

# Article Feature:

- Politics, Climate Change and Health Crises in the Fiji Context
- The current onslaught of Non-Communicable Diseases (NCD)
- General Practice's Memory Line with Dr. Ram Raju

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# — PACIFIC — SPECIALIST HEALTHCARE

## THE JOURNEY

### First Phase (achieved 2017-2020)

The first phase of the Pacific Specialist Healthcare Private Hospital involved the development of an office based facility which provided General Outpatient, Specialist clinics, Surgeries, Laboratory services, Radiology services, Pharmacy and Physiotherapy services.

### Second Phase (achieved May, 2023)

The second phase of the Pacific Specialist Healthcare Private Hospital involved the development of a 100 bed private hospital which provided on top of the existing services, Cath lab, Open Heart facility, Chemotherapy and Private Birthing,

### Third Phase (work in progress)

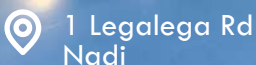
Pacific Specialist Healthcare is currently working on its third phase which includes:

**Organ Transplant Hospital - IVF Treatment Centre - Radiation Therapy**

## SPECIALTIES

CARDIOLOGY  
CARDIO THORACIC SURGERY  
NEUROSURGERY  
GENERAL SURGERY  
UROLOGY  
ORTHOPEDIC SURGERY  
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DERMATOLOGY  
OBSTETRIC & GYNECOLOGY  
VASCULAR MEDICINE  
INTERNAL MEDICINE  
GENERAL ANESTHESIA  
ENT  
LAPAROSCOPY

**PSH is looking forward to  
collaborating with all the GP's in Fiji**



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# Editorial

## Politics, Climate Change and Health Crises in the Fiji Context.

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**Background.** The Republic of Fiji is an archipelago of 330 islands in the south-west Pacific. Fiji remains an upper middle-income country with a multiracial mix of indigenous Pacific islanders, Asians of Indian and Chinese ancestry, Caucasians and mixed ethnic races. The politics has been marred with four coups, since 1987 and the current population of 880,000 co-existed in a deepened militarized-democracy from May 2006 to December 2022. Fiji lies centrally located at the intersection of the three types of island stereotypic/genetic denominations: Polynesia, Melanesia and Micronesia. The country serves as a major hub for communications, technology, travel, trade, commerce, education and the evolving international relations (IR) for the Pacific region despite intrinsic political simmering.

Serious intra-provincial politics has been the primary source of political upheavals rather than the more widely discussed interracial, consequential explanations. Following Fiji's suspension by the regional Pacific Islands Forum (PIF) for persistent delays in returning the country to democracy in 2009, the Fijian national leaders "Look North" policies resulted in the stabilization of economic instabilities. International relations with China, Russia, Middle Eastern nations (Qatar and Saudi Arabia) and Indonesia were established. Pacific leader's band-wagoned on these international relation benefits within trade and commerce despite their western liberal inclinations of past colonial influences. Geopolitically the whole world is in strategic disarray and the Pacific is existentially affected with global power play. Fiji's new coalition government is seriously challenged to re-engage with State and Non-State stakeholder.

**The Political Stage.** The fourteen (14) States in the Pacific largely consist of former colonies of the British, French, United States, now decolonized apart from West Papua, French Polynesia and New Caledonia. The Island States currently face important strategic challenges. The Chinese impact with the Belt and

Road Initiatives and economic benefits obtained via the Asian Infrastructural, Investment Bank (AIIB) with grants and soft loans. Other Person to Person (P2P) interactions and Silk Road Health diplomacy have had positive political impact in the region. Balancing international alliances with traditional allies whilst counterbalancing developmental, economic and health initiatives benefits with new partners remains problematic for Pacific leadership in the context of the evolving world order changes.

The political need for Pacific Small Island "State" remains developmental, yet the economic consequences of rapid changes in the environment, following indiscriminate mining, logging and fisheries are areas of great concern. Environmental degradation, de-forestation by rampant logging without adequate re-forestation, exploitation of the sea resources and oceanic pollution remain current and topical international relations discussion points as examples of bad governance. Such political underpinnings need to be addressed within the context of climate change mitigations as the low-lying Pacific Islands now facing existential "climate change" threats.

Pacific and Fijian leadership have articulated the existential threat resulting from the rapidly rise in sea levels and its multifactorial health adversities. They have noted the corollaries of extreme weather events in hurricanes and increased and greater frequencies of category 5 storms following periods of El Nina/ El Nino, droughts, changing rainfall patterns and the worsening impacts of flooding. The recent COP 28 has articulated greater pace to pledges in "Loss and Damage" however the talk fest has slow uptake. This remains a meaningful direction for the wider Pacific's existential threats with climate change.

**Climate Change.** Fijian leadership has been at the steering wheel, addressing Global Climate Change. The Framework Convention on Climate Change (FCCC-2005) gave the small island States of the Pacific and Caribbean's, a sizable diplomatic negotiating space, well utilized to date through the Association of Small

Island States (AOSIS). Unfortunately, the small island States are not the producers of the pollutants, as in Carbon Dioxide, Methane or responsible for the O-Zone depleting agents (CFC, HCFC). The Island States cannot move forward in their collective mitigative strategies when confronted with the global north's and rapidly advancing global south's developed countries vested Nationally Determined Contribution (NDC) caveats in reducing Carbon emissions to 1.5% increase above the pre-industrial era landmark. Fiji's International relations efforts have remained theoretically a showcase presentation without national pragmatism.

Fiji's Five (5) and twenty (20) year Climate change plans, haste-fully produced for the COP 26, falls short of a workable plan. Currently, there are professional difficulties drafting timely requisitions for Climate Funds and no funds to undertake monitoring & evaluation (M&E) of even current programs. Additionally, mitigations on human health and food insecurity have yet to be addressed. Policymakers must implement the appropriate policies and strategies when the consequences are existential- loss of health and wellbeing, territory and sovereignty. The health crisis is taking on tsunamic dimensions as will be discussed in this journal series.

**The Health Crisis.** Climate change affects every aspect of life in its current accelerating pace. Recognizing its serious threat to ecosystem, biodiversity, and health remains paramount. It remains a major existential threat to human life and health. Climate change impacts can be mitigated firstly by reducing greenhouse gas emissions and secondly by enhancing the capacity of Earth's land and oceanic surface to absorb greenhouse gases from the atmosphere. Long-term investment in renewable energy and energy efficiency is urgently needed.

A mix of mitigation and adaptation at various levels especially in the most vulnerable small island States is warranted. Adaptation to health consequences of climate change and prevention of the aggravation of climate change are key challenges for society.

Whilst State policymakers must implement personalized adaptive strategies. The health sector needs to promote research, education (for health personnel), and information (for public and policymakers) on climate change and its multiple deleterious health consequences leading to increased morbidity and mortality.

Recognizing the accelerating pace of climate change occurring as a result of the imbalance between incoming and outgoing radiation in the atmosphere, climate change is largely anthropogenic. viz a viz through increasing industrial greenhouse gas emissions. Climate change has the potential

of multiple deleterious consequences with the forecasted global mean temperatures increase up to 5.4°C by 2100 on current scientific projections.

Climate change creates water and food insecurity, increased morbidity/mortality, and population movement. Vulnerable populations (e.g., children, elderly, indigenous, and poor) are disproportionately affected. Personalized adaptation to the consequences of climate change and preventive measures are key challenges for the society.

Unfortunately, the current ministry of health and medical services in Fiji have attended organized regional meetings focused on climate resilience measures, as in "safer health facilities" through initiatives of international agencies as in KOICA and WHO. In the absence of strategic and programmatic focus at the people level, mapping and review of the wider socio-economic and health impact on communities currently facing climate change or impact of those few who have been relocated is absent. Quality of life issues inclusive of holistic health and wellness need to be researched. Additionally, addressing the quantum and pace of change to build climate resilience is necessary. These basic tenets remain un-researched and uncharted in the Fiji context.

The interconnections between Climate change, pandemics and health cannot be under-estimated. The articles in this issue demonstrate some key areas highlighting the onslaught and evolution in the 21st century of Non-Communicable Diseases in our multicultural population. The impact of the COVID-19 pandemic on healthcare, innovations that followed in digitalization, establishing a rushed Public-Private-Partnership in healthcare delivery are discussed. The more recent National Economic budget submissions to objectify national funding to private healthcare is work in progress. The increasing incidence of infectious disease- Leptospirosis, HIV and the unfathomed mental health crisis unmask in difficult economic times.

The editorial team also looks into the past with a column on Dr. Ram Rajus memories of the College. Finally, there is an abstract list of recent articles published in leading international Journals which have a focus on the Western Pacific and Fiji for your reference and reading pleasure.

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# The current onslaught of Non-Communicable Diseases (NCD)

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## **Introduction**

The current onslaught of Non-Communicable Diseases (NCD) globally, specifically in Oceania is cause for great concern to curtailing even slower national development in the region. The advancement of socio-economic indices in a country rests on adequate healthcare delivery and enabling educational networking and fine-tuning systems. Although fully aware of their country's plight most politicians appear dumbfounded when it concerns the public health issues surrounding NCD, especially Diabetes (T2D): The killer diabetes, its complications, its impact on drastically reducing national development with premature disease, disability and deaths.

## **The Fiji Scenario**

In the 1960's the indigenous population in Fiji had an incidence of 0.04% of diabetes whilst the citizens of Indian ancestry a measurable 8%- the genetic link globally. In the 1900's there was a leveling of the playing field with a steep rise to 16% in both population groups, thanks to western diets and changing sedentary lifestyles. Just too much processed fast food and sweetened sugary beverages. The Second Steps Survey by Health Ministry and supported by World Health Organization (2012-13), the figures are rolling close to 30% with local projections up to 50% by 2030.

Engaging the International Diabetic Federation in assisting Foot-care and endorsement of specialist foot-care surgeons to assist in reducing the very high amputation rates have not been followed with any degree of vigor by our local teams, unfortunately. Revamping the National Diabetic Foundation with newer and comprehensive terms of engagement needs much greater political will to impact on the lives of its citizenry.

Bilateral international Support Bilateral support from the Government of Israel in procurement of Syringes, needles, glucose-sticks, glucometers falls on deaf administrators, stuck in their processes and not focused on national need. Likewise, Australian Aid supported the initial supply of Laboratory equipment and reagents for undertaking Hb A1c and Micro albumin assessment to optimize screening is probably gathering dust in the 7 laboratories, identified as appropriate recipients for the trial project proposal. Government of Taiwan also supported training of

personnel in Data analysis specific for epidemiological research, evaluation but the officers are deployed to clinical service areas. The Indian Government set up training and later was instrumental in Jump starting the Prosthetic Limb Center in Tamavua, Fiji which effectively meant that all Fijians with obtain ability to work, walk and play and not be incapacitated in bed or a wheelchair at no cost!

## **The Pacific Eye Services**

Fortunately, the Pacific Eye Unit is operational with excellent facilities in Laser therapy and so is the National Cardiac Catheterization Laboratory for Angiograms, stents. The Operating theaters undertaking Open Cardiac surgery for our Diabetics with all the comorbidity it carries, has been terminated when the contract with the Indian group came up for negotiation at the completion of five years of successfully carrying out the procedures locally. No overlap was allowed till a new scheme was negotiated We have not been successful in renewing such with any group even after one year. A comprehensive Cardiac study, supported by World Health Organization remains unread to date by Health administrators.

## **The Kidney Dialysis Discourse**

Unfortunately, Kidney Dialysis has remained under the stewardship of private companies and the general public is financially pressed against the wall. This remains a frontier to work around by philanthropists, if the government was amenable to discussion. State subsidy should be a temporary measure and kidney transplantation laws and service delivery addressed to compliment dialysis.

## **Conclusion**

Unless Diabetes is taken to primary-care level promptly, the massive impact diabetic complications will have on communities and nation will no longer be just a medical issue but of great consequential effect on National Development. The tsunami is here and are we disaster- prepared? When will the political pundits come together and work out a suitable fiscal and programmatic rescue package?

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# Digitalisation in health within COVID-19 Pandemic

*“charting in the storm for the new normal”*

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## **Background:**

Charting the health ship in the COVID - 19 storm requires smart leadership, clarity of vision and prescribed set of measures so that the ship reaches its desired destinations with minimal harm to the crew (health and frontline workers), the ship (facilities and systems) and the passengers (vulnerables and the public at large).

The requirement for social distancing in light of COVID-19 has led to an unprecedented rise in dependence on digital technologies for both health care providers and patients. While healthcare providers turbo charge towards the digitalisation of health care, the new normal modus operandi allows for potential improvements in access, population tracking during COVID-19 pandemic, monitor individual and population vitals and epidemiological advantages such as fatality rates, survival rates and hospitalization figures as well.

Digitalisation would be considered as a means, a set of tools, not an aim for public health. They can transform healthcare services in ways that would contribute to health system goals of quality, accessibility, efficiency, and equity of healthcare. The rule of the game is to ensure that all people enjoy the benefits of digital technologies.

As public health professionals, we advocate that innovation and technology help to reduce the inequities in our world, instead of becoming another reason people are left behind. The technology and the digital environment offer new opportunities for identifying needs and delivering healthcare from prevention and health promotion to curative interventions and self-management.

