***Access to information: questions on equality, gender and geographical gap in relation to suicide prevention***

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**Abstract**

According to studies, Fiji has very high suicide cases. Yet, there is a need to further investigate research methods used, and sources used for these studies. Due to a lack of information on suicide cases in isolated and informal settlements in Fiji, WINET-Fiji (Women’s Information Network): a registered NGO decided to conducts workshops on suicide prevention in 8 locations around Fiji. While, the aim of these workshops was not to investigate suicide rates in Fiji, the data derived from the workshops conducted provide insights into the rate of suicide in Fiji. During their workshops, WINET-Fiji discussed issues such as preventive measures, warning signs, community based counselling and avoidance of silence. From these workshops, the issues that emerged indicated a lack of equality where dissemination of information in the community is concerned. Added to that, the inequality based on gender, residence of people, also became obvious factors that could have led to loss of life or attempted loss of life.

Most of the research and data collected in Fiji on suicide have been based on hospitalised cases or those sent for referral for counselling (Henson et. al, 2012; Hawton & van Heeringen, 2009; Roberts, et al. 2007). Little has been documented from isolated areas, where both attempted and completed suicide cases also exist. Thus, this paper discusses the results of the qualitative study carried out during these workshops.

Key Words: Suicide, gender, inequality, Fiji, social protection

**Introduction**

Fiji has a relatively high suicide rate based on global statistics (Henson et al, 2012; Booth, 1999; Pridmore, Lawler, & Couper, 1996; Waqanivalu, 2005; Morris & Maniam, 2000). Statistics also show that a particular group of the Fijian population are the victim of suicide; the young, and those from the Fiji Indian background (Wainiqolo, et, al 2012). While most of the incidences included in recent literature relate to reported cases of suicide, attempted suicide cases remain unreported. Unreported cases of suicide in Fiji can be due to many factors, such as the reporting system, concealment, culture and uncertainty. Previous studies have also stated similar reasons as well as the fact that many attempted suicides are underestimated due to the fact that such cases may not be reported due to a number of facts (Wadan, 2002; Roberts et al., 2007).

In order to disseminate information on suicide to women in rural areas, WINET-Fiji conducted workshops in 8 locations around Fiji. This was based on the fact that few NGOs reached out to conduct workshops on sensitive issues such as prevention of suicide, and even fewer went to very remote and isolated communities. Since WINET-Fiji is a gender based organisation, it felt the need to target women, who make up close to 50% of Fiji’s population.

A close look at Fiji’s background showed the following information: Fiji is a South Pacific island country consisting of over 300 islands. More than 80% of its population resides in the two main islands; Viti Levu and Vanua Levu. The CIAWorld Factbook for 2013 (<http://www.indexmundi.com/fiji/demographics_profile.html>) shows that Fiji has an estimated population of 890,057. Females compromise a slightly lower than 50% of the population, while 41% of the population is between the age group 25-54, 17.6% between 15-24. The 2007 Fiji Census figures indicate that 57.3% of the population are from the i-Taukei background, while Indians contribute to 37.6% of the population.. The remainder of the population are from Rotuman, European, other Pacific Islanders and Chinese backgrounds. According to the Kaiser Family Foundation 51% of Fiji’s population reside in urban areas (<http://www.indexmundi.com/fiji/demographics_profile.html>).

With nearly half the population residing in rural areas, and around the same number represented by women, it is important to know what the country is doing with regards to the dissemination and collection of information on sensitive issues such as suicide.

**Literature Review**

Suicide rates and attempted suicide rates in Fiji are relatively high. Studies conducted from as early as the 1960s have shown a consistency in the suicide rates amongst Indians in Fiji (Haynes, 1987), exceeding only the rates of those in Lithuania and Latvia (Booth, 1999). In a study conducted by Aghanwa (2000), majority reported cases of attempted suicide at Fiji’s main hospital in Suva (Colonial War Memorial Hospital: CWM), involved young Hindu unmarried females. 12% of these had a repeat suicide attempt t of which 5.1% died. While the figures for attempted suicide rates are relatively low, there could be various reasons for the lack of data of unreported attempted suicide cases. According to Narsey (2002), messages from the Hindu scriptures such as the sense of shame, condemnation, and honourable way to end one’s life have been misinterpreted. This leads to the idea of committing or attempting to commit suicide. The value of honour in the Hindu family system, the notion of shame and losing of one’s name are also related to the lack of reporting of attempted suicide incidences. Unfortunately, the Hindu religious organisations in Fiji have not attempted to address issues related to suicide amongst Hindus in Fiji.

