

Communication Disability in Fiji: Community Cultural Beliefs and Attitudes

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ABSTRACT

Purpose: *Beliefs about communication disability vary according to the cultural context, and influence people's attitudes and help-seeking behaviour. Little is known about Fijians with communication disability or the communities in which they live, and specialist services for people with communication disability are yet to be established in Fiji. An understanding of Fijian beliefs about the causes of communication disability and attitudes towards people with communication disability may inform future service development.*

Method: *An interpretivist qualitative research paradigm and the International Classification of Functioning, Disability and Health (ICF) framework informed this project's design. Scenarios of adults and children with communication disability were presented to 144 participants, randomly sampled across multiple public spaces in two Fiji cities. Thematic analysis of responses to 15 survey questions revealed participant beliefs about the causes and attitudes towards people with communication disability.*

Results: *Three clusters describing perceived causes emerged from the analysis - internal, external, and supernatural. Major clusters across child and adult scenarios were similar; however, response categories within the scenarios differed. Community attitudes to people with communication disability were predominantly negative. These community attitudes influenced individual participants' beliefs about educational and employment opportunities for Fijians with communication disability.*

Conclusion: *Determination and acknowledgement of individuals' belief systems*

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informs development of culturally appropriate intervention programmes and health promotion activities.

Implications: Speech-language pathologists and other professionals working with Fijian communities should acknowledge community belief systems and develop culturally-specific health promotion activities, assessments, and interventions.

Keywords: *Fijian, multilingual, speech-language pathology, service development, disability perspectives*

INTRODUCTION

Our beliefs underpin the development of our attitudes (neutral, positive or negative) and ultimately influence the way we participate in society (World Health Organization & The World Bank, 2011). Beliefs and attitudes are informed by language, culture, and personal experience and are ‘learned, global evaluations of an object (person, place, or issue) that influences thought and action’ (Perloff, 2008). Research in international communities has revealed that the attitudes of people without disability towards people with disability influences the level of participation a person with disability has in society, and ultimately the level of handicap people with disability experience as a consequence of their disability (e.g., Haines-Wangda, 1996; Maloni et al, 2010; Thompson et al, 2011; Sanchez and Wood, 2016).

Beliefs and Attitudes about Communication Disability

Communication is central to our humanity (Emerick, 1988). Communication disability, a broad term that encompasses many different disorders of communication (e.g., stuttering, aphasia, speech sound disorders) varies significantly in presentation (e.g., type, age groups affected, severity, etc.). Understanding community attitudes to varying types of communication disabilities in different populations (e.g., adults, children) is critical to knowing whether resources need to be developed to reduce any stigma or disadvantage (e.g., socio-economic) experienced by people with communication disability (Thompson et al, 2011; Kavanagh et al, 2015). As it is difficult to capture the diversity among people with communication disability in a single study, few authors have investigated beliefs and attitudes towards communication disorders collectively. Instead, studies regarding beliefs and attitudes towards people with

communication disability have tended to focus on one type of communication disorder, for example, on people who: stutter (Bebout and Arthur, 1997; Pachigar et al, 2011; Abdalla and St Louis, 2012; Arnold et al, 2015); have dysphonia (Yiu et al, 2011; Amir and Levine-Yundof, 2013; Brannstrom et al, 2015); or, speech sound disorders (SSD: Burroughs and Small, 1991; Overby et al, 2007; McLeod et al, 2013). An exception is a Tanzanian study by Marshall (1997), though the closed-question responses that were provided for potential causes of a defined set of communication disabilities may have inadvertently limited participants' responses. In all studies, regardless of typology, negative beliefs and attitudes to people with communication disability prevail. The strength of this negativity may be influenced by: (1) the severity of the communication disability - e.g., mild versus severe stuttering (St Louis et al, 2013); (2) the perceived ability of the people with communication disability to control their communication disability - e.g., people with SSD are viewed more positively than those with weak speech (Saunders and End, 2013); and, (3) culture - e.g., Cantonese Americans held more negative beliefs about people with communication disability than European Americans (Bebout and Arthur, 1997).

Beliefs about the Cause of Communication Disability in Fiji

Fiji is a small western Pacific Island nation with a multicultural and linguistically multi-competent population (Hopf et al, 2016). Fiji has signed the United Nations Convention of the Rights of Persons with Disabilities (UNCRPD) (United Nations, 2006), and the Incheon Strategy to 'Make the Right Real' for people with disability in Asia and the Pacific (UNESCAP, 2012). Both of these documents identify the human rights of people with disabilities and outline the principles, duties, and obligations of Fiji, as a signatory to overcoming social, legal, environmental and political conditions that act as barriers to the full participation of people with disabilities within society. Provision of services for Fijian children or adults with communication disability is within the portfolios of the Ministry of Health and Ministry of Education, and is incorporated into local policy documents, including the 'Policy in effective implementation of inclusive education in Fiji' of the Ministry of Education, National Heritage, Culture and Arts, and Youth and Sports (MoENHCAYS, 2011).