Digital tools such as mobile apps with tracing functionalities can be of substantial support in this process, identifying both known and unknown contacts of a confirmed case and possibly help in their follow up, in particular in settings with large numbers of cases where public health authorities can become overwhelmed.

## **Introduction:**

The impact on health outcomes and health inequalities must be carefully considered to ensure they contribute to social health and not detract from

it. While visiting the doctor is technically permitted under these rules, overstretched health systems, along with the need to minimise risk of contagion, means that gaining access to medical professionals has become extremely challenging.

Weak or stretched health systems exacerbate medical emergencies. This is expected to have significant consequences on overall health outcomes - and thus welfare - not only for those directly affected by COVID-19, but also those for whom vital support from health care providers has been severely limited as a result of the surge in demand.

This surge inspiringly catalyzed digital innovations as a solution to the problems during COVID-19. How to reach your patients, how to meet virtually, the smart way to project management of health projects domestically and through international providers.

## **The technological play globally:**

When it comes to the COVID-19 pandemic, we have learnt that mobile apps have the potential to bolster contact tracing strategies to contain and reverse the spread of COVID-19. In a number of countries worldwide, the use of apps has supported health authorities in monitoring and mitigating the ongoing COVID-19 pandemic, facilitated the organisation of medical follow-up of patients, and provided direct guidance to citizens on playing their part in the control of the disease. The added value of these apps is that they can record contacts that a person may not notice or remember.

The online Partners Platform, launched with United Nations Development Coordination office (UNDCO) on March 16th, was built upon a WHO-vetted checklist of 143 actions, drawn from the most up-to-date guidance created by international experts (1). Countries can choose actions from the checklist to create their COVID-19 preparedness and response plans. They can then track if they have initiated or fully completed the actions. Since all actions are fully costed, countries can also note where they need financial assistance.

The aim of contact tracing and warning is for public health authorities to rapidly identify as many contacts as possible with a confirmed case of COVID-19, ask them to self-quarantine if possible, and rapidly test and isolate them if they develop symptoms. Contact tracing is normally carried out manually by public health authorities. This is a time-consuming process

where cases are interviewed in order to determine who they remember being in contact with from 48 h before symptom onset and up to the point of self-isolation and diagnosis.

Several member states in the EU and EEA have launched or intend to launch initiatives that involve contact tracing apps in the fight against COVID-19. The use of these technologies has raised policy questions about privacy and data management, determining different approaches in different countries, especially between Asia and Europe. The adoption of the digital tools (encouraged or mandatory), a digital infrastructure enabled and activated by the national government, and the possibility to share data represent the main conditions and the most dilemmas related to the improvement of digital contact tracing strategies. In this sense, EU member states should urgently converge towards effective app solutions that minimise the processing of personal data, and recognise that interoperability between these apps can support public health authorities, especially after the reopening of the EU's internal borders (2).

**Outside of Europe, China, South Korea, Taiwan, and Singapore have developed several technologies to collect data in order to contain the dissemination of the virus.**

**CHINA:** China adopted a government-mandated QR code that shows the level of risk of the citizen in order to recognise positive cases.

**SINGAPORE:** Singapore encouraged people to install an app called "TraceTogether," which uses Bluetooth signals between nearby devices.

**HONG KONG:** Hong Kong requires all new arrivals to download the "StayhomeSafe" app,

**SOUTH KOREA:** while in South Korea the "Corona 100 m" app registers all personal data and movements by GPS that can be used by the government.

**TAIWAN:** Taiwan used a similar approach, where the contact tracing system allows the government to contact citizens to ensure they do not evade tracking by leaving their devices at home.

**EUROPE:** Apps developed in Europe, instead, are based on voluntary use, without a government obligation.

**ITALY:** From June 2020, Italy developed the app "Immuni" that is recommended, but not mandatory. This app uses a Bluetooth signal that allows recognising possible exposition to positive cases.

**FRANCE:** The French app "StopCovid" works similarly and it is based on voluntary use, as is the German app "Corona-Warn-App."

**FIJI:** Care FIJI app which uses Bluetooth technology for contact tracing.

There is evidently a different approach in digital contact tracing between Europe and Asia. This could be related to differences at political level but also to the characteristics of the population inclusive of "States" privacy laws, where the collectivist spirit of Asian Countries may encourage a common action and effort to face the virus spread. We should keep in mind, however, that such programmes can only help control the UK COVID-19 epidemic if they are effectively implemented and form part of a wider package of interventions that include social distancing, infection control, and hygiene measures.

#### **The uses in private sector:**

1. In Fiji, digital technology for telemedicine has been used by some practitioners for appointments, referral, updating appointment schedules, digital consultations, diagnostics, report writing and other means of communication with patients and professional colleagues.
2. Avenue to digitally seek second opinions for dermatological conditions have been set up with some practices with group viber or with referral for second opinion with specialists abroad e.g., dermatology conditions.
3. Use of phone or SMS for appointment reminder, treatments, updates or consultations has been established.
4. Emails for blood test result from general diagnostic services are actioned in this manner and compliment the clinical findings, before informing clients in a 24-48 hr turnaround time with results.
5. Patient were able to carry their medical history on their telemedicine profile including lists of medication and management.
6. Practitioners can closely monitor clients at home via their online medical diary on telemedicine platforms.
7. Zoom meetings for international and national meetings, Continuing Professional Development and executive business issues with the public PHC team are being undertaken.
8. Use of social media platforms such as Facebook for patient information has been established with good results. Used to reach wider audience or for individual clients. This needs a dedicated administrator for regular postings and information update. Also, to respond on a timely manner to client enquiries on both general and confidential matters. Should be open and no barriers whatsoever in communications.

#### **On the downside:**

1. On-line payment modes for GP service are in existence and clients can pay with internet banking or direct on-line deposits. There is no reliable mechanism to fast-track payments



as there are delays in payment of services by clients as well as health insurance providers (a trend seen during the COVID-19 pandemic).

2. On a wider societal level, there is need to ensure that, where there are benefits to be gained from the digitalisation of health care, such benefits are distributed in a manner that does not exacerbate or create health-related inequalities. Since digital technologies became mainstream, it is well-documented that the uptake of such technologies is not uniform across different groups in society (4). According to the Consumer Digital Index 2019, 4.1 (8%) million adults in the UK are offline, and 1.9 million people (22%) do not have the essential

digital skills needed for day-to-day life. Digital disengagement is also found to be higher amongst older people from minority ethnic backgrounds.

3. Furthermore, the shift to digitalisation may lead to a redistribution of resources away from non-users of DHTs. Evidence from India suggest that the adoption of digital technologies can come at the expense of non-users as health care professionals change their response in favour of the users (4). It would appear that empanelment by Health Insurance providers tend to be favorable to private sector clinics who operate on a digital platform.

#### **Conclusion:**

Digital technology for telemedicine has been used by some practitioners for appointments, referral, updating appointment schedules, digital consultations, diagnostics, report writing and other means of communication with patients and professional colleagues.

The use at national level for donor/partner platform is a proven means to track on resource usage. The transparency of the Platform allows donors to track what actions are taking place, where the biggest resource needs and gaps lie, and how to prioritize which allocations go where.

There is an imminent risk that improvements to health outcomes resulting from the digitalisation of health care will accrue only to those who are more willing and/or able to engage. It is therefore possible that digitalisation and COVID-19 benefits accruing to one group will come at the expense of other, less well-off groups. Therefore, digital inequality may

lead to induced health inequalities. Existing health inequalities may become exacerbated, as people who are less able to benefit from DHTs are generally those already in disadvantaged groups and the dispersed maritime communities or highlands.

The need for National Policy Development encompassing Digitization in Health is now mandatory to standardize data collection, address national needs and aspirations whilst due consideration is given to client confidentiality and address the potentials of further deterioration of health inequalities and equities in society. These measures set the health ship afloat during the COVID-19 storm as it steers on to the new or better normal.

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# Unpacking “Private-Public Partnerships” (PPP) in Fijian Healthcare

**Author:** Dr. Neil Sharma

The UN endorsed Sustainable Development Agenda (SDA-2030) target health as a basic human right amongst its aspirational goals, within its 17 goals and strategic directions. Under the specific strategic of Universal Health Coverage (UHC), increased effort is to be directed to health quality and reduce health inequities, globally. The aim is to address a wide range of health-related measures, inclusive of prevention, diagnosis, treatment, palliation and end of life support incorporated within the wide framework of public and clinical healthcare. This is inclusive of primary health care entailing public and private sector healthcare components.

Historically, UHC had been discussed, with preliminary discourse within the last two decades. Acknowledging that at the end of the Millennium Development Goals (MDG) and beginning of the SDG era in 2015 concrete effort remained at a “discussion stage” at global forums and with developed State levels, largely. The concept of Private-Public-Partnerships (PPP) took root following the global financial crises of the late 20th and early 21st century. The need to address the various fiscal constraints faced even by developed world was questioned. Public Private Partnerships (PPPs) are at the top of development financing options of governments and multilateral development banks (MDBs) in the global effort to achieve all Sustainable Development Goals (SDGs)

At the global scale, World Health Organization (WHO) has established a Health System Governance Unit which is responsible for studies into PPP in healthcare and its delivery. The salient reporting features originating in the African and East Mediterranean States, indicate the need for open ended dialogue, discussion and understanding the strengths and weakness of both the public and private primary-healthcare systems. Bringing all interested parties, inclusive of communities, Civil Society Organization (CSO), Non-Governmental Organization (NGO) bilateral and multicultural partners and transnational philanthropic organizations to establish a country specific strategic for best outcomes. The fact remains that Governments play a pivotal role however there remains no clear strategy nor there is a political will to involve the private sector as co-investor and thought partner. Realigning healthcare

needs remain paramount not just as a basic human right in any given State but as the COVID-19 pandemic has demonstrated that health underpin social, environmental, economic and national development commencing at individual, group, national and at a global level.

Fiji’s responds to addressing PPP historically was undertaken in the 2nd decade of the 21st century with preliminary discussions within the interim government to allocate 50% of the Annual Training and Productivity Authority of Fiji levy to Accident Compensation Commission and the balance to developing and running the infrastructure of primary care public/private partnerships. The PPP discourse was canned for various political reason. However, the COVID-19 pandemic unmasked a multifaceted, fragile public-health system with all its ramifications within the public clinical services. With great haste a PPP appeared without national or professional dialogue as a last political straw by the ruling political party. The current areas of PPP in Fiji’s health system apply at both macro and micro levels. The PPP with Aspen Hospital group (Macro) and that with the General Practitioner level (Micro).

Fiji’s infant Coalition Government needs to open up the Aspen/FNFP (Healthcare Fiji Ltd) agreement for clarification, tabling its strengths, weakness and its sunset clause, if any. The need to invite national dialogue for a progressive forward pathway is mandatory.

## **PPP**

1. The Australian Aspen Hospital recruitment agency was mated with Fiji National Provident Fund (FNPF) to create “Healthcare Fiji Ltd.”. This Australian Company which delved into healthcare delivery in Solomon Island during the RAMSI period having served “under makeshift tents” for emergency healthcare akin to their activation in Afghanistan for the vaccination of Afghani children. The Australian Post reports that Aspen Group profited over a billion dollars during the COVID-19 crisis out of “personal protection equipment” wholesaling and medical human resource placements in Australia.

Whilst FNPF remains a superannuation scheme to workers in Fiji, it remains the cash-cow for the government’s fiscal needs viz a viz procuring investment funding and loans without

questioning its original intentions, when board membership was politically restructured conveniently into 2023. The Agreement between the two consenting parties needs public and professional scrutiny for best outcomes.

2. As the COVID-19 pandemic ravaged the frail healthcare system, alternatives for primary health within the population mounted to a crisis with increasing excess morbidity and mortality in the domestic and clinical environments. A hasty plan to round up a cohort of private primary-health providers to service the population was devised without prior wide professional or community discussion. The lack of close monitoring, dialogue and keeping the service politically centralized has resulted in several wayward outcomes inclusive of amendments to legally binding regulation which previously upheld medical laws suitably.

A recent announcement of our current Minister of Health and Medical Services at the Annual Conference

of the Fiji College of General Practitioners indicates a major audit of the 2022, governments fiscal input into this scheme as fruitless to date. That a major reform is to be affected in 2023. However, the PPP with the private medical sector is now purposely extended and inclusive of private laboratories, dentists, general practitioners and private hospitals.

#### **Conclusion**

The need to openly dialogue both these PPP's for long term sustainability with best financial protective and health security is now. The evolving new system of governance in open democracy, needs to open the pandoras box. Unlocking digital health and other digital platforms to address innovative delivery system will strengthen such PPP's. All PPP's needs to be based on good governance, transparency, fairness as well as equity and social justice.