In studies conducted since 1960s, (Ree, 1971; Karim & Price, 1973; Haynes, 1984), cases that were reported involved the Indian population, and of the Hindu faith. However, there is limited data on attempted suicide cases. Roberts et al. (2007) used data based on police records to compare the completed and attempted suicide death rates in Fiji, during the 2000-2005 period. Only in 2003 were the attempted suicide rates higher than the completed suicide figures. In all the data, the attempted suicide rates were higher amongst the young female population.

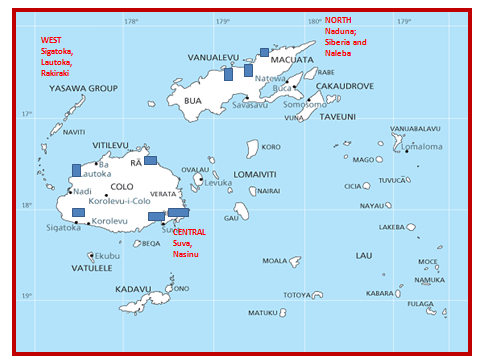
More recent figures from 2011 (Smith, n.p.) state that as many as 135 people attempted to end their lives. However, he also states that ‘these numbers do not include additional thousands of others whose actual fates are hidden, disguised or misdiagnosed”. Again, the figures were high amongst young women from Indian descendants and those residing in cane belt areas of the country. The information on suicide rates discussed in the studies conducted by Hayen (1987), Narsey (2012), Roberts etal (2007), Amos-Pace (2013), Smith(2011) and Lowe (2001) all state that the suicide rates are high amongst the Indian population in Fiji. The studies also indicate high rates of attempted suicide amongst young Hindu women. This is quite evident for cane growing areas of Fiji. It has been suggested that high rates of both completed and attempted suicide in the cane growing areas could be associated with the methods used for ending one’s life. For instance, Lowe (2001) discusses the use of herbicidal agents such as Paraquat which is used by many farmers on their farms to eradicate weeds. In a historical survey, Haynes (1987) discusses the methods used by Indian emigrants who committed suicide on the plantations due to depression, isolation, nostalgia, ill treatment, exhaustion and despair. While most died by hanging, the method used has changed over time.

Regardless of the fact that recent figures derived from FAMPAC (Families and Population Activities Centre) has removed ethnicity from data, it does not prevent one from speculating that suicide rates would still be relatively high amongst the Indian population in Fiji.

**Methodology**

In an attempt to disseminate information on suicide prevention, WINET-Fiji decided to organise workshops in areas around Fiji. A quick search for data revealed close to no information on the number of attempted suicide cases from isolated areas around Fiji.

Based on experiences from previous workshops conducted around Fiji, WINET-Fiji decided to conduct workshops in areas that had informal settlements, people from low income background, and Indian population. Previous workshops and discussions with WINET-Fiji’s networking partners had indicated that limited workshops were conducted in areas stated above.

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**Figure 1: Map showing areas where the 8 workshops were conducted**

Initially, a visit to the area was conducted, and the Trainer of Trainers (ToT) made contact with the networking partners in the area to identify prospective participants. In nearly all cases, schools in the area were selected and the Head Teacher or Principal, and community leaders helped to identify students who came from families that had social problems or who had known cases of family problems. Based on this, invitations were sent to homes, inviting parents, young adults, school leaders and community leaders to participate in the workshops.

While the workshop was not aimed at data collection, the information derived from the workshops seemed useful for future workshops, reporting purposes and for the data base that the organisation was collecting. The one-day workshop began with the registration of participants leading to an interactive session that comprised of information sharing, discussion, role play, evaluation, and sharing of confidential information through a ‘secret box’. During the first workshop it became obvious that the participants wanted to share much about suicide, had information and did not know where to share their views. Thus, later workshops collected information from participants on the number of attempted as well as completed suicides that they were aware of.