Beliefs about the cause of communication disability in Fiji are unreported; however, there is a small body of work exploring these factors with respect to other disabilities and illnesses. Gill (1988) and Aghanwa (2004) found that participants

in Fiji indicated similar causes for illness despite their studies being almost 20 years apart, having different target groups and different purposes. Gill (1988) surveyed Indian Fijian women and sought to understand beliefs about causation of any illness. Aghanwa (2004) surveyed broadly across the community, and was interested in understanding beliefs about causation of mental illness. In response to the issues being researched, specifically, their study participants cited individual causes such as congenital/genetic, acquired and/or unhealthy behaviour; social causes such as poor relationships with others; and, supernatural causes such as the will of God and witchcraft. While not directly comparable, supernatural causes appeared to be less important to the participants in the study by Aghanwa (2004) than to those in the study by Gill (1988). The lack of belief in witchcraft as a cause of mental illness was ascribed by Aghanwa (2004) as possibly due to the 'widespread western educational influences' in Fiji: a phenomenon that needs further investigation.

Attitudes towards Fijians with Communication Disability

There has been an improvement in awareness and acceptance of people with disability, according to Maharaj (2011), who wrote about attitudes to disability in the Pacific region. Whether this remains true for people with communication disability in Fiji's current climate, where literacy and employment are inextricably linked, is yet to be evaluated. People's attitudes to communication disability may be inferred from the language used to describe the act of communicating. In Standard Fijian there are terms for communicative expertise that have an evaluative meaning, either positive or negative (P. Geraghty, personal communication, 2 September, 2016). For example, the iTaukei concept of talanoa, a meeting of people to discuss matters, is central to the management of important community matters. The importance placed on communication in the iTaukei Fijian culture is supported by the presence of words for a gifted speaker (e.g., cameme, madila) or someone good at explaining things (gusumacala). Words that describe or are associated with communication disability in Standard Fijian include samila (a speech sound disorder such as a lisp), kaka(stuttering) and galu(being mute). Other Standard Fijian words associated with communication disability include yameleka, meaning short-tongued, and coci, meaning with cleft lip and/or palate (P. Geraghty, personal communication, 2 September, 2016). Fiji Hindi, the language spoken by most Indian Fijians, also includes communication disability terms, specifically goonga for any adult or child that cannot speak, and totlae or huklae for someone who has a stutter (G. Beer, personal communication,

19 September, 2016). The presence of local words associated with communication disability suggests that communication disability occurs in the Fijian community, but whether it is considered a barrier to societal participation has not been described.

Objective

Understanding community beliefs and attitudes to communication disability that reflect the unique linguistic and cultural community needs of Fiji is important for clinicians working with this community. Determination and acknowledgement of individual belief systems is imperative for developing culturally appropriate treatment programmes and health promotion activities (Anderson et al, 2003; Narayansamy et al, 2014). Thus, the main aims of this study are to describe Fijian community members’:

1. Beliefs about the cause of communication disability, and
2. Attitudes towards people with communication disability.

METHOD

This study adopted an interpretive paradigm within a qualitative research design.

Reflexivity Statement

The potential influence of the researcher on the research is acknowledged as per qualitative research protocols (O’Toole and Beckett, 2014). In this study, the first three authors are female Australians, and thus community outsiders (despite the first author having spent 7 years as a resident in Fiji) with backgrounds in speech-language pathology and special education. The fourth author is a male iTaukei Fijian, and therefore a community insider. While every effort has been made to balance the insider/outsider perspectives of the research team, the authors’ backgrounds may have influenced subsequent data collection, analysis, and interpretation. Thus, in this research an attempt has been made to create a rich view of community beliefs and behaviour surrounding Fijians with communication disabilities through a combination of emic and etic viewpoints. As such, survey methods and analysis seek to hear the personal viewpoint of the *kaiviti* (Fijian born people) while simultaneously applying an interpretivist approach to data analysis that assumes application of the authors’ implicit knowledge of Fijian culture viewed from the perspective of those who are insiders (*kaiviti*) and outsiders (*kaivalagi*: not Fiji born).

Theoretical Orientation

Often research on beliefs and attitudes towards people with communication disability focusses on the immediate context of the individual (e.g., family, school). However, Trani et al (2011) state that when conducting research there is a need to shift the focus from the individual to include the community in which people with communication disability live. The International Classification of Functioning, Disability and Health – ICF (World Health Organization, 2001) provides a suitable framework to consider communities' beliefs about communication disability (Threats and Worrall, 2004). The ICF considers the complex interactions that influence a person's experience and, ultimately, quality of life by considering the interplay between body functions and structures, activities and participation, and environmental and personal factors. The ICF accommodates coding of causes and attitudes for all health states. The established use of the ICF and the strong link between ICF Environmental Factors and Participation measures (Maxwell et al, 2012) provides a suitable framework for investigating Fijian beliefs and attitudes. The use of the ICF as a theoretical framework suggests a deductive approach to the study; however, to ensure that preconceived notions of the data did not interrupt the inductive nature of the project, the authors did their best to 'let the field reveal its reality first' (Yin, 2016).

