possible, to present my findings to the Ministry of *iTaukei* Affairs and the provincial administrators, hoping to arrive at some possible solutions to the findings. I expect to disseminate my research findings to the community and the general public through government-organised roadshows. Additionally, plans are in place to present my results to nursing symposia and health workshops in Fiji.

Presenting my research findings will be possible after the COVID-19 travel restrictions end.

I presented my research to the Fijian community living in Palmerston North. As a result, I received some requests and interest in how people living with diabetes in Fiji could receive assistance. I am currently working with a group of *iTaukei* women in Palmerston North to create a synergistic network of women who can empower one another in several matters, including health issues. These women have an influence on families in Fiji with some authority and support.

I presented to the 2020 New Zealand Fijian Research Symposium, hosted by the Unitech Institute of Technology, Auckland. The symposium attendees were Fijian students, scholars, and researchers who presented their work to an audience through online and face-to-face modes. I also presented my research findings to the Pasifika Postgraduate *Talanoa* session and the Manawatu Chamber of Commerce Doctoral Breakfast as a Massey University representative. In addition, I participated in the 3MT Competition in 2020 and received a judges' commendation.

The lack of literature on nursing care for people living with diabetes and NCDs in Fiji and the Pacific contributes to a lack of awareness of the complexity of the problem. Diabetes is the number one cause of morbidity and mortality among healthy adults. It is hoped that this thesis will trigger discussion on nursing care for people living with diabetes or NCDs in general for Pacific Island countries and territories.

Thesis Conclusion

My research set out to discover the experiences of patients and nurses experiencing and practising in the context of a diabetes epidemic. The research investigated how *iTaukei* patients described the nursing care they received and wanted to receive, and the nurses explained the care they delivered and the care they wanted to deliver. In describing the ideal nursing care they hoped for, both patients and nurse participants recited their experiences, most of which were untold and never shared. Most patient participants were unaware that other patients experienced similar nursing care. Therefore, the *veitalanoa* sessions, as a method of collecting information from the participants, became therapy. Through reliving their painful life journey and their despair with healthcare experiences, they fought hard to control their emotions and tell their stories. Unfortunately, most of the patient-participants have passed on, and those surviving are now sicker than when this study was conducted.

The voluminous global literature on diabetes and NCDs signify the relevance of a topic that concerns global health. However, there was little written about the topic for Fiji and the Pacific despite the NCDs and diabetes epidemic within Fijian and Pacific populations. Fiji was among the first few countries to adopt some public health initiatives that were developed to curb NCD incidences. Such initiatives included healthcare policies that related to taxation, nutrition, tobacco control, and physical activity. The Ministry of Health has also improved its human resources capacity by increasing the doctors and nurses to patient ratio to meet healthcare demands. However, the unending challenge for Fiji lies in the implementation, monitoring, and evaluation of its healthcare policies.

The *iTauke*i, as indigenous people of the *vanua*, have their way of knowing and dealing with sickness, which affects how they approach Western medicine. Through their cultural values of knowing, trusting, sharing, and preparing, the *iTaukei* way of life contributes to their wellness. By identifying the cultural values contained in how the *iTaukei* relate to each other, their approaches to healthcare were understood. Cultural values cannot be changed, but the approach to healthcare and making changes could be done by taking into account their cultural viewpoint.

The complexity in dealing with the many needs of patients living with diabetes and associated conditions has demanded more of the nurses' time, further straining the workforce staffing; therefore, nurses working under pressure and time constraints compromised nursing standards of practice. In addition, the nurses continuously faced many new and uncertain public health challenges that affected people's health, which prevented patients from seeking healthcare. The nurses identified the need to address stigma and conduct public awareness but were challenged by their lack of time to commit to their plans.

There will be no easy or simple solutions to managing the patient and nurse experiences of diabetes care in Fiji. Therefore, it will be essential to approach the identified problems carefully, to put the emotive nature of the findings aside, and to approach the recommendations with care, especially in a healthcare system that needs a great deal of support and a community that is deeply affected by their healthcare experiences.

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Appendices

Appendix One: Ethics Endorsement

MASSEY
UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Date: 22 June 2018

Dear Akisi Ravono

Re: Ethics Notification - **SOA 18/25** - **Patients and Nurses Vision for the Care of Diabetes in Fiji: An iTaukei perspective.**