**Workshops**

*Suva Workshop*

The first workshop was conducted in Nabua, a suburb in Suva. A primary school was selected as the venue for the workshop. Even though the vicinity of the workshop was very urban based, care was taken to select participants that were from informal settlements. Information settlements or squatter settlements have recently emerged around Suva after the movement of people from rural areas due to reasons, including land insecurities (Mohanty, n.d). School administrators in the area were also able to identify students, parents and families that showed signs of emotional, family and social problems. In order to reach out to such citizens, their contact people for instance, community leaders, parents and guardians and in some cases, people themselves were contacted and invited to participate in the workshop. All participants for this workshop were women, coming from low to very low income backgrounds Those who were parents left their children at school, attended the whole day workshop and went back home after the school had finished for the day. The decision to use school premises for workshops was based on the organisation’s previous experiences with workshops that involved women participants. Women found it easier to attend workshops during school hours and at the schools where their children attended. Two participants were below 18, twelve were between the age group of 19-24, seven were between 25-49 and one was over 50.

*Nasinu Workshop*

The second workshop was conducted in 8 miles Nasinu, a densely populated area outside the city of Suva. The trend of urbanisation has shown a steadily increasing population in this area. Most people residing in this area can be classified as working class. Many informal settlements have emerged recently based on the fact that the recent urban migrants to this area come from other parts of Fiji. In some incidences these migrants are displaced farmers from cane growing areas of northern and western parts of Fiji. As with other workshops, a school was selected as the venue and most participants were parents. There were 22 participants for this workshop, of which two were males. Three were below 18; seven between ages 19-24; twelve between 25-49 and one was over 50. Most participants were community workers, members of religious organisations or women’s clubs.

*West Workshops*

After the successful completion of these two workshops, WINET-Fiji requested for more funding from the Ministry of Health, Fiji to conduct similar workshops in the Western and Northern parts of Fiji. These requests were based on the fact that more Indians resided in these parts of the country and also due to the fact that suicide figures for Fiji have always shown that a larger number of Indians committed or attempted to commit suicide (Haynes, 1984).

Three workshops were conducted in the Western part of the country, in Sigatoka, Lautoka and Rakiraki. The locations of these workshops were again based on the availability of space at a school in the area. The 3 areas selected for the workshops were Cuvu Primary in Sigatoka, Banaras Sanatan Primary in Lautoka , and Penang Secondary in Rakiraki. Community leaders and school administrators were again resorted to to identify potential participants. There were 20 participants for each of these workshops and in all cases more women participants were present. Most participants were community workers, members of religious organisations or women’s clubs. Two of the areas that were selected for the workshops were in cane growing areas. Most cane in Fiji is still grown by Indians. One of the areas has seen a decrease in population due to land displacement issues in Fiji.

*North Workshops*

The last three workshops were conducted in the northern part of Fiji, in Vanua Levu. According to Haynes (1984), suicide incidences were high in the Northern part of Fiji and amongst the Indian community. The first workshop was conducted in Naduna, a cane growing rural settlement outside Nasea town. There were 20 participants for each of these workshops, and in all cases more women participants were present. Most participants were community workers, members of religious organisations or women’s clubs.

The second workshop in the North was conducted in Siberia, another cane growing rural settlement outside Nasea town. The participants were from a similar background as the ones who had attended the first workshop. The final workshop was conducted in Naleba, another cane growing area in the north. This was about 15 kilometres away from the urban centre, Nasea. The remoteness of the location and the fact that it was a scarcely populated community revealed details on the leadership in the community. Most of the community leaders were religious leaders and nearly the only form of communal gathering was related to religious gathering, funerals and weddings. This fact was referred to also in Narsey’s comments on suicide rates in Fiji (2002).

**Results**

Participates in all workshops were able to identify what suicide was as well as provide descriptions of the methods people used to attempt and commit suicide. The participants had limited knowledge and information on where to seek assistance or support when they knew of someone who had attempted suicide, or how to help families of suicide victims.