Participants

Non-proportional quota sampling was the method chosen to recruit participants as it ensured representative sampling of different groups within a population; however, it did not require strict percentages of individuals to reflect actual total population characteristics (Morrow et al, 2007). Participants were randomly selected across a range of sites (e.g., bus stop, shopping centre, produce market, sporting ground), and at variable times of the day and week, to reduce selection bias. Table 1 provides a summary of the demographics of the 144 participants recruited in this study. Participant demographics for gender and age groups reflected population statistics (Fiji Bureau of Statistics - FBoS, 2007). The proportion of iTaukei Fijian participants equalled reported national ethnicity statistics (56.8%); however, the number of Indian Fijian participants (16.7%) was lower than expected (37.5%), and the number of other ethnicity participants (16.0%) was larger than national levels (5.7%). Similarly, the high proportion of participants from an urban residence (past or present) does not reflect the reality of the total Fijian population. Finally, the participants also had higher levels of

Table 1: Participant Demographics (N = 144)

		Female		Male		Missing		Total	
		n	%	n	%	n	%	N	%
Gender		71	49.3	69	47.9	4	2.8	144	100.0
Age	<20	7	9.9	5	7.2	0	0.0	12	8.3
	20<30	17	23.9	23	33.3	1	25.0	41	28.5
	30<40	19	26.8	18	26.1	0	0.0	37	25.7
	40<50	13	18.3	11	15.9	0	0.0	24	16.7
	50<60	11	15.5	5	7.2	1	25.0	17	11.8
	60<70	3	4.2	5	7.2	0	0.0	8	5.6
	70<	1	1.4	1	1.4	0	0.0	2	1.4
	Missing	0	0.0	1	1.4	2	50.0	3	2.1
Ethnicity	iTaukei Fijian	42	59.2	38	55.1	2	50.0	82	56.9
	Indian Fijian	10	14.1	14	20.3	0	0.0	24	16.7
	Other	11	15.5	12	17.4	0	0.0	23	16.0
	Missing	8	11.3	5	7.2	2	50.0	15	10.4
Home language	English	19	26.8	12	17.4	0	0.0	31	21.5
	Fijian dialect	36	50.7	29	42.0	3	75.0	68	47.2
	Fiji Hindi	9	12.7	23	33.3	0	0.0	32	22.2
	Other	1	1.4	0	0.0	0	0.0	1	0.7
	Missing	6	8.5	5	7.2	1	25.0	12	8.3
Interview language	English	59	83.1	54	78.3	3	75.0	116	80.6
	Fijian	8	11.3	9	13.0	0	0.0	17	11.8
	Fiji Hindi	0	0.0	2	2.9	0	0.0	2	1.4
	Missing	4	5.6	4	5.8	1	25.0	9	6.3
Parental status	Yes parent	39	54.9	36	52.2	2	50.0	77	53.5
	No parent	23	32.4	27	39.1	0	0.0	50	34.7
	Missing	9	12.7	6	8.7	2	50.0	17	11.8
Know a PWCD	Yes	11	15.5	13	18.8	2	50.0	24	16.7
	No	53	74.6	50	72.5	0	0.0	105	72.9
	Missing	7	9.9	6	8.7	2	50.0	15	10.4
Education level	Primary school	4	5.6	7	10.1	0	0.0	11	7.6
	High school	29	40.8	32	46.4	1	25.0	62	43.1
	Tertiary	38	53.5	30	43.5	1	25.0	69	47.9
	Missing	0	0.0	0	0.0	2	50.0	2	1.4
Time in Fiji	Whole life	57	80.3	63	91.3	2	50.0	122	84.7
	Less than whole life	13	18.3	6	8.7	0	0.0	18	13.2

	Missing	1	1.4	0	0.0	2	50.0	3	2.1
Residence NOW	Urban	63	88.7	63	91.3	2	50.0	128	88.9
	Rural	2	2.8	4	5.8	0	0.0	6	4.2
	Missing	6	8.4	2	2.8	2	50.0	10	7.0
Residence PAST	Urban	30	42.3	31	44.9	0	0.0	61	42.4
	Rural	11	15.5	11	15.9	0	0.0	22	15.3
	Missing	30	42.3	27	39.1	4	100.0	61	42.4

Table 2: Causes of Communication Disability Identified During Reassembling (Phase 3) of Data Analysis (N = 144)

Cluster	Code	Sub-code	Example quotation	Number of adult scenario responses	Number of child scenario responses	Total
1. External	Abuse		'Maybe it's the mother who tried to damage the child' (P87).	2	8	10
	Bottle-feed		'My observation with my 2 toddlers was that one was breastfed and spoke when he was 2. The other was bottle-fed and spoke at 4 1/2 years old' (P130).	0	1	1
	Multilingualism		'When there is more than one language spoken at home' (P44).	0	4	4
	Stress	Family	'I think it can have to do with problems from home. The pressure can do that to people' (P52).	8	4	12
		Peers	'It is the environment they are living in. The peer pressure' (P80).	4	0	4
		Work	'Work pressure' (P109).	7	0	7

		General	'Hidden anger, broken heart and refusing to share their problems' (P55).	20	0	20
	Traumatic experience		'Shock. For example the loss of a child can send someone back to regress' (P62).	5	4	9
	Unhealthy lifestyle	Dietary	'Could be food. If they abuse their way of eating, diet. This can contribute to their disability' (P97).	11	0	11
		Drug use	'It could be from consuming drugs' (P25).	24	0	24
		Impoverished environment	'Keeping them locked up at home. There is no socialising' (P5). 'Being neglected. Not involved in family activities' (P102).	17	31	47
		Lack of exercise	'It might be lack of physical activities' (P22).	3	0	2
		Lack of sleep	'Lack of rest' (P125).	3	0	3
		General	'They might not be looking after themselves well' (P47).	10	0	12
	Subtotal			114	52	166
2. Internal	Birth trauma		'Difficulty at birth of the child' (P133).	0	9	9
	Cancer		'Cancer' (P62).	1	0	1
	Circulatory system		'Some because of high blood pressure' (P19).	12	0	12
	Existing impairment		'A disability of some sort, for example a speech impediment' (P19).	2	21	23
	Food allergy		'Maybe food allergy caused' (P77).	1	1	2
	Genetic		'I believe it can be in the genes. It might be genetic' (P52).	6	24	30