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# Value Adding - A Policy Focused view of Strain on Private Practice

**Author:** Dr. Ahmed Shakeel Shariff

## Introduction

In recent times, the healthcare industry has faced unprecedented challenges. There has been major developments in the healthcare sector and its operational dynamics in the past two decades. While Fiji was no exception to the global economic leap in the past 2 decades, the health sector also underwent the much-needed major legislative changes accordingly. To operate a private practitioner's facility has become increasingly challenging with increased requirements of capital and operational expenditures. The demand for quality healthcare, diagnostics and management is ever increasing not limited due to only advancement in healthcare but also exposure to global medical services via medical tourism. This does also challenge our local private practitioners who continuously find themselves in a competitive environment. Government policies such as the current 15% Value Added Tax (VAT) on healthcare services being the highest ever experienced by the healthcare sector. This article wishes to discuss the current value added tax (VAT) on primary healthcare services and serves as a humble plea for the authorities to reevaluate this taxation policy, shedding light on the myriad factors that have significantly impacted the cost of delivering primary healthcare in Fiji.

## The Changing Landscape of Healthcare Costs

Reflecting on the situation two decades ago, a visit to a prominent private facility in Suva would cost between \$23.75 and \$25. However, the average charges today remain around \$25, or even less in the suburbs and other parts of the country. Some general practitioners even on the outskirts of Suva or Nausori still charge \$15 for a consult and similar for small town and rural primary healthcare clinics. One would need to step out of Suva to realize the drastic contrast of affordability and economical variation within the country. Over the years, the cost of operations has seen a substantial increase due to various contributing factors.

## Factors Influencing Rising Healthcare Costs

*Several factors have contributed to the escalation of healthcare costs:*

**Increase in Salary for Medical Professionals:** The salaries of doctors, nurses, and para-medical staff have seen a significant rise.

**Rising Minimum Staff Wages:** The minimum wages for healthcare staff have increased, adding to the overall operational expenses.

**Escalating Rent Costs:** The cost of renting spaces for healthcare facilities has risen over time.

**Rise in Consumable Costs:** The expenses related to consumables, such as medical supplies, have witnessed an increase.

**Restricted Access to Government Pharmaceuticals:** The limited access to government pharmaceuticals has led to increased procurement costs.

**Compulsory Memberships and Insurances:** Various compulsory memberships and insurances, including those from professional associations, add to the financial burden.

- a. Fiji Medical and Dental Association: Compulsory annual fee of \$200.
- b. Fiji College of General Practitioners: Compulsory annual fee of \$350.
- c. Professional Indemnity Cover: Compulsory annual fee ranging from \$750 to \$1500.
- d. Public Liability Cover: Compulsory annual fee of \$700.
- e. Fiji Medical Association: Annual fee of \$380.

## Challenges Faced by Private Healthcare Operators

These factors have compelled some solo practicing doctors and clinics to adopt practices that strain ethical operations, such as undercutting consultation costs and consulting patients at home without proper documentation. The difficulties in sustaining private primary healthcare centers result in limited funds for capital investments, hindering the expansion and improvement of services, including vital areas like Radiology and Laboratory Services.

## Recommendations for Change

To alleviate the challenges faced by private primary healthcare operators and ensure the provision of affordable healthcare services, a recommendation is made to consider zero-rating on value added tax for medical centers offering primary healthcare services. This measure aims to prevent further increase in cost of services, encourage capital expenditure

for improvement, and facilitate the expansion of services.

It is crucial to clarify that this recommendation is specifically for primary healthcare centers, excluding large hospitals with operating facilities, which already enjoy existing tax incentives. By making primary healthcare services more affordable, the burden on the public (government) healthcare system could be significantly reduced.

#### **Empowering Primary Healthcare for the Greater Good**

The government's recent initiatives, such as removing VAT from prescribed medications and retaining General Practitioner-Public-Private Partnership (GP-PPP) schemes, suggest a focus on empowering individuals by making primary healthcare more affordable. These steps contribute to the overall well-being of the population and indicate a recognition of the pivotal role primary healthcare plays in mitigating the burden on the public healthcare system.

The current tax incentives support only the larger hospital with large capital investments, who usually make the larger percentage of profit compared to smaller sub-urban, rural or small town situated primary healthcare centers. These centers usually

tend to charge lower than these hospitals, look after the vulnerable and underprivileged in their community, however, these are the very centers that do not get any incentives to continue the great work they do.

In conclusion, a genuine consideration of incentives for capital expenditure in primary healthcare clinics is essential to promote their growth and reduce the strain on the government healthcare system. By fostering an environment that supports ethical operators and encourages investment in crucial services, Fiji can ensure the sustained well-being of its citizens and address the growing challenges in the healthcare sector.

*The opinions expressed herein are those of the authors and are intended for the purposes of discussion and leisure reading only. They do not, in any way, intend to undermine the perspectives of the government, the council of Fiji College of General Practitioners, or its esteemed members. The author will however be delighted to learn your views.*

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# Fatal Leptospirosis: High Index of Suspicion is paramount to prevent death

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## **Introduction:**

Leptospirosis is one of the most common zoonotic diseases worldwide with an estimated 1 million cases annually [1], particularly high risk in tropical regions including the Pacific Islands. Climate change, flooding, population growth, urbanization, poverty, and agriculture intensification are important drivers of zoonotic transmission. These factors may independently or potentially synergistically lead to enhanced leptospirosis transmission in Fiji [2].

Severe Pulmonary Hemorrhage Syndrome in Leptospirosis is due to extensive alveolar hemorrhage with a fatality rate of 50%. Severe Leptospirosis is associated with a cytokine burst characterized by high levels of IL-6, TNF-alpha and IL-10 [3].

## **Case Presentation:**

This is a case report of a severe leptospirosis seen at a subdivisional health facility in 2021 whereby a 24-year-old Fijian farmer presented with fever, reduced appetite, vomiting and joint pains. He was toxic looking and was on wheelchair when entering the Emergency Department. He had been on a fluid diet for the last 3 days prior to admission.

His vitals were: BP 11/76 mm Hg, HR 148 bpm, T 38.4 deg C, RR 20, SpO2 98% RA, GCS 15/15. Discharged after 10 hrs. in ED when vitals by then: BP 92/58, HR 111 bpm, T 36.9 deg C, SpO2 98% RA, GCS 15/15. Vomiting ceased and no diarrhea. On Day 2, he resorted to second opinion elsewhere and given oral medications (no specifics mentioned). On Day 3, patient was readmitted, now with fever, gingival bleeding and hemoptysis, jaundice, bloody nostrils and tachycardia. Vitals were; BP 90/47, HR 148 bpm, SpO2 98% RA, T 37.3 deg C, GCS 15/15. FBC showed HGB 13.9, WCC 10,410, Platelets 63,000, MCV/PCV 93/46 (lab report for day 1).

## **Management Plan of Action:**

4L of IV fluids was administered under acute care with antipyretic medications and close observation in the first 10 hrs. before being discharged and for review in 3 days. No IV antibiotics was given, and no serology reports was noted despite the test being done on day 1. It was on day 3, with specialist consultation at tertiary level, that the diagnosis of severe leptospirosis was made and for immediate admission to ICU. He died later in ICU shortly thereafter.

## **Discussion:**

Diagnosis of leptospirosis in Fiji should be primarily based on CLINICAL ASSESSMENT. The case definition for suspected leptospirosis is based entirely on clinical assessment- a detailed history and thorough examination is therefore crucial for early diagnosis.

Patients who fit the case definition for SUSPECTED LEPTOSPIROSIS [Annex II] should be promptly treated so that the risk of severe complications and death are minimized.

Leptospirosis can be difficult to distinguish from other acute febrile illnesses and can range from a mild febrile illness to a life-threatening disease. The progression of the disease can be rapid if untreated and two distinguishing symptoms of leptospirosis are conjunctival suffusion and calf tenderness [4].

The number of days since the onset of symptoms is important for determining which laboratory tests should be ordered, and for interpreting test results. The date of onset of illness should also be recorded on laboratory request forms and notification forms (Annex III).

-Laboratory Testing: In Fiji, we have many readily available tests we can do to diagnose and help manage leptospirosis. A basic panel should include a full blood count (FBC), urea, creatinine and electrolytes, liver function tests, Leptospira rapid antigen tests, blood cultures and also a chest x-ray and ECG. Further confirmatory testing can be done at the Mataika House through ELISA and PCR testing.

Both the rapid test and ELISA/ PCR tests detect Leptospira IgM antibodies, which do not appear until at least 5 days after the onset of illness. In the first 5 days of illness, a negative test is not useful for excluding a diagnosis of leptospirosis [5].

## **-Initiation of Treatment based on National Guideline:**

If the onset of illness is within 5 days, please start appropriate treatment as the diagnosis should be made on clinical assessment. If a patient fits the case definition for suspected leptospirosis, treatment should not be stopped if results of RDT and/or ELISA IgM are negative. If the initial RDT or ELISA IgM is negative, the test should be repeated after 2 to 3 weeks.

If a patient fits the definition for a suspected case, treatment should be started immediately. [Annex I]. Treatment should not be delayed if leptospirosis diagnostic tests are not available, or while waiting for laboratory results. All patients who fit the criteria for suspected leptospirosis should be given antibiotics

[Annex II]. If leptospirosis is considered as a likely differential diagnosis, treatment can be started even if the patient does not fit the case definition.

**Conclusion:**

Clinical presentations of Leptospirosis can range from mild non-specific febrile illnesses to severe life-threatening complications including acute renal failure, pulmonary hemorrhage, cardiac arrhythmias, shock, liver failure, coagulopathy, and aseptic

meningitis. Leptospirosis can lead to multiple severe complications if it is misdiagnosed or diagnosed late which include; acute pulmonary hemorrhage, acute renal injury, acute liver injury, myocardial complications and neurological sequelae. High index of suspicion can change the disease outcome in whatever the health delivery level.

Annex I: Case definition

**CASE DEFINITIONS for LEPTOSPIROSIS:  
Suspected, Probable, Confirmed**

|   |
|---|
| <p><b>A. SUSPECTED CASE = All 3</b> of the following criteria fulfilled.<br/>Note that a suspected case is defined by clinical assessment alone.</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p><b>Criteria 1. Acute onset of fever (<math>\geq 38^{\circ}\text{C}</math>) , headache, and myalgia</b></p> </div> <p style="text-align: center; font-size: 2em; color: #0070c0;">+</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p><b>Criteria 2. At least one of the following clinical features:</b></p> <ul style="list-style-type: none"> <li>▪ Conjunctival suffusion (red eyes)</li> <li>▪ Jaundice (yellow eyes)</li> <li>▪ Acute renal failure (increased or decreased urine output)</li> <li>▪ Haemoptysis or blood-stained sputum</li> <li>▪ Other bleeding including gastrointestinal bleeding, epistaxis, petechiae</li> </ul> </div> <p style="text-align: center; font-size: 2em; color: #0070c0;">+</p> <div style="border: 1px solid black; padding: 5px;"> <p><b>Criteria 3. At least one epidemiological risk factor in the past 3 weeks:</b></p> <ul style="list-style-type: none"> <li>▪ Occupation: farmer, abattoir worker, outdoor worker, cleaning streams, exposure to sewage &amp; garbage</li> <li>▪ Contact with animals: livestock (especially pigs), rodents, pets, wildlife</li> <li>▪ Contact with floodwaters or during the post-flood period</li> <li>▪ Contact with other freshwater, soil or mud: rivers, lakes, waterfalls, gardens</li> <li>▪ Living conditions: live in rural area or village, no metered water at home</li> <li>▪ Live or work in a current hotspot area, e.g. recent clusters or outbreaks</li> <li>▪ Link to a recent leptospirosis case, e.g. household member, co-worker</li> </ul> </div> |
| <p><b>B. PROBABLE CASE = suspected case with at least one of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Positive Rapid Diagnostic Test (SD <i>Leptospira</i> IgM) <sup>1</sup></li> <li>▪ Positive <i>Leptospira</i> ELISA IgM (Panbio) <sup>2</sup></li> </ul>  |
| <p><b>C. CONFIRMED CASE <sup>3</sup> = suspected case with at least one of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Positive <i>Leptospira</i> PCR <sup>4</sup></li> <li>▪ Microscopic agglutination test (MAT) <sup>5</sup>: Single sample with titre of <math>\geq 1:400</math>, or a 4-fold rise in titres between samples taken 14 to 60 days apart</li> <li>▪ Isolation of leptospires by culture <sup>5</sup></li> <li>▪ Identification of leptospires in tissues <sup>5</sup></li> </ul>  |

## Annex II

### 7.1 Antibiotics

All cases of suspected leptospirosis should be treated with antibiotics. Mild cases can be treated with oral antibiotics, but severe case required IV antibiotics for at least 7 days.