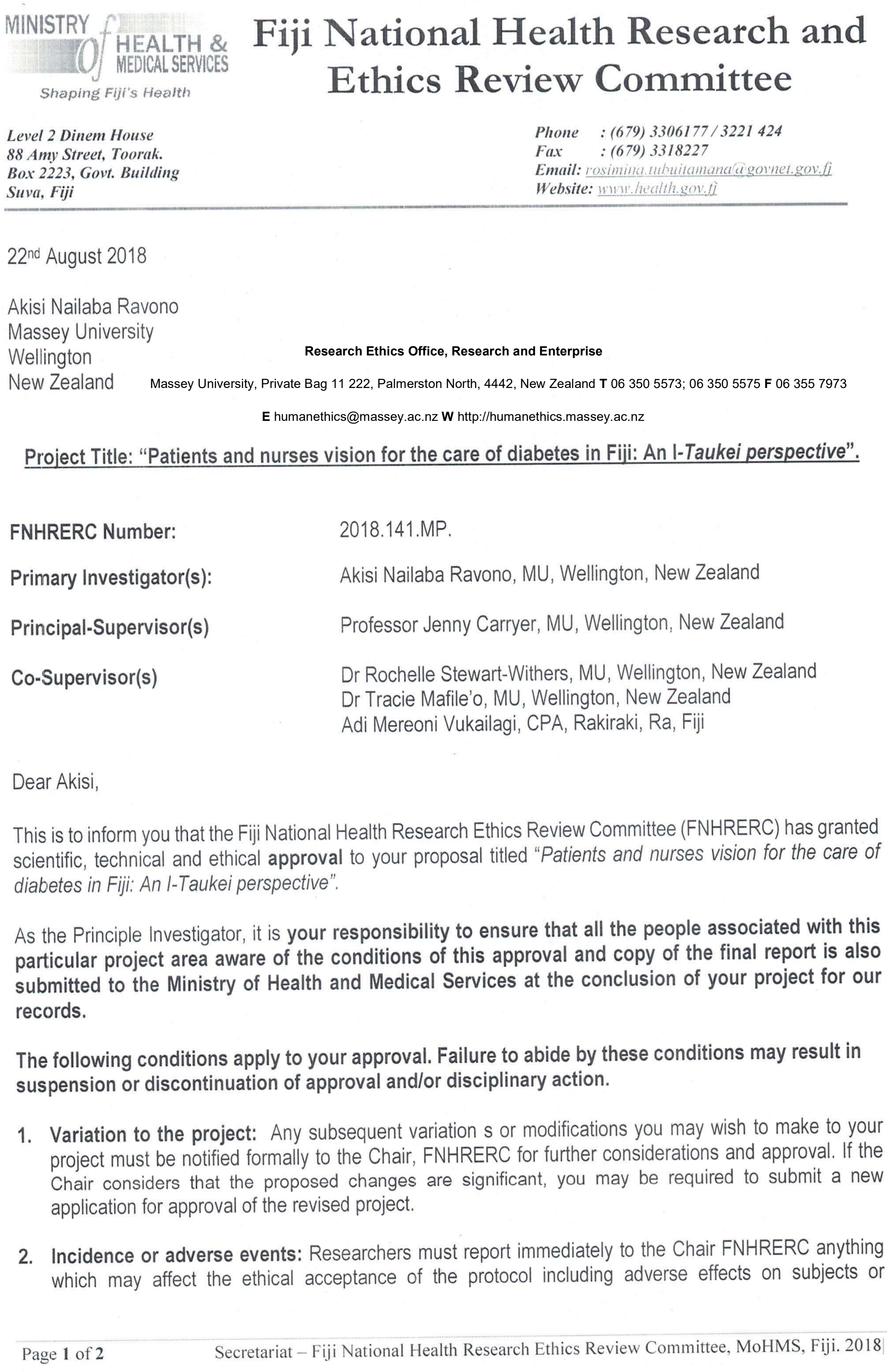
Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Southern A Committee** at their meeting held on **Friday, 22 June, 2018**.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Associate Professor Tracy Riley, Dean Research
Acting Director (Research Ethics)



MINISTRY of HEALTH & MEDICAL SERVICES
Shaping Fiji's Health

Fiji National Health Research and Ethics Review Committee

Level 2 Dinem House
88 Amy Street, Toorak.
Box 2223, Govt. Building
Suva, Fiji

Phone : (679) 3306177 / 3221 424
Fax : (679) 3318227
Email: rosimina.tubuitamana@govnet.gov.fj
Website: www.health.gov.fj

22nd August 2018

Akisi Nailaba Ravono
Massey University
Wellington
New Zealand

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Project Title: "Patients and nurses vision for the care of diabetes in Fiji: An I-*Taukei perspective*".

FNHRERC Number:	2018.141.MP.
Primary Investigator(s):	Akisi Nailaba Ravono, MU, Wellington, New Zealand
Principal-Supervisor(s)	Professor Jenny Carryer, MU, Wellington, New Zealand
Co-Supervisor(s)	Dr Rochelle Stewart-Withers, MU, Wellington, New Zealand Dr Tracie Mafile'o, MU, Wellington, New Zealand Adi Mereoni Vukailagi, CPA, Rakiraki, Ra, Fiji

Dear Akisi,

This is to inform you that the Fiji National Health Research Ethics Review Committee (FNHRERC) has granted scientific, technical and ethical **approval** to your proposal titled "*Patients and nurses vision for the care of diabetes in Fiji: An I-Taukei perspective*".

As the Principle Investigator, it is **your responsibility to ensure that all the people associated with this particular project area aware of the conditions of this approval and copy of the final report is also submitted to the Ministry of Health and Medical Services at the conclusion of your project for our records.**

The following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and/or disciplinary action.

1. **Variation to the project:** Any subsequent variation s or modifications you may wish to make to your project must be notified formally to the Chair, FNHRERC for further considerations and approval. If the Chair considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised project.
2. **Incidence or adverse events:** Researchers must report immediately to the Chair FNHRERC anything which may affect the ethical acceptance of the protocol including adverse effects on subjects or

unforeseen events that may affect continued ethical acceptability of the project. Failure to do so may result in suspension or cancellation of approval.