	Infection		'It may be thrush sickness' (P14).	3	1	4
	Injury		'They might have been in an accident' (P54).	19	12	31
	In-utero		'Maybe the mothers are alcoholic and drank a lot during pregnancy' (P6).	0	52	52
	Mental health	Depression	'Mental issues. For example depression et cetera' (P127).	2	0	2
		Unspecified	'Mental disease' (P19).	1	3	4
	Neurological	Bell's palsy	'Bell's palsy' (P118).	2	0	2
		Brain damage	'Stroke' (P77).	52	0	52
		Brain tumour	'Take them to the hospital as they may have suffered a stroke or other medical condition. For example a brain tumour or hearing loss' (P15).	2	0	2
		Degenerative	'Degenerative diseases of nerve and muscle system' (P135).	3	0	3
	Non-specific illness		'Maybe they are just sick' (P33).	13	6	19
	Old age		'Probably because they have grown old' (P43).	4	0	4
	Sensory	Hearing	'Unknown deafness' (P138).	3	5	8
		Vision	'Poor sight' (P14).	1	1	2
	Subtotal			127	135	262
3. Super-natural	Curse		'Witchcraft practices' (P123).	9	7	16
	Fate		'God gave that' (P82).	4	9	13
	Subtotal			13	16	29
4. Unknown	Don't know		'Sometimes the problem comes and we don't know' (P85).	8	8	16
TOTAL				254	203	457

tertiary education experience (47.9%) than previously reported in the general community (13.5%) (FBoS, 2007).

Instruments

The community survey was an adaptation of the survey methodology developed by Wylie et al (2017) for examining help-seeking and self-help for communication disability in Ghana. The current research extended the survey by adapting concepts from Maloni et al (2010) and Marshall (1997). A pilot study of the survey in Fiji revealed good content validity despite the questions having originated in other parts of the world (e.g., Africa). Following the pilot study, the question content remained unchanged but minor changes were made to the mode of gathering demographic information. The final survey contained 15 questions: 7 specific to children, 5 specific to adults, and 3 applicable to either children or adults. Before a specific question on how the participants would help a person with communication disability and what they believed to be the cause of communication disability in either a child or an adult, the following 2 fictional scenarios, developed by Wylie et al (2017), were presented:

1. Child scenario - *I would like you to think about your family. Imagine there was a child in your family who was 5 years old and not yet talking (Wylie et al, 2017);*
2. Adult scenario - *Imagine that there was an adult in your family. When they woke up, you noticed that their speech was not clear and was very difficult to understand. It did not seem to improve. One side of their face was not moving well (Wylie et al, 2017).*

Four additional questions probed personal and community attitudes, by enquiring how the community feels about people with communication disability, and what schooling and occupational opportunities should be available for people with communication disability. Finally, participants were asked to comment on any aspect of supporting people with communication disability in Fiji.

Procedure

Ethical clearance was obtained from both the Fiji Ministry of Education (RA 29/14) and Charles Sturt University Human Research Ethics Committee (2014/153). Four data collectors were trained to conduct the interviews: the first, second, and fourth authors, and a female iTaukei Fijian. All four were fluent in English; two were also fluent in Standard Fijian with rudimentary skills in Fiji Hindi. During

training of the data collectors, inter-rater reliability of the first author and each data collector's interviewee response transcription was compared. Transcriptions of core concepts were in agreement in more than 90% of all cases.

Data was collected across a variety of public sites in the cities of Nadi and Lautoka, in Western Fiji. Data collectors, wearing an identifying T-shirt, approached people at random and provided them with an information sheet (available in English or Standard Fijian, in regular or large print). If the person agreed to become a participant, key information was read out loud by the data collector to ensure that the content had been understood. Participation in the study was voluntary, and informed consent was documented before specific questioning took place. Participants were informed that they could stop the interview at any time. The data collector wrote down the participant's responses to each question as close to verbatim as possible. After the interview, participants were asked to take the completed form and either place it in a collection box (to denote participation) or keep the form (to denote withdrawal from participation). As a token of thanks, they were then offered a cold drink and biscuit/crackers.

Data Analysis

All interview responses were analysed using inductive thematic analysis, guided by the 'five phased analytic cycle' as described by Yin (2016), namely compiling the data, disassembling, reassembling, interpreting, and concluding. The idea was to move beyond a descriptive analysis of the data to identify the meanings behind these experiences. In Phase 1, all interview responses were typed, placed in a spreadsheet, then imported into the computer-assisted qualitative data analysis programme NVivo10. Phases 1 and 2 - compiling and disassembling coding - brought together responses across survey questions related to each study aim. Phase 3 had reassembling coded similar responses across a broad number of groups, and clustered responses. Where a framework was available, it was employed for coding. For example, when coding participants' employment options for people with communication disability, the International Standard Classification of Occupations or ISCO-08 (International Labour Organization, 2012) was applied. Finally, in Phase 4, these clusters were interpreted with reference to existing literature and the ICF, so that in Phase 5 conclusions could be arrived at. For example, while analysing the clusters relating to causal data, it involved following similar processes to those described in Haines-Wangda (1996), Kim (2001) and Aghanwa (2004). During Phases 3 - 5 of the analysis, consensus

checking between the first author and the fourth author, who had conducted the majority of the interviews, was carried out. If there was initial disagreement, discussion took place until a coding consensus could be reached. For reporting purposes, transcribed responses that were incomplete (e.g., due to omission as a result of time constraints during online transcription or Fiji English dialect differences) have been revised to reflect written Standard English grammar. Finally, where some questionnaires were partially incomplete due to interviewer recording error, it has been noted in tabulation.