**Table 4.**

Recommended antibiotics and dosages for the treatment of leptospirosis

a) ORAL ANTIBIOTICS - for treatment of mild cases

|                               | ADULTS  | CHILDREN   |
|-------------------------------|---|--|
| <b>1<sup>st</sup> choices</b> | <ul style="list-style-type: none"> <li>▪ <b>Doxycycline*</b><br/>100mg bd for 7days</li> <li style="text-align: center;">OR</li> <li>▪ <b>Amoxicillin</b><br/>500mg tds for 7 days</li> </ul>   | <ul style="list-style-type: none"> <li>▪ <b>Amoxicillin</b><br/>50mg/kg/day, divide into 8 hourly doses, for 7 days</li> </ul> |
| <b>Alternatives</b>           | <ul style="list-style-type: none"> <li>▪ Erythromycin 500mg qid for 7 days</li> <li>▪ Azithromycin 1g, followed by 500mg bd for 2 days</li> <li>▪ Clarithromycin 500mg bd for 7 days</li> </ul> | <ul style="list-style-type: none"> <li>▪ Erythromycin 12.5mg/kg/dose (max 500mg/dose) 8 hourly for 7 days</li> </ul>           |

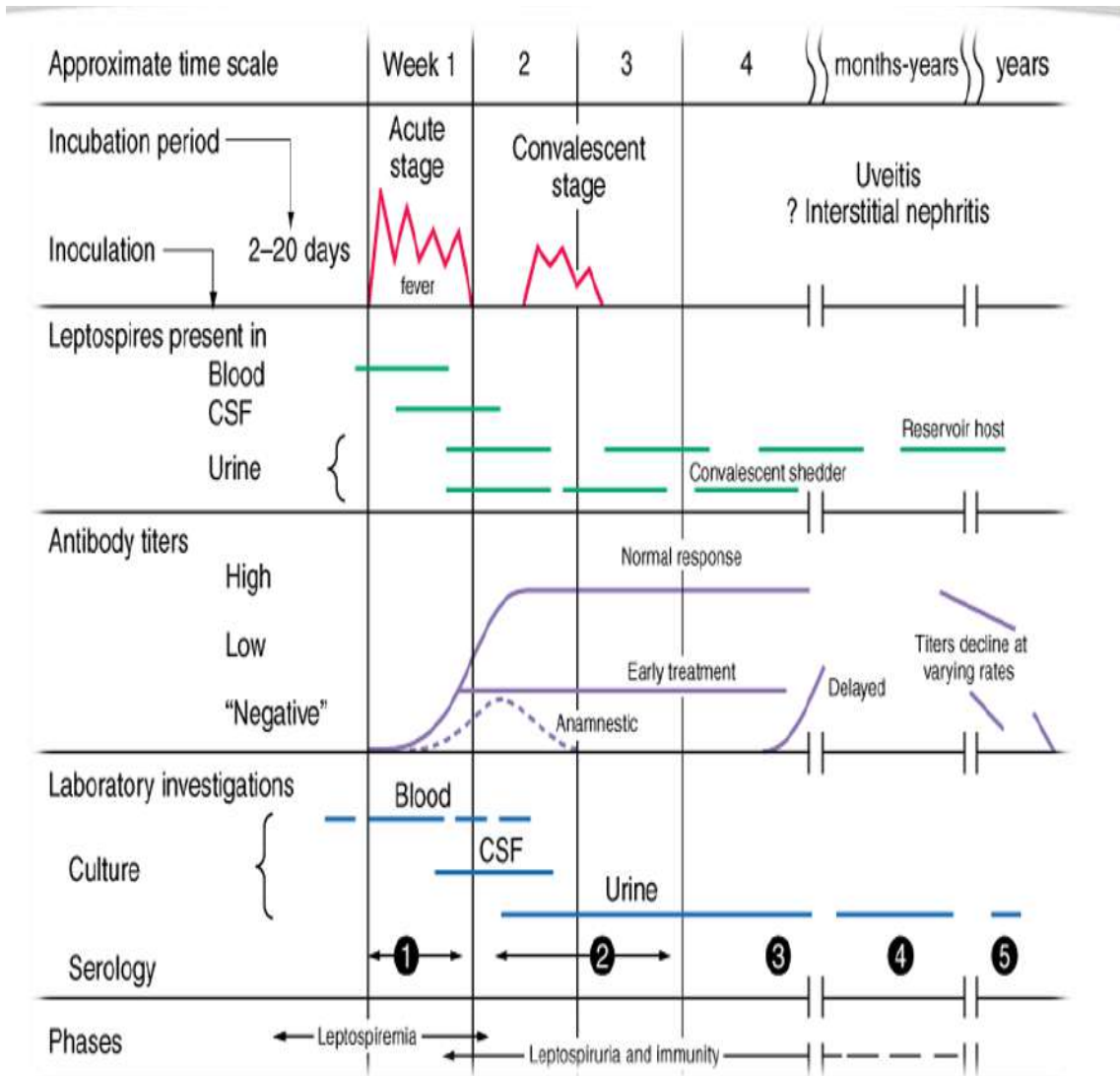
\*Note: Doxycycline should not be used in pregnancy, breastfeeding, or children <9yo

b) Intravenous Antibiotics - for treatment of severe cases, at least 7 days

|                               | ADULTS   | CHILDREN  |
|-------------------------------|--|---|
| <b>1<sup>st</sup> choices</b> | <ul style="list-style-type: none"> <li>▪ <b>Crystalline Penicillin G</b><br/>1.2g (2 mega units) 6 hourly</li> </ul>   | <ul style="list-style-type: none"> <li>▪ <b>Crystalline Penicillin G</b><br/>30 to 50 mg/kg 6 hourly</li> </ul>   |
| <b>Alternatives</b>           | <ul style="list-style-type: none"> <li>▪ Ceftriaxone 1 to 2g daily<br/><b>Use 1st line in ICU, or if suspect typhoid (2g daily)</b></li> <li>▪ Ampicillin – 1 to 2g 6 hourly</li> <li>▪ Cefotaxime 1g 6 hourly</li> <li>▪ Erythromycin 500mg 6 hourly (slow infusion)</li> </ul> | <ul style="list-style-type: none"> <li>▪ Ceftriaxone 100mg/kg (max 2g) daily<br/>Use 1st line in ICU, or if suspect typhoid or meningococcal</li> <li>▪ Ampicillin 50mg/kg (max 2g) 6 hourly</li> <li>▪ Cefotaxime 25mg/kg 6 hourly</li> <li>▪ Erythromycin 25mg/kg 6 hourly (slow infusion)</li> </ul> |



Annex III: Appropriate laboratory testing in incubation period, acute phase and convalescent stage



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Annex IV: Mapping level of care based on clinical and investigations.

| DANGER SIGNS & SYMPTOMS  |   |  |   |
|--|---|--|---|
| Increasing disease severity →  |   |  |   |
| LEVEL 1:<br>Outpatient care if patient fulfills ALL of the following criteria: | LEVEL 2:<br>Inpatient care at Sub-divisional Hospital if: | LEVEL 3:<br>Inpatient care at Divisional Hospital if ANY of the following:   | LEVEL 4:<br>ICU management if ANY of the following:   |
| No cough or other respiratory symptoms   | No cough or other respiratory symptoms →                  | <ul style="list-style-type: none"> <li>▪ Cough</li> <li>▪ Shortness of breath</li> <li>▪ RR &gt;20/min</li> </ul>  | <ul style="list-style-type: none"> <li>▪ RR &gt;28/min</li> <li>▪ O<sub>2</sub> sat &lt;90% on 6L of O<sub>2</sub> by mask – need non-invasive ventilation</li> <li>▪ Haemoptysis or blood-stained sputum</li> <li>▪ Abnormal CXR</li> </ul>  |
| Normal BP  | Normal BP →   | <ul style="list-style-type: none"> <li>▪ Systolic BP &lt;90mmHg</li> </ul>   | <ul style="list-style-type: none"> <li>▪ Systolic BP &lt;90mmHg despite adequate fluid replacement</li> </ul>   |
| No signs of bleeding   | No signs of bleeding →                                    | <ul style="list-style-type: none"> <li>▪ Any signs of bleeding</li> <li>▪ Platelets &lt;100,000/mm<sup>3</sup></li> <li>▪ Increased prothrombin time and/or INR</li> </ul> | <ul style="list-style-type: none"> <li>▪ Haemoptysis or blood-stained sputum</li> <li>▪ Gastrointestinal bleeding</li> <li>▪ Platelets &lt;50,000/mm<sup>3</sup></li> </ul>   |
| Normal urine output  | Normal urine output →                                     | <ul style="list-style-type: none"> <li>▪ Acute renal failure (oliguria or polyuria)</li> <li>▪ Electrolyte imbalance</li> </ul>  | <ul style="list-style-type: none"> <li>▪ Haemodialysis should be considered if any of:                             <ul style="list-style-type: none"> <li>• Urea &gt;30 mmol/L</li> <li>• pH &lt;7.2</li> <li>• Potassium &gt;5.5 mmol/L</li> <li>• Anuria or severe oliguria</li> <li>• Volume overload with pulmonary oedema</li> </ul> </li> </ul> |
| No jaundice  | No jaundice →   | <ul style="list-style-type: none"> <li>▪ Jaundice</li> </ul>   |   |
| Normal heart rate and rhythm   | Normal heart rate and rhythm →                            | <ul style="list-style-type: none"> <li>▪ Cardiac arrhythmias</li> </ul>  |   |
| Normal consciousness   | Normal consciousness →                                    | <ul style="list-style-type: none"> <li>▪ Altered consciousness</li> </ul>  | <ul style="list-style-type: none"> <li>▪ Glasgow Coma Score ≤12</li> <li>▪ Seizures</li> </ul>  |
| No vomiting  | → Vomiting and needs IV antibiotics or fluids             |  |   |
| Ambulatory   | → Not ambulatory  |  |   |

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# The Laws Governing HIV Non-Disclosure, Exposure and Transmission in Fiji: Is Criminalisation of Deliberate Transmission Enough to End the HIV Epidemic?

**Author:** Dr. Akaash Prasad

## **Introduction**

HIV/AIDS represents a spectrum of disease that is caused by infection with the Human Immunodeficiency Virus (HIV) and will lead to a state of immune deficiency (AIDS) in its most advanced stage. Recognised and globally accepted routes of spread for HIV include; sexual transmission (most common), transmission via blood (unscreened transfusion, infected needles, etc) and vertical transmission in pregnancy and childbirth. The number of people living with HIV in Fiji has doubled in the past 10 years with 2022 and 2023 being years with high incidences of HIV infection. Sadly, not all who are diagnosed are willing to start treatment. With a high viral load, as seen in untreated HIV infection, the risk of transmission of HIV is considerably higher. Internationally, the policies governing an aspect of HIV/AIDS termed Non-disclosure, Exposure and Transmission (for the purposes of this discussion: HIVNET) have been highly debated due to the sensitive nature of this disease. Policy makers are often trying to protect the rights of persons living with HIV when making laws about HIVNET.

## **Case:**

A 30-year-old patient requests for routine blood tests at a private hospital. The doctor, after history and examination, explains the tests to be done. Using the HIV Testing and Counselling (HTC) principles, informed consent was gained after pre-test counselling. Blood tests were done and the HIV point of care test came back reactive. The sample was sent to a reference laboratory for confirmatory testing and was confirmed positive. The patient returned for review of results and post-test counselling was done revealing the positive test result.

## **Discussion:**

**Pretext:** How a patient responds to receiving life altering news differs from patient to patient and the outcomes can take two totally different paths: All practitioners who have had some experience and training in HIV Testing and Counselling (HTC) know very well what is to be done if they see a patient who has tested positive for HIV as there is a set protocol for referral of the patient, initiation of treatment and notification of sexual partners. However, this only if the patient has accepted their HIV status, is agreeing to notify and start treatment. Of course, it is the role of the doctor, while proceeding with sensitivity, to be persistent with counselling efforts and aim to get the patient to choose what is best for them, however,

what is the next step when all efforts are coming to dead ends? What needs to be done when faced with a patient who outright dismisses this positive result and chooses to continue spreading the disease? Is it the moral obligation of the practitioner to notify someone about this patient who has the potential to spread HIV to an unknowing sexual partner? Is there a law in place that governs HIVNET? If the reason for non-compliance is encouragement to do so by a religious or political leader, can they be taken to task? Since viral loads determine transmissibility, can refusal of treatment be considered a negligent act of attempted transmission?

**The current law:** In Fiji, the HIV/AIDS Act of 2011 is the prevailing document as stated in section 4(1) of the named act. This Act constitutes of laws which protect from unlawful discrimination, coercion and stigmatisation; allow unrestricted access to protection and prophylaxis; lay down the protocol for HIV Counselling and Testing; ensure confidentiality through the entire process of testing and counselling, give provisions by which sexual partners of people living with HIV/AIDS (PLWHA) may be notified if the person themselves fails to cooperate; and allows unconsented testing of donated blood and blood products. It should be pointed out here that Part 6 of the HIV/AIDS Act of 2011 has been repealed. This part, titled DEALING WITH UNLAWFUL ACTS, may have been (rightly so) repealed due to overly broad criminalisation of HIVNET. However, since this area is no longer governed by the HIV/AIDS Act of 2011 and should a need arise to prosecute any individual for accusations of HIVNET, other more stringent laws may be utilised, such as the Crimes Act of 2009. CR 383 of the Crimes Act states that, "A person commits a summary offence if he or she unlawfully or negligently does any act which is, and which he or she knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life." This as well may be argued in court since HIV with treatment is no longer a disease dangerous to life. Therefore, the laws governing intentional and negligent transmission of HIV need to be specific and free from ambiguity.