3. **Monitoring:** Projects are subject to monitoring at any time by the Committee

4. **Annual/Final Report:** You must submit a progress report at 6 months of your study and an annual/final report at the end of the year or at the conclusion of the project if it continues for less than or more than a year. Also you are to present the evidence back to the participating institutions.

Please quote the FNHRERC number and the name of the project in any future correspondence.

If you have any further queries or require any additional information, please do not hesitate to contact the Secretariat on telephone: (679) 3306177 ext. 340170 or email: rosimina.tubuitamana@govnet.gov.fj.

We wish you all the best in your study.

……………………………
Mr. Shivnay Naidu
Chairperson
Fiji National Health Research Ethics Review Committee

MINISTRY OF ITAUKEI AFFAIRS

ITAUKEI TRUST FUND BUILDING COMPLEX 87 QUEEN ELIZABETH DRIVE, SUVA

P.O.BOX 2100, GOVERNMENT BUILDING, SUVA, FIJI.

TELEPHONE: (679) 3100 909 FAX: (679) 3317 077

Reference: MTA - 4/99/8-2 23 rd April, 2019

Akisi Ravono

School of Nursing
College of Health
Social Sciences Tower
Massey University
NEW ZEALAND.

Re: Research Request — MTA Letter of Support

In response to your request dated 9th April 2019, this is a support letter by the Ministry of iTaukei Affairs (MTA) for you to carry out medical research in the chosen research areas of [redacted] medical areas from April to June 2019.

It is noted that your research is titled, "Patients and Nurses Vision for the Care of People Living with Diabetes in Fiji.

Mandated to oversee the welfare and good governance of the iTaukei community under the iTaukei Affairs Act 1945, this letter is granted on the condition that the following will be undertaken:-

i. Roko Tui responsible for the proposed site(s) be informed of the research objectives and the communities that will be impacted in the process;
ii. Free Prior Informed Consent (FPIC) guideline Principle is obtained by researcher and evidence of this provided with a copy of final report;
iii. Individuals/communities that participate in the research are appropriately informed of the objectives and duration of the research;
iv. Cultural sensitivity and traditional protocols are observed;
v. All fieldwork and research activity is to be put on hold on Sunday; that Sundays' be respected as a day of rest;
vi. Status update(s) of the ongoing fieldwork be submitted at regular intervals to the respective Provincial Council office and the designated MTA desk officer;
vii. That the respective village communities are acknowledged in the research report;
viii. A copy of the finalized research findings report is submitted back to the community; and
ix. A Copy of the finalized research findings report document with corresponding Free Prior Informed Consent (FPIC) forms is submitted to the Ministry of iTaukei Affairs, and the Provincial Council's office.

Kindly be advised that this support letter is also based on you meeting institutional requirements from other line Ministries / Government Departments that are directly/indirectly linked to your area of research interest.

The designated officers, as point of contact with regards to reporting and other necessary issues is Salaseini Naiduki on email: salaseini.naiduki@govnet.gov.fj or telephone: 3100909 (ext 1027).

You are advised to liaise with the Roko Tui [redacted], Roko Tui [redacted] and Roko Tui [redacted] upon arrival, for further assistance.

Meleti Bainimarama

A/Permanent Secretary for iTaukei Affairs

Appendix Two: Consent Forms

MASSEY UNIVERSITY
COLLEGE OF HEALTH
TE KURA HAUORA TANGATA

Working Title: Patients and nurses vision of care for diabetes in Fiji: An *iTaukei perspective*

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: .... **Date:** ....

Full Name - printed ....

Te Kunenga
ki Pūrehuroa

School of Nursing
Private Bag 11222, Palmerston North 4442, New Zealand **T** 06 356 9099 **www.massey.ac.nz**

MASSEY UNIVERSITY
COLLEGE OF HEALTH
TE KURA HAUORA TANGATA

Working Title: Patients and nurses vision of care for diabetes in Fiji: An *iTaukei perspective*

FOCUS GROUP PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion.

I understand that all information I give will be kept confidential to the extent permitted by law, and the names of all people in the study will be kept confidential by the researcher.

Note: There are limits on confidentiality as there are no formal sanctions on other group participants from disclosing your involvement, identity or what you say to others in the focus group. There are risks in taking part in focus group research and taking part assumes that you are willing to assume those risks.

I agree to participate in the focus group under the conditions set out in the Information Sheet.

Signature: .... **Date:** ....

Full Name - printed ....

Please note: All consent forms will be kept separately from the written and tape-recorded responses.

If you feel you need to, and agree to participate in the individual interview, please indicate your contact below;

Name:____

Physical Adress:____

____

Phone Contact:____

Preferred Contact time:____

Appendix Three: Information Sheets

Working Title: Patients and nurses vision for the care of diabetes in Fiji: *An iTaukei perspective*

INFORMATION SHEET FOR NURSE PARTICIPANTS

Researcher Name: Akisi Ravono

Type of Project: Research

Purpose of the Project: To explore patients expectations of their care and how nurses plan to deliver care for patients in an iTaukei perspective.

Research project for the Doctorate of Philosophy degree (Nursing), Massey University, Manawatu Campus, Palmerston North, New Zealand.