RESULTS

Community Beliefs about the Causes of Communication Difficulties

Participants reported a large number of novel causes for communication disability. Table 2 lists the clusters, major codes, and sub-codes of reported causes of communication disability. Most participants could provide at least one or more potential cause for communication disability in either a child or an adult. However, there were 13 participants who did not know why a communication disability might occur: 5 participants did not provide an adult cause, an additional 5 did not provide a child cause, and 3 did not provide either an adult or a child cause. Three major clusters emerged from the gathered data: external, internal, and supernatural causes. External causes are ascribed to Environmental Factors from the ICF (WHO, 2001) acting upon the people with communication disability. These causes were judged as being within the direct control of people with communication disability or their caregiver/s. Internal causes, ascribed to impairments of Body Structure or Body Function from the ICF (WHO, 2001), were not attributable to the direct control of people with communication disability. Supernatural causes were also out of their control. Supernatural causes were considered as Environmental Factors (WHO, 2001) pertaining to social norms, processes and ideologies specifically related to spiritual and religious beliefs.

In both scenarios, participants more frequently cited internal rather than external or supernatural causes. In the adult scenario, external and internal causes were relatively evenly distributed; in the child scenario, internal causes were more than twice as many as external causes. These differences were mostly accounted for by the large number of causes related to poor lifestyle choices and life stressors for the adult scenario. Supernatural causes were much less frequent than the other clusters. Curse was evenly distributed for both scenarios, but fate was more than

twice as frequently mentioned for the child scenario. While the major clusters were present for both the child and adult scenarios, the trends within each cluster varied; thus each scenario is dealt with separately below.

Community Beliefs about the Causes of Communication Difficulties in the Child Scenario

Internal and external causes, both attributable to negligent caregiver behaviour, were the two most frequently identified causes for communication disability in a child. Poor parental health (an internal cause mostly attributed to the mother during pregnancy) was most often identified as the main cause. In-utero exposure to drugs (e.g., alcohol, marijuana, nicotine, kava), poor maternal diet, and failed abortion attempts were also commented on. For example:

“Comes from pregnancy if the mother doesn’t take care of herself. My friend is a marijuana smoker and her baby came out not talking” (P 98).

“Comes from a lack of vitamins and nutrients when the mum is still pregnant with the child” (P 12).

“I believe that in Fiji when some children are born they have a disability because the mothers try to abort their babies with Fiji medicine” (P 97).

Participants also understood the importance of a rich communication environment for supporting children’s communication development. Consequently, environmental deprivation, an external cause, was the next most frequently identified cause.

“From personal experience, I have seen a 3-year-old unable to speak because his parents neglect him and never talk to him. So he makes sounds instead of speaking. I think neglect by parents can be one of the contributing factors” (P 144).

The next three main causes of communication disability were internal. The blame for the disability shifted from the caregivers to circumstances considered beyond their control. One suggestion was a genetic predisposition:

“Isn’t that a medical question? Genetics. Something to do with genes. Doctors need to answer. That is a big question.” (P 62).

Another cause was a concomitant diagnosis (e.g., autism, learning disability, hearing or visual impairment, physical malformation or dysfunction):

"It can be psychological, for example, a traumatic experience, fear, or shyness. Or a child may have a physical disorder like tongue-tie or deafness" (P 135).

A third cause was accidental physical injury or sickness during birth or early childhood:

"Birth may have caused complications" (P 138).

"Sickness or accident after he/she was born" (P 133).

Consistent with Aghanwa (2004), supernatural causes were hardly reported as a cause for communication disability in a child. As a subcategory, fate was marginally more frequent than curse. With regard to fate, the communication disability was often seen as a gift from God, and an opportunity to learn rather than a punishment:

"I believe it's God's willingness to give that child that gift so that we as individuals are able to believe and understand that God is great" (P 17).

In contrast, a curse was a punishment for a historical misdeed done by the caregiver or child:

"Maybe because of the parents. Possibly some things the parents have done in the past" (P 23).

The final causes suggested by participants were all external. Caregiver abuse of the child (e.g., physical, psychological), experiencing family stress, or witnessing a traumatic event, were all thought to lead to a communication disability. Some participants believed that language exposure (e.g., the type or number of languages spoken at home or at school) could cause communication disability:

"Sometimes language. Teachers speak English/Urdu/proper Hindi. At home we speak our language. That's the problem with the kids" (P 101).