**Position of the UNAIDS on this matter:** In 2013 the UNAIDS published a document titled "Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations. In order to prevent, treat, and care for HIV patients, this document calls on states to: (i) focus their efforts on increasing the use of effective, evidence-based, and rights-based public health approaches; and (ii) restrict the use of criminal law to cases that are truly blameworthy and where it is

necessary to achieve justice. States should improve HIV education programs that teach individuals how to prevent HIV infection and how to avoid spreading it, as well as assist individuals in obtaining the resources and services necessary for HIV prevention, treatment, care, and support. Further, according to the 2008 Policy Brief on the Criminalization of HIV Transmission published by UNAIDS and the United Nations Development Programme (UNDP): Restricting the application of criminal law to instances of intentional transmission (i.e., where a person knows his or her HIV-positive status, acts with the intention to transmit HIV, and does in fact transmit it) can help address some of the concerns raised by the overly broad criminalization of HIV non-disclosure, exposure, and transmission.

**Security versus Liberty:** Issues with Criminalization of HIVNET: The issue with criminalising HIV non-disclosure and exposure is that not every sexual act performed by a person living with HIV will spread the infection to their sexual partner. Even though there is a risk of transmission with every sexual encounter, there are now ways to mitigate these risks and bring them to close to zero. Correct and consistent use of male condoms and compliance to anti-retroviral therapy bring HIV transmission risk down to 1-2 in a 100 and less than 1 in 100,000, respectively. One study proved that with a viral load less than 200 copies per mL, transmission is no longer possible even without a condom, which are the same odds as being struck by lightning! With this data, is it fair for the person living with HIV who is compliant to ART and has an undetectable viral load to disclose their status at the risk of discrimination, stigmatisation and alienation? As per the UNAIDS, non-disclosure and exposure should not be criminalised if the act in question did not cause transmission of HIV and if the person living with HIV took necessary precautions to prevent transmission.

**Specific Criminalisation of Intentional Transmission:** In situations when a person living with HIV, knowing their status, the mode of transmission and the outcomes of untreated HIV, deliberately acts in a manner that can and does transmit HIV to another person, criminal law SHOULD be used. The defence of not knowing that unprotected sexual intercourse spreads the infection should not stand as pre-test counselling does include this information. The provision to penalise such an act may be found in the Crimes Act of 2009. The problems, however, are firstly proving that such an 'act' has occurred and second proving intent. It comes down to the word of the complainant against that of the defendant. The act of transmission (sexual intercourse), even though HIV status is undisclosed, is usually consensual and there is no medical or forensic evidence that may link the accused to the act conclusively. To contrast, in in-

stances of rape, sufficient forensic, medical and genetic information is available to the court following proper police investigation. To add insult to injury, a potential case of deliberate transmission of HIV may only arise months to years after the inoculation of the virus. When it comes to intent to cause transmission, proof is almost impossible to find and therefore the question arises whether intent should be considered immaterial in cases of accused deliberate transmission, just as consent is considered immaterial when it comes to sexual crimes against children/young persons.

**Religious Misguidance:** All practitioners have at some point in their career come across a patient or relative of a patient who is overly religious; even to the point that they refuse essential lifesaving treatment despite being given all the necessary evidence. Religious freedom is a fundamental right but so is the right to health and to access essential medical care. When it comes to saving lives, should misguiding leaders face trial for deterring and endangering the lives of the people concerned? What can be done if the reason for someone diagnosed with HIV not taking ART is a promise of divine healing? This is a very precarious topic to start discussing as it incites different emotions for different people. Also, the effects of getting religious leaders to court may be profound and may even risk civil unrest given how religiously invested our nation is. Therefore, a case-based approach would be more advantageous than a blanket law.

**Public Health Action:** A lot of work has been done to spread awareness about HIV in Fiji over the past decade, yet the number of people living with HIV has doubled since 2010.

Where are our public health efforts failing? Are we being reactive for a disease that warrants proactive mitigation? Should our efforts be directed towards removing the age-old social taboo of sexual education? Is being a conservative society a valid excuse for not engaging with our children in discussions which will make them more responsible adults? Is Fiji enroute to becoming another small nation like Eswatini and Lesotho where HIV is rampant? Will we wait to find out or act in anticipation?

**Mandatory Comprehensive Sexuality Education in Schools:** the WHO implies commencement of CSE as early as five years of age. Of course, this education will be centred around learning about their bodies, recognising sexually offensive behaviour and expressing clearly their emotions. As children grow, they internalise many questions about their changing bodies which need to be addressed before they start alternate means of getting information, including asking peers who are just as confused as them. Knowledge

about sexual intercourse, sexually transmitted disease, contraception and pregnancy may be reserved for the fifteen- to eighteen-year-old age groups. This may prove to be our best chance of controlling the HIV incidence rates as the adults of the generations to come will be equipped to make informed choices about their sexual health.

**Recommendations:**

1. Formation of a Standing Committee which will be mandated to meet and renew the laws governing HIVNET at regular intervals and on a need basis; and propose changes to legislations based on the most recent data and science on HIV/AIDS.
2. The HIV/AIDS Act of 2011 needs to be reviewed specifically looking at the repealed part 6 section 40 titled Deliberate or attempted infection.
3. It should be considered a negligent act by law, if a person living with HIV has not taken the necessary precaution to prevent transmission at any particular sexual encounter, including but not limited to; using a condom with disclosure of their HIV status and taking antiretroviral therapy regardless of viral load.
4. The Court should be able to order any individual accused of deliberate HIV Transmission to be tested for the virus, which may already be the case.
5. Religious organisations should join in the fight to make the society more receptive to sexuality education and more conducive to public health efforts to curb HIV incidence.
6. Make Comprehensive Sexuality Education mandatory in all public and private schools. An informed society is a responsible society. The Ministry of Health or anybody chosen by the WHO should take up the task of designing an inclusive CSE program.

Entry to a higher education institution should also be dependent on the successful completion of this program. It's a shame that a young adult who has just finished high school knows more about how a plant reproduces than how he/she does! The entire education system should be reviewed, but that's a discussion for another time.

**Conclusions:**

The judicial system is not perfect and, realistically, will never be perfect. However, that should not deter policy makers from doing their due diligence in making laws which encompass the entirety of HIV; including sex education, human rights of persons living with HIV, strengthening legislations for the protection of (both) persons living with HIV and those that are not. Making legislations on HIV transmission will only curb the deliberate transmission of HIV but will not help in controlling the HIV epidemic. An educated population who are well aware of the risks of unprotected sex, including pregnancy and sexually transmitted disease (and the extent and severity of their complications) will make informed choices about their sexual health. As recommended by the WHO, Comprehensive Sexual Education should be a lifelong process and not a crash course at the end of a child's school years. It must include, recognising threats, learning about one's body, expressing emotions efficiently, learning about pregnancy and contraception, sexually transmitted diseases and also must allow them to clear any doubts they have. Information and education will determine whether Fiji becomes a nation of progress or one burdened by HIV.

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# Cognitive Assessment: A Retrospective Clinical Case Study

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**Key words:** cognitive assessment, cognition, Mini-ACE, ACE, Dementia

## Abstract

This case presents a classical presentation of cognitive impairment. A course of medications, counselling, and supportive measures resulted in appropriate clinical and personal and social outcomes. Resuming work is part of cognitive behaviour therapy. Cognitive assessment as in this case was important not only for diagnosis and reassessing management plans, but also to assess patient's ability to consent and resume work. If there is marked cognitive impairment and the patient is deemed unfit to consent, an Existing Power of Attorney (EPOA) is activated and collateral consent form next of kin is obtained to release medical information to GP and HR.

## INTRODUCTION

### Case Presentation:

Mr AE, 29-year-old IT/M, presented to SMCL with complain of not going to work for 6 weeks.

Collateral history from the wife revealed that patient was loud and talking to self and just did not feel like going to work.

Patient had a similar episode in 2021 with associated history of twitching of neck. He did not seek medical attention then and opted for spiritual healing. The patient did not have any pre-existing medical conditions and was previously well.

There is no significant family history of mental disorders.

Patient lives with his wife, 2 children and mother-in-law. He commenced work as a laundry assistant in a resort one year ago. And he has been smoking 3-4 joints of marijuana per day for the last 10 years. Additionally, he had a BSP loan of \$3000 and overdue payments in courts for which a bailiff was notified.

On initial visit to the clinic, patient was uncooperative. Patient was referred to specialist psychiatrist hospital in Suva with the help of police escort. Patient was admitted in Saint Giles hospital for 2 weeks and discharged.

On his second review at the clinic examination revealed a fit- looking young man. Vital signs were normal. (T- afebrile; Pulse - 68bpm, regular; BP- 124/70mmhg; SpO2 - 98% RA; RR - 20; CBG- 5.0). Head, eyes, ears, nose and throat examination was normal. Chest examination was normal. Abdomen and cranial nerve examination was normal. Mental status

examination (1) revealed normal physical appearance and behaviour with no tics and good eye contact. His attitude was cooperative. His speech was average and well-articulated. His mood appeared normal with logical and meaningful thought process and normal thought content with no suicidal or homicidal thoughts and no phobias, obsessions or compulsions. His perception was normal. And cognition was assessed using Mini- ACE and was 29/30. Patient had good insight and judgement.

Investigations were done to rule out any organic causes of delirium. No abnormality was detected on laboratory and radiological investigations.

The patient was diagnosed with substance induced psychosis with a differential of schizophrenia.

### Management and Outcome:

Patient was referred to Saint Giles Hospital for specialist psychiatric assessment. He was diagnosed with Substance Induced Psychosis with differential diagnosis of Schizophrenia and admitted to the men's psychiatric ward. The patient undertook a course of Benhexol 2mg once a day and Haloperidol 5mg once a day for two weeks. Additionally, counselling was provided concerning drug induced psychosis.

Based on the patient's progress during the two weeks of inpatient management, he was discharged from Saint Giles Hospital and referred to his General Practitioner for review and ongoing management.

Upon review after a month of initial presentation, patient requested to resume work as this would improve his mental health. Human resources required a fitness for work assessment from the general practitioner. A repeat mental status evaluation was carried out with a repeat cognitive assessment. Urine tests for full drug panel was also repeated on review.

### Discussion:

Cognition refers to the mental process of acquiring knowledge and understanding. These cognitive processes include attention, thinking, memory, judging and problem-solving. Higher level functions encompassing language, perception, imagination and planning. Cognitive processes affect every aspect of our lives, from studying to working to living. (2)

### Causes of Cognitive Impairment

Causes of cognitive impairment can be outlined using the mnemonic DELIRIUMS. (3)

1. Drugs: AOD, benzos, narcotics, SSRI, anticholinergics, Digoxin, antihistamines, muscle/bladder relaxants, toxins and heavy metals.

2. Environmental factors: hypothermia, hyperthermia, hearing aids, eyeglasses, contact lenses
3. Lack of oxygen (Hypoxia): MI, PE, anaemia, or high PCO<sub>2</sub> states e.g. COPD.
4. Infection: sepsis, encephalitis, meningitis, syphilis, pneumonia, UTI, skin ulcers, shock
5. Retention of urine or stool (constipation)
6. Intracranial abnormality: Seizure, Stroke, TIA, ICH, embolus, SOL (space occupying lesion), TBI (Traumatic brain injury).
7. Underhydration/undernutrition: Dehydration/poor oral intake/NPO
8. Metabolic and endocrine: Hypoglycaemia, hyperglycaemia, HHS (hyperglycaemic hyperosmolar state), DKA (diabetic ketoacidosis), thyroid disorders, electrolyte abnormality and impaired renal function: Na<sup>+</sup>, K<sup>+</sup>, Ca<sup>+</sup>, Mg<sup>++</sup>, BUN/Cr.
9. Sleep disturbances in anxiety and depression
10. Vascular causes: heart failure, renal failure, liver failure
11. Age

#### **Medico- legal considerations:**

Cognitive assessment is critical to assess for patient's ability to consent and for fitness to work. Patient consent is required to release information to third party, GP (psychiatrist to GP) and HR (GP to HR). Fiji's Mental Health Decree 2010 (3,4,5) and Constitution of the Republic of Fiji (Section 11.3) was also closely considered in this case.

#### **Cognitive Assessment Tools:**

Some of the tools used for cognitive assessment are:

1. Mini ACE (Addenbrooke's Cognitive Examination)
2. MOCA (Montreal Cognitive Assessment)
3. ACE - III Addenbrooke's Cognitive Assessment III - Full assessment

Mini-Addenbrooke's Cognitive Examination (Mini-ACE or M-ACE) is the recommended cognitive assessment screening tool in New Zealand. The New Zealand version of the Mini-ACE is a shorter version of the New Zealand version of the ACE-III. The Mini-ACE is a brief cognitive screening test that evaluates four main cognitive areas (orientation, memory, language, and visuospatial function). The Mini-ACE is specially recommended screening tool for use by primary care. It has replaced the Montreal Cognitive Assessment (MoCA©) and was chosen for three main reasons. Firstly, it takes around five minutes to complete. Secondly, it is straight forward and easy to use. Finally, it is free and uses familiar testing techniques. (4)

The first cognitive component assessed is attention. Orientation is scored from 0 to 4. Ask the patient for day, date, month and year and score 1 point each for one correct answer. An error of 2 days is allowed for

the date (e.g., 24th when the actual date is the 26th).

The second cognitive aspect assessed is memory. Here anterograde memory is being assessed and scored from 0 to 7. Instruct the participant: "I'm going to give you a name and address and I'd like you to repeat the name and address after me. So, you have a chance to learn, we'll be doing that 3 times. I'll ask you the name and address later." Only the response from the third trial is scored. NZ has 3 versions of Mini- ACE. Versions A, B & C have different addresses. In Fiji, we can improvise using a local address which is easier to recall by local patients.