The reasons given by participants to attend the workshop were:

* to learn more about suicide,
* to deal with social problems associated with youths in the area,
* cope with suicidal personals-especially those who had cancer, or other sicknesses
* to provide counselling to those who were in self-threatening situations,
* being able to identify suicidal people around them, and

to impart knowledge to others in their community and family.

While detailed information had not been collected from the Suva and Nasinu workshops, the workshops conducted in the West and North of Fiji provided sufficient information on the cases of completed and attempted suicide incidences amongst the Indian population in Fiji.

The following table provides the information that had been collected:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Data from Workshops** | | | | | | | | | | | | | | | | | |
| **Cases of suicide discussed** | | | | | | | | **Attempted as well as Completed** | | | | | | | | | |
| **Age** | |  | |  | |  | | **Gender** | |  | **Ethnicity** | |  | |  | **Attempted** | **Completed** |
|  | **below 18** | | **19-24** | | **25-49** | | **over 50** | | **Male** | | **Female** | **Fiji Indian** | | **Fijian** | | **Other** | **Total** | **Total** |
| **Sigatoka** | 7 | | 6 | | 8 | | 1 | | 7 | | 15 | 15 | | 6 | | 1 | 11 | 11 |
| **Lautoka** | 6 | | 3 | | 12 | | 6 | | 16 | | 11 | 26 | | 1 | | 0 | 12 | 15 |
| **Rakiraki** | 3 | | 7 | | 6 | | 0 | | 7 | | 9 | 14 | | 0 | | 2 | 6 | 10 |
| **Naduna** | 3 | | 5 | | 16 | | 1 | | 17 | | 8 | 20 | | 3 | | 2 | 17 | 8 |
| **Siberia** | 5 | | 3 | | 4 | | 1 | | 9 | | 4 | 9 | | 4 | | 0 | 9 | 4 |
| **Naleba** | 6 | | 4 | | 1 | | 1 | | 6 | | 6 | 12 | | 0 | | 0 | 5 | 7 |
|  | |  | |  | |  | |  | | |  | |

Table 1: Details of cases of attempted and completed suicide discussed during workshops in West, North Fiji

Mostly youths comprised the 22 cases that were discussed during the workshop in Sigatoka. Cases involving women who were from Fiji Indian origin were higher. Both attempted and completed case had similar figures.

In Lautoka, there were more incidences of suicide that involved people under the age of 18, more males and Fiji Indians. More completed cases were discussed.

While there were fewer cases discussed in Rakiraki, there were still cases from Fiji Indians and those from the 19-24 age group. Victim numbers were similar for both males and females.

An interesting fact that emerged from this workshop was the reason for attending the workshop. None of the participants had attended a workshop on suicide prevention before. A few were victims of attempted suicide, or had someone in the family who had committed or attempted suicide. There were also concerns that many suicides were being committed in the community and there was an urgent need to educate, prevent and provide support in the community.

The workshops in the North revealed similar information where ethnicity, age and gender of completed and attempted suicide cases were concerned. Naduna, another cane growing area revealed cases of more Indian male, above the age of 25 and those attempting to take their lives.

Siberia and Naleba are also cane growing areas, however, both places showed less suicide cases being discussed. None the less, Indians, below the age of 18 victims were mentioned.

**Post Workshop Feedback**

A number of issues were raised following the workshop. These were on the issues such as the importance and need for such workshops, the lack of involvement of people in the area for such workshops in the past, and the lack of follow up workshops.

*Importance and need for workshops*

None of the participants had attended a workshop on suicide prevention in the past. Very few had heard of such themes for workshops. Most participants’ previous workshop attendance had been on microfinance and enterprising, health issues, human rights, and women’s rights issues. No workshops had been conducted on any mental health issues in the area either.

Counselling for parents, teachers and children was another area for discussion based on the fact that victims of suicide were now much younger. Issues such as parental responsibility, parental care, exam pressure, peer pressure amongst the young, and anger management were also issues that were thought to be of importance. Reasons for taking or attempting to take one’s life, such as those discussed during the workshops are not new. Studies conducted by Lowe (2001), Haynes (1987), Henson et al. (2012), Roberts etal (2007) have found similar trends. Incidences of young women attempting to take their lives due to family pressure, inability to bear children or male child, issues with relationships have been discussed. The situation facing those under the age of 18 is somewhat different. It seems that the act of suicide or intention to commit suicide marked a highly emotive state of rebellion Incidences of relation issues were also discussed.