Community Beliefs about the Causes of Communication Difficulties in the Adult Scenario

The adult scenario involved the sudden onset of communication disability. It was therefore not surprising that more than one-third of the participants directly mentioned that brain damage, most often stroke (cerebrovascular accident), was the cause of communication disability. Other internal causes that were reported were predominantly medically related. For example, conditions relating to cardiac (e.g., hypertension, myocardial infarction) or neurological function (e.g., Bell's

palsy, degenerative conditions) and cancer (brain or body). However, the most prevalent category for cause was external, namely, living an unhealthy lifestyle. Aspects of lifestyle within the control of people with communication disability (e.g., personal drug use, poor diet, lack of sleep or exercise) rated high within this scenario, as did living in an environment where others neglected the people with communication disability (particularly a lack of communication opportunities):

“They don’t take their health seriously. Too much alcohol” (P 16).

“Maybe they were neglected a lot and will find difficulty speaking after sometime” (P 24).

“Being neglected. Not involved in family activities” (P 102).

Mental health causes were classified as both external and internal. External causes were much more frequent and were predominantly related to difficulty in managing life stresses, for example, involving interactions with family, work, peers, or in general. Undergoing traumatic experiences was also a potential cause of communication disability:

“Distress. They’re worried about something and it just snaps their brain. My mum died of stroke. She had high blood pressure. She was angry with my brothers. She was half brain-dead and could only talk in one word” (P 100).

“Too much pressure from work or home” (P 2).

Internal causes related to mental health were rare, but included depression.

Another group of internal causes included infection, illness, and accidental injuries (especially to the head) when the person with communication disability was younger, or more recently:

“Also caused by a sickness that grows on the tongue like small boils. We use layalaya (wild ginger). We clean, we peel, we squeeze, and give to people. Also too many sweets can affect tongue. My cousin had that problem. He is okay now” (P 98).

“Maybe they are just sick” (P 33).

“Could be some injury when they were younger” (P 27).

“Due to a car accident or road casualties that the adult was present in. They might have gotten their nerves damaged” (P 121).

Attitudes towards People with Communication Disability

Attitudes towards people with community disability were noted by asking an indirect question about how the participants thought their community viewed such people, and two direct questions about issues of participation for people with communication disability - specifically, what education and employment opportunities the participants believed should be available to people with communication disability. Each of these is discussed below.

Community Attitudes to Fijians with Communication Disability

The responses of 130 participants were recorded, as 8 participants' responses to the question were uninterpretable due to illegible transcription, and 6 participants stated that they did not know how their community viewed people with communication disability. From the responses three clusters emerged: discrimination, disablism, and acceptance. The largest group of participants reported that attitudes to people with communication disability in their community were predominantly discriminatory. They stated that people with communication disability were viewed as less valuable to society, unwanted by some in the community, an object of pity, and the butt of ridicule. Such attitudes resulted in limited opportunities for participation in society:

"Sometimes people look down on people with disabilities. We don't want to involve them with any activities" (P 37).

"They are not cared for. If we do something, they are only given a little bit of work" (P 97).

"The first reaction will be 'oh, what a pity'. They feel sorry and think nothing" (P 61).

"Some don't like them. They make fun of them" (P 65).

The next largest group of participants, those within the disabling cluster, stated that their community viewed people with communication disability as individuals in need of care:

"They support them when they need help" (P 7).

"They find ways to help them so that they can help themselves" (P 106).

"We'll try our best to get back his normal talking" (P 101).

Within the two main clusters there was a large amount of cross-over. Frequently

participants would mention both community attitudes of discrimination and disablism in their responses:

“Some are good. They look after them. While others are bad and do not care for people with communication disability” (P 39).

“Some will support them while others discriminate against them” (P 21).

The smallest group of participants mentioned community acceptance of people with communication disability:

“My community views communication disability as part of the community and they are treated as equal as others” (P 9).

“It’s a normal thing because he’s just a normal human being” (P 41).

The following sections outline how these community attitudes translate to participation of people with communication disability in educational and employment opportunities.

Education Opportunities for Children with Communication Disability

The majority of participants stated that children with communication disability should attend a special school. The remaining participants recommended mainstream schooling, and one person recommended home-schooling. Two participants did not provide a response. When asked why children with communication disability should go to a special school, many of the responses were non-specific. Participants did not know exactly what a special school would provide that was different to a mainstream school, but responses clustered around four themes: specialised curriculum and materials, skill of teachers, supportive learning environment, and as a stepping-stone to mainstream schooling. Almost half of the participants believed that special schools make learning easier for children with communication disability as they have an easier curriculum and disability specific materials and teaching methods (e.g., sign language):

“[Special school] is the most best place for a special child with a disability to go to because they will learn more and better there” (P 12).

“Because [special school] will be easy, rather than going to a regular school” (P 37).

“Special schools have specially trained teachers and special equipment to meet the needs of disabled children” (P 123).

Many participants also believed that teachers at special schools had special training to support children with communication disability (or any disability):

“Since at [special school] we have skilful teachers who are able to communicate with them” (P 18).

“[Special school] is the appropriate place where they can be educated because the tutors are specialised in dealing with those cases” (P 55).

“People at [special school] are of the same nature. People at [special school] are trained for the same purpose and same disability” (P 94).

A similar number of participants believed that special schools have a more supportive learning environment than mainstream schools for children who need extra help to access the curriculum. Within this theme the participants’ primary concern was for the child’s emotional state. Consequently participants believed that special schools would be a haven from the discrimination that may be prevalent in mainstream schools. They also believed that special schools had a reduced student-teacher ratio, and that being around children with similar disabilities would create more opportunities for the child with communication disability to develop friendships:

“Regular school will have bullies, whereas in a special school they will be treated well” (P 23).