Project Description and Invitation:- A brief Summary

Health-care professionals must at all times be prepared to offer best possible outcomes for individuals who seek their attention. The vision of care explains what a person as a patient or a healthcare professional desire from a relationship to assist the health needs of a patient. A key to the patient-centred approach is understanding the patient experience. This research will explore patient’s expectations of their care and how it connects to the care that nurses plan to deliver for a patient in an *iTaukei* community setting. This research will use the experiences of people living with diabetes mellitus as the primary disease, but inevitably, they will have coexisting long-term conditions. It will also use the experiences of nurses who have more than three years of working with people with diabetes.

An invitation

Bula vinaka! Thank you for agreeing to read this information. You are invited to participate in the study that examines the patients and nurses vision of care for diabetes in Fiji from an iTaukei perspective. As a nurse participant, you are helping us better understand how nurses explain the type of care they want to deliver to patients suffering from diabetes.

Participant Identification and Recruitment

Thank you for responding to the flyer to participate in this research based on your experiences of looking after people with diabetes. You are selected because you are an iTaukei with more than three years of work experiences of looking after people with diabetes. There will be two venues for data collection -[redacted] & [redacted] medical areas. Five nurse participants will participate in a focus group discussion that adopts a workshop structure from each medical area. The workshop will include meals, and you will receive a small reimbursement of your return fare. Breaks will be allocated in between questions.

Project Procedures

You will be joining another four participants to engage in the group discussion, which is held at the Ministry of Health Conference room. The discussion will adopt a workshop approach so it will take three to four hours of your time. All discussions will be tape recorded and you have the right to edit your own input.

We acknowledge that you may not share some important and confidential information, therefore if you agree, you can further participate in the individual interview, which will be held at your clinic at a later time to your convenience. The individual interview will take one to two hours of your time and will be tape recorded. You have the right to edit the recorded interview.

You will be asked to answer anonymously and in strict confidence ten questions about your experiences in both the group discussion and individual interview methods. All responses will be tape-recorded.

You can clarify any issues/questions relating to the questions asked with the questionnaire administrator. If you do not feel comfortable with some of the questions, you can choose either not to answer them or withdraw from the study. If I see that you are showing some signs of distress, the discussion may be paused for that moment and continued at a later time.

Data Management

Be assured that all your answers to the research questions will be kept strictly confidential. No names or any other form of identification will be associated with your responses. Data collected from this research will be pooled and may be used for further research. After the discussions, I will summarize your responses back to you and you can ask for deletion of some information you wish to delete. No names will be associated with the recorded information.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study at anytime;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*
- *ask for the recorder to be turned off at any time during the interview.*
- *You have the right to decline to answer any particular question.*

Project Contacts

Any queries you have regarding this research should be addressed to Akisi (researcher) on telephone 3390032, Mobile (Vodafone): 9272534; (Digicel) 7305503 or Supervisor: Professor Jenny Carryer, School of Nursing, College of Health Phone +64 6 356 9099 extension 85343

- **Copy of approval from the Fiji Ministry of Health Research and Ethics Committee**
- **Copy of approval from Massey University human ethics Committee**

<u>MUHEC APPLICATION</u>

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 18/25. Any concerns about the conduct of this research can be clarified by contacting Dr Lesley Batten, Chair, Massey University Human Ethics Committee: Southern A, telephone +646 356 9099 x 85094, email humanethicsoutha@massey.ac.nz.

MOH APPLICATION

Committee Approval Statement

This project has been reviewed and approved by the Fiji National Health Research and Ethics Committee: FNHRERC Number: 2018.141.MP. Any queries must be forwarded to the Secretariat on telephone (679) 3306177 ext 340170 or email: rosimina.tubuitamana@govnet.gov.fj

Working Title: Patients and nurses vision for the care of diabetes in Fiji: *An iTaukei perspective*

INFORMATION SHEET FOR PATIENT PARTICIPANTS

Researcher Name: Akisi Ravono

Type of Project: Research

Purpose of the Project: To explore patients expectations of their care and how nurses plan to deliver care for patients in an iTaukei perspective.

Research project for the Doctorate of Philosophy degree (Nursing), Massey University, Manawatu Campus, Palmerston North, New Zealand.

Project Description and Invitation:- A brief Summary

Health-care professionals must at all times be prepared to offer best possible outcomes for individuals who seek their attention. The vision of care explains what a person as a patient or a healthcare professional desire from a relationship to assist the health needs of a patient. A key to the patient-centred approach is understanding the patient experience. This research will explore patient's expectations of their care and how it connects to the care that nurses plan to deliver for a patient in an *iTaukei* community setting. This research will use the experiences of people living with diabetes mellitus as the primary disease, but inevitably, they will have coexisting long-term conditions. It will also use the experiences of nurses who have more than three years of working with people with diabetes.

An invitation

Bula vinaka! Thank you for agreeing to read this information. You are invited to participate in the study that examines the patients and nurses vision of care for diabetes in Fiji from an iTaukei perspective. As a patient participant, you are helping us better understand the type of care patients suffering from diabetes expect to receive from nurses.

Participant Identification and Recruitment

Thank you for responding to the flyer and agreeing to participate in this research based on your experiences of living with diabetes. You were chosen because you are an *iTaukei* with more than three years of illness experiences of diabetes. There will be two venues for data collection - [redacted] & [redacted] medical areas. Five patient participants will participate in a focus group discussion that adopts a workshop structure from each medical area. The workshop will include meals, and you will receive a small reimbursement of your return fare.