The third cognitive assessment on Mini- ACE is verbal fluency. This is scored from 0 to 7. The patient is asked to name as many animals as possible. The total number of animals the patient names in one minute is recorded. This includes insects, humans, prehistoric, extinct and mythical creatures (e.g., unicorn).

The fourth aspect of cognitive assessment is visuospatial abilities. This includes clock drawing and is scored from 0 to 5. The patient is asked to draw a clock face with numbers on it. Once finished, patient is asked to put the hands at "ten past five". A maximum of 1 point is awarded for a reasonable circle. 2 points is awarded if all numbers are evenly distributed within the circle. 2 points are awarded if the length of both hands is correct and are placed on the correct numbers.

The final aspect is memory recall. This is scored from 0 to 7. The patient is asked to recall the name and address that he was asked to repeat in the beginning. Scoring is done out of 7 by giving 1 point for each item recalled.

The total Mini-ACE score is 30. Higher scores indicate better cognitive functioning. There are 2 cut-offs: 25 and 21. 21 is used with patients as part of a dementia assessment.

*Disclaimer: Patient consent was obtained for the case study.*

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Abridged Reference.

1. Farrell, 2023
2. Te whatu Ora, 2023
3. Farrell, 2023
4. New Zealand Dementia Foundation, 2023
5. New Zealand Dementia Foundation, 2023

| <b>MINI - ADDENBROOKE'S COGNITIVE EXAMINATION<br/>New Zealand Version A (2020)</b>   |                       |                       |  |               |  |
|--|-----------------------|-----------------------|--|---------------|--|
| Name: _____<br>Date of Birth: _____<br>Hospital No. or Address: _____<br>Age at leaving full-time education: _____<br>Occupation: _____<br>Handedness: _____   |                       |                       | Date of Testing: ___ / ___ / ___<br>Time of testing: _____<br>Tester's name: _____<br>Designation: _____ |               |  |
| <b>ATTENTION</b>   |                       |                       |  |               |  |
| ➤ Ask: What is the   | Day<br>_____          | Date<br>_____         | Month<br>_____   | Year<br>_____ | <b>Attention</b><br>[Score 0 – 4]<br><input style="width: 40px; height: 20px;" type="text"/> |
| <b>MEMORY</b>  |                       |                       |  |               |  |
| ➤ Tell: "I'm going to give you a name and address and I'd like you to repeat the name and address after me. So you have a chance to learn, we'll be doing that 3 times. I'll ask you the name and address later."<br><br>Score only the third trial. |                       |                       |  |               | <b>Memory</b><br>[Score 0 – 7]<br><input style="width: 40px; height: 20px;" type="text"/>    |
|  | 1 <sup>st</sup> Trial | 2 <sup>nd</sup> Trial | 3 <sup>rd</sup> Trial  |               |  |
| Ram Prasad<br><br>3 kaudamu<br><br>Kinoya<br><br>Nasinu  | _____                 | _____                 | _____  |               |  |
|  | _____                 | _____                 | _____  |               |  |
|  | _____                 | _____                 | _____  |               |  |
|  | _____                 | _____                 | _____  |               |  |
| <b>FLUENCY - ANIMALS</b>   |                       |                       |  |               |  |
| ➤ <b>Animals</b><br>Say: "Now can you name as many animals as possible. You have one minute. Go ahead."  |                       |                       |  |               | <b>Fluency</b><br>[Score 0 – 7]<br><input style="width: 40px; height: 20px;" type="text"/>   |
|  |                       |                       |  | 22            | 7  |
|  |                       |                       |  | 17-21         | 6  |
|  |                       |                       |  | 14-16         | 5  |
|  |                       |                       |  | 11-13         | 4  |
|  |                       |                       |  | 8-10          | 3  |
|  |                       |                       |  | 7-8           | 2  |
|  |                       |                       |  | 5-6           | 1  |
|  |                       |                       |  | <5            | 0  |
|  |                       |                       |  | total         | correct  |
|  |                       |                       |  |               |  |

FIGURE 1b. MINI ACE PAGE 2



Name: \_\_\_\_\_ Date of Testing: \_\_\_ / \_\_\_ / \_\_\_  
 Date of birth: \_\_\_\_\_

**CLOCK DRAWING**

*[For the clock drawing, present the form to the person (patient) as is (i.e. upside down).  
 Cover up the name/address in the Memory recall section so that it cannot be seen.]*

➤ Clock: Ask the subject to draw a clock face with the hands at ten past five. (For scoring see instruction guide: circle = 1, numbers = 2, hands = 2 if all correct).

**Visuospatial**  
[Score 0 – 5]

**MEMORY RECALL**

➤ Cover the address below and ask "Now tell me what you remember about that name and address we were repeating at the beginning."

|   |                                  |  |
|---|----------------------------------|--|
| Harry Barnes<br><br>73 Church Street<br><br>Woodville<br><br>Hawkes Bay | .....<br>.....<br>.....<br>..... | <b>Memory</b><br>[Score 0 – 7]<br><input type="text"/> |
|---|----------------------------------|--|

**TOTAL SCORE** \_\_\_\_\_ / 30

# The Evolving Inter-Generational Health Trends of the Fijian Girmitya progeny

Author: Dr. Neil Sharma

## Abstract

In the Gimit era (1879-1920), Fiji recorded the highest incidence of girmitya deaths of all the British sugar colonies (1). Underpinned possibly, with malnutrition, Communicable Diseases (CD), was the leading cause. Non-Communicable Disease (NCD) ranked lowly on the cause of death certification.

Post Gimit (1921), credible data analysis only became available from the 1960's. This dataset demonstrates the insidious increase of NCD related morbidity and mortality into the 1980's (2). The last two decades of the 20th Century, data analysis demonstrates a massive increase in Diabetes, and Cardiovascular Disease. In the 1st two decades of the 21st Century we face an explosion of NCD related premature deaths (3).

On current "projectional trajectories" medical research forecast a future where a wider range of NCD complications eventuate. This is compounded by the health impacts of climate change, increasingly frequent and forceful adverse weather events and pandemics (4). An existential threat exists in the Pacific Small Island States (PSIDS) and Fiji specifically. Associated climate related changes and extreme weather disasters complicate the lifestyles of the already medically compromised Fijian Girmitya progeny. Improving health literacy strategies, addressing the commercial determinants of health and rebranding lifestyle modifications may hold the important keys to reversing increasing premature morbidity and mortality.

## Introduction

With the abolition of Slavery (1833), global demand for human labour escalated sharply, especially within the expanding British Empire. The unprecedented waves of migration of over 1.3 million Indian workers under the British Empire saw the arrival of 60,965 indentured laborers (girmitya) to the Fijian shore under the authority of Colonial Governors, starting with Arthur Gordon and continuing until 1920 (1,5,6).

This paper provides a narrative of the evolving intergenerational health trends of the Girmitya based on available data and review of scientific literature. Second, the paper reviews the current WHO projections in drawing up a forward strategy to contain the NCD crisis. Third, targeting the three areas of Health Literacy, Policy Review on Commercial Determinants of NCD and rebranding Behavioral Modifications are the "low hanging fruit" to easily arrest the upward spiraling NCD Crisis.

## The Gimit Era (1879-1920)

Of the approximately 61,000 brought to Fiji, around

8,500 or 14%, perished from a variety of causes within the areas of acquired medical conditions, suicide, homicide and accidents (1,4,5). Most deaths were recorded early in their stay in Fiji. Fiji recorded the highest incidence of girmitya death within all British colonies (1,5).

A literature search on "Girmityas' health" was undertaken in 2017 at the National Archives, Fiji. Late Professor Brij Lal's data on health issues during the indentured period in Fiji was reviewed. Comparative data from the colonial secretary's reports over the gimit era from published and unpublished sources were assessed for comparison. A "Fresh Eyes" approach with respect to the original morbidity/mortality dataset in light of modern medical diagnosis was then undertaken (7).

The analysis of the rations and caloric requirements for heavy tasking work were undertaken to determine whether inadequate calories provided led to a stage of chronic malnutrition using the Harris-Benedict Equation. This entailed having to calculate the daily minimum caloric requirements for indentured workers for the type of work they were required to do using newer scientific methodology. This demonstrated that there was at least a 24% shortfall in the caloric requirements for adult male workers in the indenture ration packs. Workers were provided these packs for 6 months on starting the indenture period.

The shortfall, together with lack of any provision of reasonable protein sources, are compelling factors in causing malnutrition. Given the massive shortfall in the minimum dietary requirements for the type of work being done on plantations, it is proposed that malnutrition on the plantations during indenture was a chronic factor(6). Further the Girmityas' Health Review, 2017 analyzed the original morbidity/mortality dataset in light of modern medical diagnosis and gaps highlighted.

It is proposed that the causes of death listed in the official reports could not have been determined with any scientific levels of confidence. There is no documentation or record on the factors which the officials used, viz a viz a checklist, to identify the cause of death of a girmitya (7). Finally, the 2017 study proposed that chronic malnutrition in indentured workers could have been the underlying cause of most of the deaths, which were erroneously listed in official reports as resulting from a number of other causes (5). Compounded with other variables like poor sanitation, parasitic exposure, hard tasking labour, physical and mental torture, chronic malnutrition on Fijian plantations underpinned and consequently contributed to the highest morbidity and mortality rates within all of the Britain's sugar colonies (5,7).

### **The Post-Girmit Era (1921-1960)**

The Secretary of Health's Annual Reports remains of variable and limited scientific value in colonial times (4). Only in the 1960's credible, comprehensive and formal medical research commenced. An insidious and gradual increasing number of NCD from the hospital reports were noted. (2,3) Drs. Sutton, Parshu Ram, Cassidy, Bakani and Salik Govind undertook pioneering work in data collection, analysis, reporting and publication in the medical literature. Their efforts resulted in health service reviews but marred with slow administrative policy directives within the healthcare system over the subsequent forty years (1960-2000).

### **The Evolving Pattern of Disease (1960-1980)**

A steady increase of NCD's in the community was statistically noted. Diabetes mellitus and cardiovascular diseases being the focus of studies (3,4). The patterns of diabetic presentations were quite different in the two ethnic communities although the disease centered around the 40-year age group, interestingly 40 years after the end of indenture era. In the girmitiya progeny the classical presentation was followed by diabetic screening and diabetic sepsis undertaken, to reach a diagnosis. The "itaukei" (indigenous) community presented with diabetic sepsis as the lead symptom, followed by screening and classical symptoms of diabetes in the 3rd position. Type-one diabetes, coma and renal complications were rarely noted in the initial dataset. Gestational diabetes was rare (3%).

Ground breaking studies in the incidence of diabetic complications by Dr. Cassidy had taken place in 1964-65 noting the multi-organ impacts. Only 10% of diabetes was a stand-alone diagnosis. Other target organs for diabetes at that stage included cardiac, ocular and kidneys, in that order in the girmitiya progeny. The Dr. Bakani 1964 study on the rising incidence of cardiac disease was the catalyst in the establishment of a two-bed coronary care unit at CWM hospital, Suva (8). The clinical load at the clinics were mounting and reflected in the hospital statistics with limited comprehensive workforce capabilities. Diabetes mellitus was red flagged in 1971 by the lead physicians at the three divisional hospitals.

On the recommendation of the World Health Organization (WHO) in 1980, initiatives to establish a custom-built national body to address NCD was proposed (9). After much sustained effort, The National Diabetic Foundations was established in 1984. Local protocols were developed following Australian institutional exposure provided to a doctor, two nurses and a dietitian. Professor Zimmet who had undertaken extensive epidemiological studies on NCD in 1980 in Sigatoka, Suva and the Lau group of islands was very supportive to this initiative. On the persistent efforts of Chief Clinician Dr. Parshu Ram, his professional colleagues from abroad and the local private sector saw the Foundation establish a strong foothold. These efforts were endorsed by the late Ratu KKT Mara, Prime Minister of Fiji (9).

### **The NCD Epidemic (1980-2000)**

Two decades of the twentieth century 1980-2000 demonstrates the cataclysmic increase in both the incidence and prevalence of diabetes and cardiovascular NCD. Dr. Salik Govind reviewed the increasing incidence of cardiac diseases as co-morbidity to diabetes mellitus in the 1983-86 period, within the evolving clinical scenario. The increasing clinical workload, influx of inpatient care, increasing morbidity and mortality were of great concern to the leaders in the medical community.

Although the indigenous population had a much lower incidence of NCD-Diabetes mellitus previously, the incidence rapidly caught up and started presenting with NCD complications inclusive of cardiac presentations. The political events of 1987 (Coup d' Etat) affected service delivery with a 33% loss of manpower in the doctor's cadre and the whole NCD effort took a steep slippery slide to the end of the 20th century (8).

### **The Tsunami of NCD (2001-2022)**

The first two decades of the 21st century demonstrates a tsunamic rise in both incidence and prevalence of NCD in both the ethnic communities, no longer exclusive in the girmitiya progeny. No longer a disease of the fourth decade of life, the evolving disease patterns and presentations continued to occur as individuals in their 20-30's became symptomatic or suffered cardiac shock, rhythm disturbances and premature death. Presentations earlier in the second and third decades of life especially in the girmitiya progeny with worsening co-morbidities and mortality was noted (3,8).