“Because at [special school] teachers have special training and can deal with individual needs. There are too many kids in a regular classroom to deal with a child with a speech problem” (P 102).

“In regular schools, children with disabilities are vulnerable to bullying and abuse, et cetera” (P 122).

“[Special school] allows for one-on-one teaching. And also being with like- minded children may help” (P 138).

“He or she would be with children that he or she can relate to” (P 131).

The final group of participants, who believed that children with communication disability needed special schools, felt that special schools were a stepping-stone to attending a mainstream school:

“In Fiji they put them in special school and analyse them there. Once the children can do the work, then they move them to regular school. My friend’s child was like

that. He was very slow. He spent one year in a special school then they put him in a regular school. Now he's in year 8" (P 100).

"Send to special school first to better understand the condition. Regular school afterwards to blend in with the rest" (P 132).

Almost one-third of the participants believed that a child with communication disability should go to a mainstream school. In contrast to those who chose a special school, these participants were aware that communication disability did not presuppose existence of other disabilities (particularly intellectual). These participants thought that mainstream school attendance was a child's right, that it would support the child's self-concept development, and it would broaden the knowledge of teachers and typically developing children within the school:

"Everyone is equal and deserves the same education as every other child" (P 30).

"A child with communication disability isn't necessarily slow or mentally ill. That child may need more care and support in attending a regular school, but at least he or she won't be condemned to the title of a special needs child" (P 144).

"Allowing students to attend regular school will train all the teachers in our country to be more effective in every aspect of teaching" (P 9).

"It will be hard for the child in the beginning, but it will be a learning process for both him or her and the others [typically developing children]" (P 128).

There was one participant who believed that home-schooling was the best option for a child with communication disability:

"Neither [special or regular school]. I think the ideal situation for a child like this would be to home-school. Having people around him or her that know how they act is important. Regular school may be too harsh and special school would destroy all confidence" (P 120).

Employment Opportunities for People with Communication Disability

The majority of participants believed that people with communication disability were employable; however, almost one-fifth did not think a person with communication disability could do any type of work:

"How do they survive? Can't say much. Go to welfare officer and ask for social welfare" (P 67).

“Can’t work. Someone will have to look after them” (P 75).

Of the participants who stated that people with communication disability were employable, one-sixth believed that these people could do any type of job if they had the right attitude and opportunity to learn:

“People with communication disability can do anything as long as their heart is willing to do it” (P 12).

“People with communication disability are able to do things that an average person can do. The only thing that they cannot do is speaking but that doesn’t mean they are different from us” (P 121).

The majority of the remaining participants believed that people with communication disability could work, but they would be restricted in their choice of employment by the extent of their disability. Referring to working in the tourism industry, one participant said:

“It’s more what they are not available to do. For example, they couldn’t do telecommunications or front-of-house. They can do back-of-house. It’s not harming their intelligence or physical ability I think” (P 62).

Analysis of the jobs suggested by these participants for people with communication disability reveals the group’s diverse beliefs. The two most frequent recommendations were professionals (e.g., artists, musicians, and teachers of the deaf) and elementary occupations (e.g., domestic help, packer, and messenger). Clerical support workers were next, particularly, office jobs that involved typing, followed closely by farming or fishing related occupations (coded as skilled agricultural forestry and fishery workers). Other suitable roles were craft and related trades or workers who worked with their hands (e.g., tailor, carpenter, handicraft maker), and least frequent was driver (coded under plant and machine operators and assemblers). It is noteworthy that no participant suggested that people with communication disability could hold a managerial or armed forces role.

DISCUSSION

The beliefs about the cause of communication disability in this community may relate to external, internal, and supernatural causes. Internal causes, based on concepts of impairment (in Body Structure or Body Function) and disorder or disease states (of a Health Condition), are essentially outside the control of people

with communication disability (WHO, 2001). However, the study participants almost equally believed that the Environmental and Personal Factors displayed in the social behaviour of people with communication disability and/or their caregivers could similarly cause communication disability. Consistent with Aghanwa (2004), very few of the participants in this study ascribed supernatural causes to communication disability. A shift in causal belief systems has not changed the community attitudes reported. Similarly, as reported by previous authors about other groups of people with disability, people with communication disability are often treated by the members of this community as objects of discrimination or sympathy. When people with communication disability are viewed as different and requiring the help of others, the attitude translates into limited opportunities for meaningful participation in society, as evidenced in the education and employment findings presented. A discussion of each of these points follows.

Changing Beliefs without Changing Attitudes

Societal beliefs are an important element of attitude formation acknowledged in Environmental Factors of the ICF (WHO, 2001). Community beliefs about the cause of communication disability were predominantly rooted in an understanding of Western medical science; however, the difference in the adult and child scenarios suggested that these participants are 'standing on the fence' regarding beliefs about the cause of communication disability in a child. While they acknowledge the influence of disease and disorder concepts derived from Western medicine, many of them also ascribe social causes and apportion a large amount of blame to deprivation within the child's pre- or post-natal environment. A positive factor that could be built upon in future health promotion activities is that many participants understand the importance of the social environment and acknowledge the need for a rich communicative environment for development of successful communication.