Project Procedures

You will be joining another four participants to engage in the group discussion, which is held at the Ministry of Health Conference room. The discussion will adopt a workshop approach so it will take three to four hours of your time. Breaks will be allocated in between questions. All discussions will be tape recorded and you have the right to edit your own input.

We acknowledge that you may not share some important and confidential information, therefore if you agree, you can further participate in the individual interview, which will be held at your home at a later time to your convenience. The individual interview will take one to two hours of your time and will be tape recorded. You have the right to edit the recorded interview.

You will be asked to answer anonymously and in strict confidence ten questions about your experiences in both the focus group discussion and interview methods. All responses will be tape-recorded.

You can clarify any issues/questions relating to the questions asked with the questionnaire administrator. If you do not feel comfortable with some of the questions, you can choose either not to answer them or withdraw from the study. If I see that you are showing some signs of distress, the discussion may be paused for that moment and continued at a later time.

Data Management

Be assured that all your answers to the research questions will be kept strictly confidential. No names or any other form of identification will be associated with your responses. Data collected from this research will be pooled and may be used for further research. After the discussions, I will summarize your responses back to you and you can ask for deletion of some information you wish to delete.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study at anytime;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*
- *ask for the recorder to be turned off at any time during the interview.*
- *You have the right to decline to answer any particular question.*

Project Contacts

Any queries you have regarding this research should be addressed to Akisi (researcher) on telephone 3390032, Mobile (Vodafone): 9272534; (Digicel) 7305503 or Supervisor: Professor Jenny Carryer, School of Nursing, College of Health Phone +64 6 356 9099 extension 85343

- **Copy of approval from the Fiji Ministry of Health Research and Ethics Committee**
- **Copy of approval from Massey University human ethics Committee**

<u>MUHEC APPLICATION</u>

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 18/25. Any concerns about the conduct of this research can be clarified by contacting Dr Lesley Batten, Chair, Massey University Human Ethics Committee: Southern A, telephone +646 356 9099 x 85094, email humanethicsoutha@massey.ac.nz.

MOH APPLICATION

Committee Approval Statement

This project has been reviewed and approved by the Fiji National Health Research and Ethics Committee: FNHRERC Number: 2018.141.MP. Any queries must be forwarded to the Secretariat on telephone (679) 3306177 ext 340170 or email: rosimina.tubuitamana@govnet.gov.fj

Appendix Four: Flyers

AN INVITATION:

PARTICIPATION IN A RESEARCH PROJECT ON:- PATIENTS & NURSES VISION FOR THE CARE OF DIABETES IN FIJI

*For iTaukei nurses

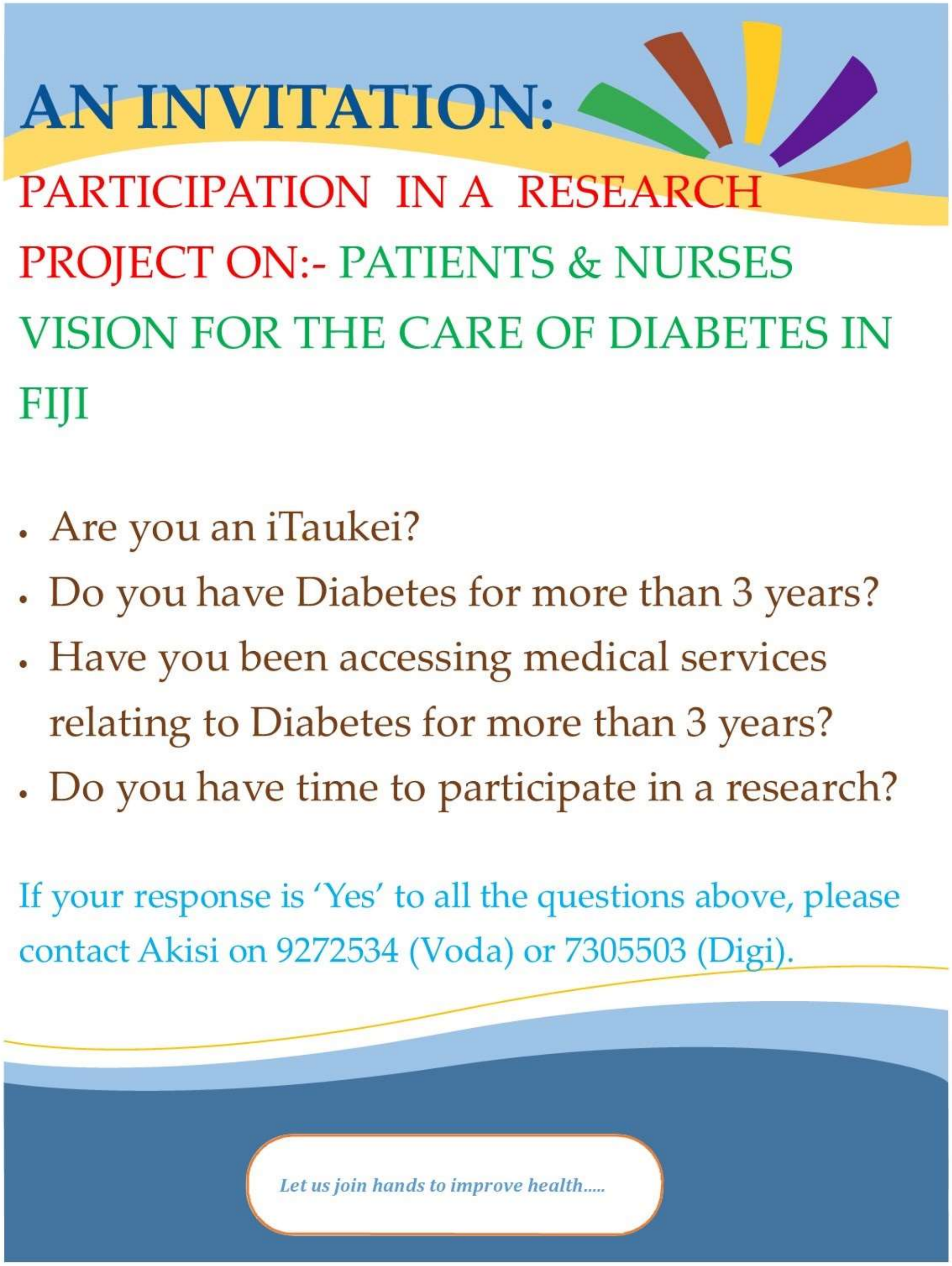
Worked for 3 years and more

Nursed patients with Diabetes

Have time to spare for research

If your answer is 'Yes' to all, please contact Akisi on 9272534 or 7305503 on collect call.

Let us join hands to improve health.....



AN INVITATION:

PARTICIPATION IN A RESEARCH PROJECT ON:- PATIENTS & NURSES VISION FOR THE CARE OF DIABETES IN FIJI

- Are you an iTaukei?
- Do you have Diabetes for more than 3 years?
- Have you been accessing medical services relating to Diabetes for more than 3 years?
- Do you have time to participate in a research?

If your response is ‘Yes’ to all the questions above, please contact Akisi on 9272534 (Voda) or 7305503 (Digi).

Let us join hands to improve health.....

Appendix Five: The participants

The nurse-participants

Litia

Litia had more than five years of nursing experiences with patients living with diabetes. She was one of the two nurses from the health centre that attended the foot care program, and she is a 'foot nurse.' Litia attended to all patients with diabetes that needed follow-up care at the clinic. She also had a zone[71] and is responsible for the MCH clinic for her specific area.

Epeli

Epeli had more than five years of nursing experiences with patients living with diabetes. During the research, he was working as a registered nurse at a sub-divisional hospital. He was waiting for the boat to return to the island. He had not attended any extra training on diabetes.

Rosi

Rosi had more than five years of nursing experiences with patients living with diabetes. She attended the foot care program and is a 'foot nurse' in one health centre. Rosi was responsible for all patients with diabetes that attend the follow-up clinic. She was a zone nurse and controlled the MCH clinic on an allocated day to people from her zone.

Loma

Loma had more than ten years of nursing experiences with patients living with diabetes. She worked in a health centre and had an allocated zone. Loma was responsible for home visitations, conducting shift clinics and attending to patients at the clinic. Her husband is from one of the villages in her zone; therefore, she had a good connection with her patients. She had not attended the foot care program.

Lisi

Lisi worked in a remote health centre with another nurse and was responsible for a zone. Being a *tauvu* to her population, Lisi had a good relationship with them. She had not attended

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[71] Zone- an area within a medical area, assigned to a nurse

the foot care program. Lisi had more than ten years of nursing experiences with patients living with diabetes.

Ana

Ana had more than twenty years of nursing experiences with patients living with diabetes. She worked in one of the sub-divisional hospitals and has not attended the foot care program. Ana had retired and was re-employed to mentor the younger nurses and fill in the nursing staff shortage. She was a midwife and worked in various health care facilities around Fiji. Ana also had some overseas work attachments.

Vika

Vika had more than twenty years of nursing experiences with patients living with diabetes. She worked in one of the sub-divisional hospitals and had expertise in community nursing. Despite working as a community nurse for more than ten years, she had not attended the foot care program.

Vere

Vere had more than ten years of nursing experiences with patients living with diabetes. She worked in one of the sub-divisional hospitals and had not attended the foot care program. Vere had community nursing experience.

Nunia

Nunia had more than ten years of nursing experiences with patients living with diabetes. She worked as a ward nurse in one of the sub-divisional hospitals. Nunia had not attended the foot care program. Nunia had experiences in community nursing.

Selai

Selai had more than five years of nursing experiences with patients living with diabetes. She was working at a sub-divisional hospital for two years after spending three years of community nursing. Selai had not attended the foot care program.

Lusi

Lusi had more than five years of nursing experiences with patients living with diabetes. She worked at the maternity unit in one of the sub-divisional hospitals and had not attended the foot care program. Lusi completed three years of community nursing.

The patient-participants

Jale

Jale was a 67-year-old, diagnosed with diabetes in 2013, who had developed a blister on his left big toe in 2016. He assumed it was a small wound until he started experiencing chills and rigours. Diagnosed with diabetes foot sepsis, Jale faced the worst – the need to consent for a toe amputation, which he did. While admitted, his wound did not improve; therefore, he received amputation to his forefoot. His amputated wound had healed, and he attended the follow-up clinic. Jale was married and lived with his extended family in the village. According to Jale, diabetes was common among his adult relatives.