### **Projectional Forecasts (2020-2050)**

On current projectional trajectories medical research forecast a problematic future where a wider range of NCD complications eventuate. Apart from stand-alone diabetes mellitus (10%) and cardiovascular diseases, the compounding complications by co-morbidities, cancers and mental health components continue to unmask insidiously. If meaningful early interventions to this NCD crisis are not mobilized early, the girmitiya progeny face an existential dilemma. The health impacts of climate change, extreme weather events and forecasted future pandemics will impact strongly on an NCD compromised girmitiya progeny and that of his itaukei brethren.

The trifecta of Health Literacy, Policy Review on Commercial Determinants of NCD and rebranding Behavioral Modification can become the practical foundation, in arresting the spiraling NCD Crisis.

#### **1. Health Literacy**

General Literacy is classified as basic, functional and creative. Strangely, Fiji claims a general literacy of 99% based on four years of unsupervised attendance in primary school, without any caveats within its variable educational environment. Unfortunately, basic numeracy and literacy does not provide abilities

to process practical health literacy. Consequently, the gap between comprehension and application of knowledge to health issues remain wide and deep (10,11).

The Health ministry's Wellness Promotion unit and the Education ministry must reconcile this literacy gap and act, at all levels in the school system and in community educational programs. The onus remains to align the education system and health's wellness policy directed programs (11). The absence of such alignment worsens health inequities in the communities. The need for such issues has been repeatedly spelt out and evident in even the more recent 2015 Yanuca Declaration voiced by Pacific leaders (12,13). The target is to enhance true functional health literacy.

Reflections on addressing health literacy remains at the heart of health promotion in the 21st century. Raising health literacy to address the worsening global health inequities remains urgent work in progress. Multisectoral approaches to identify the social determinants of health (SDoH) inclusive of commercial health determinants (CDoH) which reduce health inequities is not unscalable.

Currently the mis-match between comprehension level of health promotional material and instructional methods are set much higher to our populations general functional state of literacy. Innovative reorientation of healthcare policy and program delivery using the top-down and down-up approaches can address the current health promotion gaps. A new NCD policy direction needs to be considered, with focused programs which are monitored and evaluated, real-time to enhance health literacy (13,14).

## **2. Policy Review on Commercial Determinants of NCD**

Commercial Determinants of Health (CDoH) is a new field of study and classification, within Social Determinants of Health (SDoH) covering three salient areas. First relates to unhealthy commodities that contribute to ill-health. Second, they include business, market and political practices that are harmful to health and are used to sell these commodities by securing a favorable policy environment. Finally, the inclusion of the global drivers of ill-health, such as market-driven economies and globalization, that have facilitated the use of such harmful practices (16,17).

There are four major areas of health interest in the CDoH. The consumption of Tobacco, Alcohol, ultra-processed Fast-Food and the Sweetened Sugary Beverages (SSB) industries; transnationally visible who contribute to significant NCD related ill-health. The impact is much more evident in the low resourced developing countries and more so in the Pacific Small Island States (18). Fiji is not an exception and our girmitya progeny along with the indigenous population, no longer an exception due to the evolved lifestyle and subject to premature onset NCD risk.

Following a 2009 Food and Agriculture Organization

(FAO) Vanuatu Summit, Fiji's Health Team decided to commence national level consultations with all parties dealing with Food, Drinks Alcohol, Tobacco industries. This initiative was supported by United Nations organizations, Bilateral partners and Civil Society organizations, in a wide and open arena. Areas of public awareness, Industry policy changes, government regulation, grading of food outlets, product reformulation, enforcement and taxation were tabled for discussed.

Great strides were made in policy drafting, law changes with increased taxation, new regulations, annual licensing and fees restructuring for stakeholders followed. Enforcement within the tobacco industry eventuated successfully. However, the SSB industry working outside the gambit of the larger group, sought political leverage for self-regulation to a limited number of like-minded transnational and national corporations. British Health Forum study (2018), specifically published a review on Fiji's failed Self-Regulation Limitations (18)

More recently the Lancet in April of 2023 has projected the future role of the commercial sector in global health and health equity (19). The discussion is not about the overthrow of capitalism nor a full-throated embrace of corporate partnerships. No single solution can eradicate the harms from the commercial determinants of health-the business models, practices, and products of market actors that damage health equity and human and planetary health and wellbeing. Evidence shows that progressive economic models, international frameworks, government regulation, compliance mechanisms for commercial entities, regenerative business types and models that incorporate health, social, and environmental goals, and strategic civil society mobilization together offer possibilities of systemic, transformative change, reduce those harms arising from commercial forces, and foster human and planetary wellbeing (19).

Despite WHO having initiated a new programme of action, the Economic and Commercial Determinants of Health, with four goals: to strengthen the evidence base; develop tools and capacity to address the commercial determinants; convene partnerships and dialogue; and raise awareness and advocacy help is not being sought by Pacific Small Island States (17).

Within the Fijian jurisdiction the Wellness Policy has been in the draft stage for the last eight years. Dysfunctional policy development with the current program deficiencies and non-existing enforcement strategies are producing no programmatic gains. This remains a politically motivated strategy as State Capture stalls implementation of a forward plan. The SSB and the Fast food Industries are still the elephants in the room and continue to economically benefit whilst the health inequities reach a crisis tipping point (20).

## **3. Behavioral Modification**

The UN endorsed "Best Buy's Strategy" of 2010, is in fact still a comprehensive targeted approach in addressing the NCD crisis globally. However cultural,

traditional and country specific initiatives need to be factored in any rebranding exercise. Fiji's draft Wellness Policy is an example when the lead organization has absolved itself of any responsibilities. Fiscal support is absent and monitoring & evaluation surely belong to the policy makers and program directors. The draft has not been endorsed in the last eight years and lacks direction. A major refocus is needed if the NCD crisis is to be gated.

As 80% of deaths are related to NCD currently it remains mandatory to prioritize Policy direction to addressing improving strategies to raise Health Literacy in schools, communities and nationally with awareness, legal input into laws, regulations and the enforcement of legislations. A major review of the social determinants, especially the Commercial Determinants of health needs to be addressed. Sandwiched between improving Health Literacy effort and Commercial Determinants of Health, one has Modification/ Rebranding the Best Buy's strategies to contain NCD crisis. This remains an inter-generational health issue of global concern if society fails to make this effort.

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#### Conclusion

The inter-generational health trends of the Fijian Girmitya and their progeny demonstrates the evolution of morbidity and mortality from communicable disease to non-communicable diseases over the last 144 years. Each decade has unfolded the evolution of a complicated mix of disease patterns with a problematic incidence and prevalence. The inter-twinning of disease patterns with the itaukei / indigenous is no coincidence but very much related to commonalities in lifestyle risk we carry in a post-colonial nation.

The future projectional forecasts remain a stern warning to consider immediate remodeling of strategies in health literacy on one hand and managing commercial determinants of health on the other. Behavior modifications once restructured and enforced will be the crowning center piece.

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# General Practice's Memory Line with Dr. Ram Raju (Part 1-4)

## Part 1

### Preamble

GP or what was commonly ka Private Doctors or Private Practitioners (PP) dates back to the early Colonial History, soon after deed of cession in 1874

Doctors recruited by the Colonial Administration were allowed to make extra money privately

FSM graduates were once considered in the 1920's and 30's to likewise earn an extra shillings or pounds but this was declined or deemed unwise

It was not until the 1970's when submissions were made to the Ministry of Health by Fiji Medical Association (FMA) to allow FSM graduates into private practice (PP). Under the leadership or presidency of Dr Kanhaiya Lal Simdari (better ka Ken Lal), a bill was passed in Parliament clearing a pathway for FSM graduates to become a GP if they wished, after serving 5 yrs in govt.

Prior to this only non FSM graduates were allowed PP and they were all obviously graduated overseas namely India, Australia or New Zealand. After completing their internships majority set up private clinics in almost all the urban centres in Fiji

Two interesting articles have been published in the College Journal by two early pioneers of GP - Dr Cecily Hands of Sigatoka and Dr Paul Hemming of Bayly Clinic Suva.

## Part 2

### My early days and WPMPA

I resigned from the civil service after 7 yrs of working in various centres in Fiji. Upon internship in 1977, I was posted to Lomawai Health Centre in 1978 taking over from Dr Vakacegu who was a retired government doctor

In 1979 I was lured into Radiology by a friend of mine Dr Satend Nandan (formerly of Tavua) who was a senior Radiology Registrar at CWMH. Satend was diagnosed with brain cancer and didn't have long to live and told me to come over to take up his position and a chance to go overseas soon for further training. He was a good friend of my eldest brother when they studied together at Shri Vivekananda College in Nadi

I was newly married (Dec 1978) and moved to Suva in Jan 1979 renting a flat not far from CWMH

In 1981 I was awarded a WHO scholarship in Radiology at the Royal Melbourne Hospital for 6 months. It was an intensive training course in General Radiology, rotation in all the disciplines namely Intervention, Renal, GIT, CVS, Spinal, Neurology and the Limbs

Melbourne University was the back drop for all academic sessions in Anatomy, Physiology and Physics (Radiation etc)

There were weekly clinical sessions in Radiology,

Surgery and Medicine that I often attended.

Ultrasound was just introduced in 1981 which was housed in Radiology Dept and training had just started for Radio-Sonographers

I returned to CWMH armed with a good deal of knowledge and experience and I was awarded a Certificate in General Radiology by the Australian College of Radiologists

In 1982 I was transferred to Lautoka Hospital Radiology Dept as a senior medical officer where I worked until late 1983 alongside Dr Jagdishwar Raj

Radiology didn't quite appealed to me as a discipline, much as I tried to accept and progress further. I loved working more as a clinician and every Saturday and sometimes Sundays helped out in the GOPD, both at CWMH and Lautoka Hospital. The Medical officer in charge of GOPD as well as the medical superintendents accepted an extra hand and voluntary services

And just before my resignation from Lautoka Hospital, I was given an opportunity, upon a special request, to rotate in all the disciplines at Lautoka Hospital that included Paediatrics, Obs/Gyne, Medicine and Surgery. Orthopedics and A&E were not established at that time of my resignation in late 1983

I wanted to set up my practice in my home town of Sigatoka and to be closer to my parents and other family members in Nasau, Valley Road. It was a grand home coming to a place I loved and craved so much. Our ancestral home was next to Sigatoka River and when I was a young toddler admired the river swell during hurricanes and cyclones. In fact found it exciting even more when the rivers would flood our farmlands and roads meaning no schools for several days !!

In early 1984 I finally set up a practice in Naibale, Korolevu but maintained my Sigatoka Town Practice during the day from 8am to 3pm

I would come back to Korolevu by 4pm to hold clinics at Hyatt Regency (now Warwick Fiji Resort) from 4-4.30pm and later at Naviti Resort for ½ an hour. I would be free by 5 or 5.30pm to join soccer training with staff from Hyatt and Naviti Resort. There was a ground near Naviti Resort that was maintained by Naviti which still exists today next to the main highway

I represented Nadroga Soccer team for several years (1984-1986) but at that time ka Sigatoka Soccer Association. I also played for Nadroga in 1978 when I was posted at Lomawai Health Centre

And one of the reasons for me to take up Radiology in those early days at CWMH and Lautoka Hospital was this very reason, to play soccer and hockey. There were no after hrs call !!

I represented FSM for 4 years in both soccer and hockey as a medical student. Saturdays Hockey at Albert Park in those days and Soccer on Sundays. FSM was in the senior division of Suva Soccer Association and a well respected team in Suva Hockey Association

FSM provided buses to take players from Tamavua campus and Hoodless House down to Albert Park on both days and brought us back just before evening dinner. It was a wonderful service provided by FSM in those days which existed for donkeys of years

Coming back to my private practice and in late 1986, I moved to Nadi when Dr Munswamy Naidu was selling his practice together with his house in Sagayam Rd

Leaving for Nadi was a very difficult decision, emotionally, as my parents and other family members didn't want me to leave Sigatoka. Living in Naibale wasn't easy as there was no electricity nor tapped water. I relied on rain water for drinking and cooking and a hilly damn water for washing purposes. A small diesel generator gave some comfort for 3-4 hrs at night

Despite the drawbacks I enjoyed staying with the community at Naibale and made everlasting friends. Naibale was the backdrop of a true community medicine and from here I started the crusade for the formation of a National Body and subsequently FCGP

I was into "politics" from a young age. I became active with FSM Student's Association. One of the first issues raised by me was \$2.00 a fortnight allowance paid to us as students that was deemed too little. We agitated and won an increase to \$4.00 per fortnight!!