In contrast to other responses, supernatural causes of communication disability were infrequently mentioned. Initial studies investigating the cause of mental health (Gluckman, 1969) and general illness (Gill, 1988) reported a preponderance of traditional beliefs as the cause of these conditions. This study and two others conducted on mental health (Aghanwa, 2004; Sivakumaran et al, 2015) acknowledge some Fijians' continued belief in supernatural causes; however, in all studies these beliefs appear secondary to other causes. This finding may suggest

a weakening of traditional beliefs over the intervening time period between these studies. Alternatively, it may also be accounted for by variability in beliefs across health conditions (communication disability versus mental illness).

While traditional beliefs were less frequently reported, this does not appear to have altered community attitudes towards people with communication disability. Participants predominantly reported community attitudes as discriminatory or disabling, and rarely accepting of people with communication disability. Such attitudes suggest that the dominant cultural value is one of social exclusion for people with communication disability. Such attitudes not only are in conflict with the premises of the 2006 United Nations Convention on the Rights of Persons with Disabilities, of which Fiji is a signatory, but also align with the reported view of many people in Western countries (for a summary see Thompson et al, 2011).

Restricted Educational and Employment Opportunities for Fijians with Communication Disability

The Convention on the Rights of Persons with Disabilities (United Nations, 2006) recognises that education and employment are a human right for all people with disabilities. The participants in this study placed participatory restrictions on people with communication disability with regard to education and employment. Most participants believed that children with communication disability should go to special schools. This finding may reflect the study's sampling sites as there are 3 special schools in the area; however, it is more likely consistent with Tavola (2012) who stated that Fijians have a dominant 'mind-set that children with disabilities should attend separate schools'. Recent efforts to introduce inclusive education (Pillay et al, 2015) to Fiji, and the print and television media associated with these efforts, may have influenced the opinion of the few participants who believed special school was not an option or only to be considered as a stepping stone to mainstream education.

Most participants believed that people with communication disability were employable. Given the high unemployment figures reported for people with disabilities in Fiji (e.g., 89% unemployment reported by FNCDP, 2010; 78% unemployment reported by Devi, 2012), employment beliefs held by participants, despite the given restrictions, may offer hope. Whether beliefs about employability convert into employment opportunities for people with communication disability requires further investigation. The participants' recommended employment

areas excluded authority roles (e.g., in the management and armed forces) and included a preponderance of roles that only required low-level formal education. Where professional roles were suggested, these were either related to the person's disability (e.g., teacher of the deaf, translator of sign language) or a natural talent (e.g., musician, artist). Such beliefs, that assume incorrectly that people with communication disability are incapable of succeeding in advanced formal learning or as leaders in the Fijian community, need to be addressed by raising awareness about the potential of people with communication disability and by providing the necessary community support to ensure that these people reach their full potential.

CONCLUSION

To develop culturally competent models of service delivery for people with communication disability in Fiji, an understanding of community expectations for people with communication disability is important (Hopf and McLeod, 2015). The mismatch between results presented suggests that Fijian beliefs about, and attitudes towards, people with communication disability may be in a state of flux. Addressing negative attitudes requires development of an effective policy response from governments in Fiji and around the world. Thompson et al (2011) suggest that there are three policy levels for attitude change: personal, organisational, and structural. Significant work across all of these levels has been conducted in Fiji (Hopf, 2014); however, there is more that can be done. At the personal level, people with communication disability are rarely, if ever, a focus of disability-related media in Fiji. Raising awareness of the capabilities of people with communication disability through positive portrayal, supported opportunities for contact, and public media presentations may break down persisting stereotypes (Thompson et al, 2011). At the organisation level, resources are required to ensure that the community of people interacting with people with communication disability in education, health, and employment settings are well-informed. Providing widespread information and awareness training about the capacity of people with communication disability to be productive members of the community is a potentially effective method for reducing stigma (Thompson et al, 2011). At the structural level, the much-awaited Fiji ratification of the 2006 United Nations Convention on the Rights of Persons with Disabilities (Parliament of the Republic of Fiji, 2016) will hopefully result in the provision of the necessary resources (e.g., locally-trained culturally and linguistically matched speech-language pathologists / communication disability specialists) to ensure

that people with communication disability have the same opportunities to live happy productive lives as others in the community.

Implications

The results of this study suggest that Fijians in the study sample are aware of people with communication disability in their communities and have developed belief systems that influence the participation of these people in society. Speech-language pathologists and other professionals working with Fijian communities should acknowledge the belief systems of this community and develop culturally specific health promotion activities, assessments, and interventions accordingly.

Limitations

All efforts were made to ensure the credibility and dependability of the data analysis presented; however, a number of limitations are evident. There were two potential issues with survey design. Firstly, in a multilingual community, the term 'communication disability' is potentially confused with the ability to communicate in more than one language, rather than a language disability per se. Possible evidence of this confusion was provided by one iTaukei Fijian participant who, when asked if he/she knew anyone with communication disability, stated, "My cousin is married to an Indian woman and sometimes we don't understand". Secondly, structuring the survey with the scenario questions, prior to questions asking about beliefs and attitudes may have predisposed the participants to respond in a certain way. This was more likely in the adult scenario where dominant beliefs about cause were clearly centred on the possibility of the adult in the scenario having had a stroke. The sample of participants is also likely to have influenced results, as there were a higher number of educated urban dwelling participants and fewer Indian Fijian people than the numbers reflected in national statistics. Finally, the authors have interpreted attitudinal responses that indicate that a person requires help, as disabling. Understanding more about how Fijians help people with communication disability could clarify whether the helpful behaviour reported in this study is actually enabling or disabling.

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