Jese

Jese was a 54-year-old diagnosed with diabetes in 2013, when he stepped on a nail, and his wound did not heal but was discharging an offensive smell. He had a right toe amputation and later received amputation to his forefoot. He further underwent an amputation below the knee. During the veitalanoa, he was regularly attending the dual clinic. Jese had excellent support from his extended family members and took his medications as prescribed. Jese also had family members living with diabetes.

Jeke

Jeke was a 48-year-old who lived with his extended family in his wife's village. He was diagnosed with diabetes in 2014 and had a right forefoot amputation in 2018, which he said was unnecessary since it was only a blister from a few scratches. He referred to his wound as the horse's foot[72] that has not entirely healed. During the veitalanoa, he had been attending the follow-up clinics regularly and was well-known to the nurses. Jeke described his family and community as supportive.

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[72] Horses' foot- patients compared the shape of an amputated forefoot to that of a horses' foot.

Juta

Juta was a 61-year old diagnosed with diabetes for more than five years. He was employed in the civil service when he received the amputation. I observed Juta on his clinic day. He had excellent family support. Juta's wife fully supported him since his amputation. Juta's wound started from an unhealed broken skin wound between his toes.

Jone

Jone was a 67-year-old who has had a right below-knee amputation and had the most experience accessing health care. He had been living with diabetes for more than ten years. Jone has had several hospital admissions, including trips to the operating theatre for a dressing change, wound debridement and amputation. He regularly attended the clinic. Jone mobilised on the wheelchair and was supported fulltime by his nephew. Jone was married and had excellent family support. He could not recall what exactly happened but realised the offensive smell discharging was from his foot. Jone described his wound as 'blackish.' Jone's fore-foot wound did not heal and was infected, with thick, yellowish offensive discharge. He received daily wound dressing at a nearby health centre until his hospital admission for a below-knee amputation.

Jope

Jope was a 50-year-old and married with four children. He had been living with diabetes for more than five years and had a right below-knee amputation. During the veitalanoa, he was regularly attending a follow-up clinic and was consistent with his medication. Jope had excellent family support. Jope knew a lot of people living with diabetes who do not follow healthcare advice and clinic.

Leba

Leba was a 39-year-old and diagnosed with diabetes in 2014. She had a three-year-old granddaughter who lived with her. Leba has a family history of diabetes and hypertension.

During the veitalanoa, Leba had been regularly attending the dual clinic. She was on anti-hypertensive and anti-diabetic medications, which, according to her, caused severe side effects. She only took them two to three days before her clinic. She was also taking herbal medicines for hypertension and diabetes. She was happy with her status.

Kesa

Kesa was a 29-year-old, a single mother to two children, who depended on her parents for support. Kesa also received monthly social welfare financial assistance and food vouchers. She was diagnosed with diabetes three years ago and had been regularly attending the dual clinic. During the veitalanoa, Kesa was on medications but admitted to not consistently taking them.

Mere

Mere was a soft-spoken 74-year-old, the oldest participant in my research. Mere is a widow and was living with her extended family. She had been living with diabetes for more than five years and had hypertension. Mere attended the dual clinic. She was partially blind but declared she had stable glycaemic control. She had good family support.

Laisa

Laisa was 62-years old, diagnosed with diabetes in 2009. She was a strong-willed woman who did not consent to limb amputation. She successfully sought alternative therapy for her foot sepsis and was very proud of her achievement. Laisa’s husband also had diabetes. Her brother-in-law had bilateral BKA. Laisa continues to attend the dual clinic for blood sugar monitoring only.

Peci

Peci was a 44-year-old diagnosed with diabetes for more than five years and attended the diabetes clinic since diagnosed with the disease. In 2018, she developed hypertension and is now attending the dual clinic. Peci and her husband both had diabetes, on treatment and also take herbal therapies.

Sera

Sera was a 56-year old diagnosed with diabetes in 2016 and regularly attended the follow-up clinic. Sera had stable glycaemic control and alternate medications with herbal therapies. According to Sera, her husband also had diabetes but continue to deny his diagnosis. She had been convincing him to live healthily but had yet to be successful.

Appendix Six: Glossary of Fijian words

Bati:	Warrior, belonging to the warrior tribe
Bobo:	Hand massage
Bogi va:	Observance of the fourth night of traditional therapy (ethnomedicine)
Boka:	Presentation of goods to compensate for absence from the community
Bou:	Tall post in a house that holds the ridgepole
Bula:	Health or life and also used to greet or welcome a person
Bula sautu:	Wellness, in holistic fulfilment of life's demands and circumstance
Bula vakayalo:	Spiritual health
Bulubulu:	Burying of wrongdoing through a traditional presentation
Burebasaga:	People from the western and southern parts of Viti Levu, belonging to the provinces of Rewa, Nadroga, Serua, Kadavu off the coast of Suva, and parts of Ba and Namosi.
Burua bula:	Celebration feast for a person who is to succumb to their illness
Butu:	Foot massage