This gave us more money for beers !!. A carton of beer at that time (long necks only) cost us \$8.00 and if 4 of us got together, a handsome meal used to be ordered at new Peking Restaurant that was most popular restaurant at that time (and few to choose from). New Peking is still there in Victoria Parade, not far from popular nightclubs of that time (and still is)

In 1973 I headed the FSM Food Committee for a year and brought about changes desired by the students. Fish and Chips and other delicacies soon added to the menu

I went to the Principal Dr Bhupendra Pathik with the request for changes and quite surprisingly he agreed to the list of changes to the menu, saying to me "the brain will function well once the stomach is satisfied and you need to have the brain functioning well to pass exams"

In 1975 I lost the election for Presidency of FSMSA to Latu Sisifa, a Tongan medical student who was together with me in my class. I believe he migrated to Australia as a Gynecologist in later life. My class was one of the smallest graduating class of 1976, only 7 with 2 sitting supplementary examinations. The following graduated successfully: Bhagat Ram (deceased), Shama Raj, Kamla Samujh (married and settled in Seattle, USA), Nisha Hanif (somewhere in

Sydney), Shamsheer Ali (Surgeon Port Pirie, Australia). Dr Semesa Matanaicake (deceased) and Kumar P Singh (Pathologist, Syd) were the 2 who sat supplementary examinations and graduated later

Dr Guy Hawley Senior was the Principal of FSM when I enrolled and about 3 years later, Dr Bupendra Pathik took over the leadership.

I did my internship at Lautoka Hospital including final year medical student attachment for 3 months. I loved Lautoka as I studied at Natabua High School for 4 yrs (stayed in the hostel) and Lautoka became my favorite soccer team. And I returned to Lautoka Hospital as a Senior Radiology Registrar in 1982 and worked alongside Dr Jagdishwar Raj and Om Prakash Trehon who was about to return to India

As a member of FMA, I was quite active in helping organize seminars etc. There was a bit of political turmoil at FSM when Dr Bhupendra Pathik was being removed as the head to be replaced by an expatriate by the name of Prof Harry Lander from Adelaide Uni

I was requested by FMA secretary at that time Dr Karam Singh to lobby support from FMA members in the west in the form of a petition calling for his reinstatement as the Principal of FSM. I could see the injustice so had no hesitation in collecting signatures from doctors based in Sigatoka to Rakiraki Hospital. I did this exercise during my off duty hrs but the news got to headquarters for an investigation on my role

A meeting was called in the conference room with all the consultants and MS Dr Peni Rika presided over the meeting. I was asked to explain which I did quite confidently as I believed Pathik was denied the justice he deserved. Peni Rika concluded the meeting by requesting me to steer away from politics accepting my explanation

Dr Deo Dutt Sharma was the president of FMA at that time and soon we heard the news about rotten eggs splashed on Harry Lander's head in the FT headlines news !!

### **Part 3**

#### **Coming back to WPMA and FCGP**

Based in Korolevu and Sigatoka, I was devoid of contacts with colleagues and CME programs that I missed dearly. I never missed any of the clinical sessions at Lautoka or CWMH. I started the first ever conference for the radiographers when I was in Suva when I returned from Melbourne in 1981 and continued pushing for Radiographers seminars thereafter

Private Medical Practitioners Ass (PMPA) was formed in Suva sometimes in 1980/81 and I got interested in their seminar that was held in Holiday Inn (it was Travelodge at that time) in 1984.

PMPA was formed largely for the GP's in the Central Division and one of the first items on their agenda was to implement a uniform fee schedule. Dr Surend Singh was the first president and Robin Mitchell as the

first secretary. The group of GP's met on a monthly basis at Club Fiji

PMPA could be regarded as the first association of GP's in Fiji and some of the founding members were

1. Surend Singh
2. Meena Singh
3. Isoa Bakani
4. Robin Mitchell
5. Rosemary Mitchell
6. Naqasima
7. Konrote
8. Mahendra Hazratwallah
9. Panna Hazratwallah
10. Prakash Mehta
11. Ram Krishna Reddy
12. Murari Lal
13. Dr Vijendra
14. Prem Mani Rati Ram

#### Part 4

When I attended their seminar at the Travelodge, I planned to become a member as I was eligible and the name was PMPA, but I was encouraged instead to form a similar organisation in the Western Division and then perhaps plan for a National Body of GP's. And somehow I got a copy of their constitution (that was only a couple of pages) which allowed me to push ahead to formally launch a similar association in the West

Armed with a small manual typewriter (non electric), I started to write letters to ALL the GP's in the Western Division, from Rakiraki to Sigatoka. I started calling all the GP's as well and finally we had our first inaugural meeting in Lautoka. That was in 1985 and gave birth to Western Private Medical Practitioners Ass. (WPMPA)

Dr Subarmani Govendar of Lautoka was the first president and myself as the secretary. The first task was similar to PMPA group, setting up a uniform fee schedule and organizing seminars. The consultation charges at that time varied from \$1.00 to \$3.00 and we all decided to raise it to \$5.00. However due to differences in socio-economic status of each district this figure could not be imposed by all the members in the West

As we progressed though, the minimum consultation charges was gradually raised and this time each district agreed to have uniform charges, rather than a set figure uniformly applied to all.

Fiji Medical Association Western Branch (FMAW) was quite active at that time that was led by late Dr Peni Rika as the President and late Dr Raghwa Narayan as the Secretary/Treasurer. Their prime focus was CME and organizing seminars, nothing else

We were warmly accepted by FMAW and allowed us to have our ECM at every mini seminar that was invariably jointly organized, 2-3 times/year. Some notable seminars were held at Wananavu Resort,

Naviti Resort, Rakiraki Hotel, Fijian Hotel, Seashell Cove, Lautoka Hotel, Waterfront Hotel and numerous other places including Lautoka Hospital

WPMPA was soon established with a membership of about 27 members and yearly subs of 25.00.

The founding members were:

1. Nar Deo Sharma, Raki Raki
2. Vimal Sharma, Tavua
3. Balwant Singh Rakka, Ba
4. Jayant Patel, Ba
5. Mrs Nima Patel, Ba
6. Amrit Gohil, Ba
7. Satish Awadh, Ba
8. Rajendra Bali, Ba
9. Subarmani Govendar, Ltk
10. Sefanaia Tabua, Ltk
11. Isac Karim, Ltk
12. Rajend Sharma, Ltk
13. Yenkat Raju, Ltk
14. Vijay Kapadia, Ltk
15. Brij Jamnadas, Ltk
16. Isimeli Waqabaca, Ophthalmologist, Ltk
17. Davend Nandan, Nadi
18. Saras Nadndan, Nadi
19. Arthur Dass, Namaka
20. Guna Gounder, Nadi
21. Vrajlal Raniga, Nadi
22. Munsamy Naidu, Nadi
23. Avinash Naidu, Sigatoka
24. Cecily Hands, Stk
25. Arjun Singh, Stk
26. Ram Raju, Stk
27. Mahendar Singh, Stk

As the secretary/treasurer of WPMPA I kept the pressure for a national body. PMPA were duly informed of the progress as well as the GP's in Labasa and Dr Joeli Taoi in Savusavu

The progress was promising. I moved to Nadi in late 1986 which allowed me better access to talk to and engage with members. Letters, phone calls and faxes were often the means of communication apart from meetings at seminars

Mini seminars were conjointly organized with FMA Western Branch which was the most active chapter in Fiji. At every mini seminar executives of WPMPA met to discuss the progress of the College

We were on the threshold of calling for a national meeting when the darkest chapter in our political history struck us. 14th May 1987 dealt a severe blow which derailed all our efforts. It was now a game of survival of the fittest and the strongest !. Doves of professionals left the country which included quite a good number of GP's. The future appeared bleak and uncertain. Businesses collapsed and there was hardly any business or economic activities. Tourism collapsed and all overseas missions advised their countries against travelling to Fiji

I had acquired the property and clinic of Dr Munsami



Naidu with a big and entire loan from Westpac for which I couldn't meet the repayments. The bank allowed me repayment holiday for up to 6 months but unfortunately the interest on loan kept accumulating.

Frantic efforts were pursued on the political front with overseas friendly nations like NZ, Australia, USA urging dialogue and discussions which led to the Deuba accord to restore democracy, normalcy and a care taker govt led by Ratu Mara. But Rabuka had other ideas and executed the 2nd coup 4 months later (25th Sept 1987) which added further woes

Dr Ponnu Gounder who was the Medical Superintendent of Lautoka Hospital at the time of the 1st coup (and Consultant Pathologist) was unceremoniously forced to resign. Late Dr Benjamin Lomaloma was installed as the MS who was also another staunch Rabuka man

Ben was quite a remarkable doctor who was TB control officer in the Western Division, always sported a handkerchief around the back of his neck to absorb sweat. That was a unique trademark of Ben

Dr Ponnu Gounder decided to enter General Practice and soon joined Bayly Clinic with Dr Davendra Nandan. Ponnu defied all odds, as a Pathologist, and became

a successful GP in a very short time. As a Pathologist he started the first ever private lab services in the western division, providing a wide range of services

A number of GP's from the west closed their businesses and left for Australia namely Satish Awadh from Ba, Vimal Sharma from Tavua, Guna Gounder from Nadi, Sarat Naidu from Nadi Hospital and Wahid Khan from Tavua Hospital. They all left to take up courses in Alternative Medicine like Acupuncture and Homeopathy, courses offered by a clever agent who promised citizenship as well which never materialized. To make ends meet some of them became seasonal workers picking up potatoes, fruits etc

They all returned to Fiji eventually and relocated their practices

There was a similar exodus of GP's from Central Division as well as a few from Labasa but none of them returned to Fiji

We lost the urge or interest to meet for CME programs. Eventually as normalcy dawned upon us we once again combined with FMA Western (Peni Rika and Raghwa Narayan were still holding fort)

*Part 5-6 in Next issue.*

## ABSTRACTS

1. British Journal of General Practice:  
Analysis: Integrating public health and primary care: the response of six Asia-Pacific countries to the COVID-19 pandemic British Journal of General Practice, July 2021 Pg. 326-9

2. WPSAR Vol 13, No 4, 2022:  
Descriptive analysis of deaths associated with COVID-19 in Fiji, 15 April to 14 November 2021 WPSAR Vol 13, No 4, 2022 | doi: 10.5365 wpsar.2022.13.4.964.

### 3. WHO publication:

Towards better engagement of the private sector in health service delivery: a review of approaches to private sector engagement in Africa. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

#### Executive summary

Over the last five years most African countries have integrated Universal Health Coverage (UHC) as a goal in their national health strategies. Yet, challenges still exist to progress in translating this commitment into equitable and quality health services, and to increase financial protection. To attain health-related goals and particularly UHC, the 2030 Sustainable Development Goals (SDGs), emphasize the need to strengthen partnership between government, civil society and businesses (1). To reach the agenda's objectives, governments need to find ways to effectively harness the public and private sectors (2). As also outlined in the WHO's Thirteenth General Programme of Work (GPW13), the response to social, environmental and economic determinants of health requires multisectoral approaches anchored in a human rights perspective (3). To this aim, it is crucial for governments to strengthen their governance approaches. This includes stronger accountability for health and well-being by all sectors and partners in the health system. The African Union (AU)'s "Addis Ababa Commitment toward Shared Responsibility and Global Solidarity for Increased Health Financing Declaration" (4) - also known as the ALM Declaration - has been a crucial step towards this direction. It seeks to galvanise greater cooperation between the public and private sectors for delivering sustainable, effective, efficient and equitable health for all, and to safeguard health security.

To effectively engage the private sector in health, countries necessitate greater understanding of the contribution of the private sector to healthcare. This has been spurred by limitations of not having a strategy or the corresponding resources necessary for effectively engaging with the private sector in

health. While previous work to engage the private sector in health has largely been vertically driven, often focused on specific diseases or conditions, a health systems response is needed. This needs to be led by government as part of its stewardship role and cannot be delegated to partners. This ambition aligns with the recently launched World Health Organisation (WHO) strategy, "Engaging the private health service delivery sector through governance in mixed health systems." (5) The strategy redresses a critical health system governance gap for the effective engagement of the private sector in health in the context of UHC.

The WHO's Health Systems Governance Unit together with the WHO region for Africa and the WHO region for the Eastern Mediterranean undertook a joint landscaping to better understand current approaches to engage with the private sector in health, and governance of the private sector in health. The study reinforced the awareness on the growth in the scope and role of the private sector in health service delivery in Africa. The COVID-19 pandemic has notably served to reinforce the need to engage with the private sector in health in the continent and have exposed the limitations of not having a strategy or the corresponding resources, the "skill and will" necessary to effectively work with the private sector in health.

There is a need for a shift of mindsets to see the private sector as a co-investor and thought partner in the public health systems. This mindset shift is needed at different levels of the health system and along the healthcare value chain. While traditionally the private sector has been viewed as a source of financing to be tapped, governments should reorient their outlook to one of knowledge exchange and co-creation with the private sector as a means of unlocking innovation, building stronger African health systems and delivering health for all.

### 4. IDS Working Paper: Institute of Development Studies Working Paper Series:

"Nobody should talk about it": Fijian health system resilience and the COVID-19 pandemic Sharon McLennan, Apisalome Movono & Johanna Thomas Maude ISSN 1179-2973

### 5. www.thelancet.com Vol 37 August, 2023 9:

A single dose of quadrivalent HPV vaccine is highly effective

Against HPV genotypes 16 and 18 detection in young pregnant women eight years following vaccination: a retrospective cohort study in Fiji Supplementary data related to this article can be found at <https://doi.org/10.1016/j.lanwpc.2023.100798>.

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