*Lack of women participation*

A concern that was raised was the lack of women participation in such workshops. This was aired by women based on the fact that in most cases workshops were held in urban areas, making it difficult for them to attend. It needs to be noted that all workshops were held at the school where most participants’ children were studying. The fact that the workshop was held during a school day, during school hours made it very feasible for parents to attend the workshop without facing any prejudices and intimidation.

Secondly, women discussed the issue of workshops dominated by men, and by leaders in the community, who did not disseminate the information once they returned to the community. Participants described their past experiences and/or lack of dissemination of information due to the fact that the participants were usually popular community figures who frequented workshops, and were in regular contact with organisations who conducted workshops. The selections of participants for these workshops were thus applauded by women.

In a particular area, the fact that the community was sparsely populated and that social functions that took place in the community raised the issue of community domination by male religious leaders. These situations led to either sensitive issues being ignored or were discussed only amongst the men folk.

A few recommendations were made during the sessions. The first was theneed for NCOPs to have community based support centres, provide early intervention systems, and to include community leaders in workshops. The idea of having a counsellor at the nearest police station was raised as well. It was mentioned that the participants who had experience and knowledge on how to guide and assist in respective situations should be included in such workshops.

**Discussion**

The eight workshops revealed much about suicide rates, preventative measures, awareness and geographical gap in Fiji. Most of the workshop participants were women, from Fiji Indian background and from low income status and in six cases, from isolated areas. These conditions for the workshops were predetermined due to the fact that most of the cases of completed and attempted suicides were found amongst the Fiji Indian community. Previous studies focussing on the history of suicide in Fiji (Lal, 1992), as well as data collected from these workshops emphasise these facts. Similar to previous studies, no gender differences were found for attempted and completed suicide, while for both Fiji Indian numbers remain high (Booth, 1999).

The discussions during workshops in the north and the west provided information on the suicide rates in these two areas of Fiji. Discussions also reflected the fact that suicide rates were still high in the Fiji Indian community. Recent data entry system in Fiji has removed ethnicity from the data being collected. Other facts on suicide that emerged were that, Fiji Indian male and female figures were high for both attempted as well as completed suicides. These figures were similar to those discussed in the Henson et al (2012) and Roberts et al (2007) studies. These findings clearly demonstrate a discrepancy between the figures mentioned during the workshops with those that have been reported or included in the NCOPs data on suicide in Fiji.

In all workshops, the participants echoed the sentiments that there was an urgent need for more workshops to address the issue of suicide. The participants, whether they were from Suva, Nasinu or isolated areas in Fiji; all had similar views. This fact reconfirms WINET-Fiji’s assumptions that existed prior to the workshops - . that there are not enough workshops being held in isolated or low income populated areas of Fiji.

WINET-Fiji had identified areas in Fiji that were not frequent locations for community workshops. The method WINET-Fiji used to identify the locations was based on a pre-workshop survey to gauge the community’s knowledge, experience and awareness on suicide. None of these areas had previously hosted a workshop on suicide. None of the participants, especially women had ever been informed about the symptoms, myths, understanding and methods by which victims of attempted suicide, and families of completed suicide victims could be counselled.

**Recommendation**

WINET-Fiji believes that there exists a gender, ethnicity, and geographical gap where information, networking, training and counselling for a sensitive issue as suicide is concerned. The fact that most suicides are still being committed or attempted by Fiji Indians (after more than 100 years of reporting) is a serious issue. For a small country like Fiji, that has one of world’s highest suicide figures; the fact that many attempted suicide cases are not being reported is a serious concern.

Recent reports on the increasing suicide rates amongst the younger age group are not new information for WINET-Fiji. The data collected form these workshops show that most attempted and completed suicides are committed by the younger generation from Fiji Indian background.

WINET-Fiji believes workshops on suicide cannot be conducted in urban areas or for organisational leaders. The need is definitely strong and urgent in low income, and in isolated communities where few workshops are held, but where suicide cases are more. It also believes that the gender and racial biasness need to be removed when health issues such as suicide prevention workshop planning is done.

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