Cokonaki:	Presentation of boka
Dau soli wai:	A person who dishes out herbal therapies
Dauveiqaravi:	Providing assistance to a sick person
Dreu:	Relationship between people of Vanua Levu and certain tribes in Viti Levu
Duru:	Posts of the house which holds the wall plates
Gunu:	Drink
iCavuti:	Title accorded to the chief, vanua or the iTaukei person
iSevusevu:	The formal announcement of arrival and purpose of a visit in an iTaukei village or community
iSoro:	Conduct of formal apology to make peace with one another.
iTaukei:	An indigenous person in Fiji, and is considered to be the traditional owner of the land and registered in the book of indigenous persons (Vola ni kawa bula)
iTovo vakavanua:	Respectable standard of conduct of that relates to the vanua
Kai:	From the same island, province or neighbouring province
Kakana:	Ceremonial food prepared to mark a special occasion
Kalou mai bulu:	Ancestral God

Kalou mai lagi:	God of the heavens, present
Koicalevu:	The relation between two tribes from the West
Koro:	Village
Kubuna:	People from the provinces of Tailevu, Naitasiri, Lomaiviti, and parts of the western provinces of Ba and Ra.
Lalaga:	Wall of a house
Lewenivanua:	People in the vanua
Macake:	Generalised sickness, usually of unknown origin, when treated in children for oral thrush
Madua:	Embarrassment
Mana:	Blessings, of a supernatural source
Mataqali:	Relationship between tribes also mean clan
Matanigasau:	Formal apology to correct mistakes
Matanitu:	Confederacies, including several Yasana (provinces)
Matanivanua:	Spokesperson of the vanua
Mate sureti:	Invited diseases relating to NCDs
Maseki:	The relation between two tribes from the West
Na icurucuru:	Entry point, referred in this study as village entry

Naita:	The relation between two tribes
Na itatau:	Farewell
Na itukutuku:	Information received
Na navunavuci:	Conception
Na vakavakarau:	Preparation
Na vakavinavinaka:	In appreciation
Roko Tui:	Provincial Administrator Executive officer of the Yasana
Sili:	Digital examination of a woman normally performed by a traditional midwife
Solesolevaki:	Working together to help the needy
Tabu:	Forbidden taboo, which relates to being prohibited from either a thing or person
Tabua:	Whales' tooth, a most valuable iTaukei traditional artefact used for formal ceremonial purposes
Takitaki:	Serving of cooked food to another
Tako lavo:	The relation between two tribes from the West
Taleva lesu:	Looking back, reviewing
Tanoa:	Large wooden bowl made from specially picked wood

Tara:	A gentle press on the affected area, in particular for burn injuries
Taucoko ni qaravi tavi:	Wholistic performance of tasks
Taukei:	Dominant and owner of something, for the iTaukei, it is always referred to as the landowners
Tauvu:	A form of relationship that is shared by people from different iTaukei tribes from different parts of Fiji, and are traditionally allowed reciprocal rights of spoiling each other
Tekivu na isema ni veiwekani:	Beginning of a relationship
Tevutevu:	Spread of mats for a special person
Tikina:	Districts formed by several villages
Tokatoka:	Enlarged family unit or group descendant from brothers
Tovata:	People from the north east of Fiji, belonging to the provinces of Bua, Macuata and Cakaudrove on the northern island Vanua Levu, as well as the Lau Islands.
Turaga ni koro:	Village headman responsible for supervising all activities in the koro
Vale:	Dwelling house
Valenibula:	Hospital

Vakanomodi:	Respectable form of silence
Vanua:	Relating to the land, people, and everything on it. It also relates to the chiefs and is announced during traditional ceremonial functions.
Vakarokoroko:	Being respectful
Vakaturaga:	Chiefly demeanour
Vasu:	Relation of woman accorded as descendants of a female member of the tribe/clan
Veibatiki:	Two tribes of warriors whose totem is never to be consumed in the presence of another
Veidokai:	Respect
Veidolei:	Reciprocate
Veidovi:	Sharing food and drinks with another
Veikilai:	Knowing a person
Veilomani:	Act of *loloma* (love) towards another also known as yalo vata, duavata
Veinanumi:	Thinking of or considering others
Veimaroroi:	Act of keeping someone safe from harm
Veisiko:	Visitations, normally during illness

Veisorosorovi:	Exchange in performance of traditional apologies between two parties
Veitalanoa:	A formal account of Talanoa, a conversational method
Veitauriligataka:	Also, *Cakacaka vata/duavata*- working together to a common goal
Veivakademeni:	Giving special attention to someone
Veivakaliuci:	Placing needs of others before one's own
Veivakamarautaki:	Keeping someone happy to elevate their mood
Veivakamenemenei:	Offering special treatment
Veivakani:	Offer food to someone over a period of time
Veivakaturagataki:	Diplomatic and careful display of respectful behaviour
Veivakavaletaki:	Providing accommodation to a person
Veivuiyava:	Spiritual means of blessing forgiveness through feet washing
Veivukei:	Helping another person
Veiwekani:	Relationships
Vola ni kawa bula:	Register for all indigenous persons in Fiji
Wainimacake:	Bitter drinks prepared to counter macake-blood sugar

Wainimate:	Medicine
Wainimate vakavavalagi:	Western medicine
Yamo:	Light hand massage
Yanu:	Relationship between people from the islands
Yaqona:	A traditional drink made from the root and stem of the Piper Methysticum
Yasana:	Province
Yava:	Foot
Yavusa:	Tribe of blood relatives of many patrilineal groups of families
Yavutu:	Tribes of common ancestry