



# *The Pharmatimes*

*MAKANS*

*A Journal for Doctors in Hospital, General Practice and Allied Professionals*

July - September 2020

VOL: 19 / NO: 2



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Greetings: A belated happy Easter, Eid, Holi et Raksha bhandan.

2020 argues in catastrophic times for humanity. Aptly named the

Corona Virus (SARS-CORVID-19) reminds medical historians of the impact humankind has had on his environment and its other living beings. The fragile medical systems globally will fault and morbidity-mortality become closer allies. Pandemics do this every so often in history.

With the shifting epicenter to Europe, America, India and now the Southern Hemispheres impending cooler months again will mean public health havoc in the Southern Continents. Interesting, the question that COV19 was manufactured in the helms of Military Science seems doubtful as the bell-shaped timeline distribution of 12weeks is reassuring in China. Not dissimilar to the distribution of other six (6) influenza viruses. However, its virulence makes one wonder of its air borne abilities rather than a contact based zoonotic exposure, now in humans.

As public health advocates, private medical practitioners need to brace up, adding advocacy, containment and treatment to the mild-moderate cases. The severe ones will probably not make it in our fragile healthcare systems chronic pharmaceutical shortages, bed blocks, bed shortages and intensive care most problematic, without technology with human resource limitations, without adequate personal, protective equipment (PPE). I leave the socio-economic depression for our politicians and economic pundits as food for thought.

The national appropriation bill endorsement gives you time to ponder on things big and small.

This volume also carries another Fijian policy gap analysis on “Disability”. How, this is being addressed in our communities, in the wider Pacific needs greater input by health and social welfare advocates. We are in the midst of a public health crisis and must think widely. What needs to follow is your ethical and professional vision on the disabled in our midst. Your letters to the Editor will add value. What are you, additionally undertaking for your disabled clients/patients, in your settings? Please put pen to paper, for publication. This issue reminds us of the importance of “self-care” in these unprecedented times. A personal thank you to Dr Joe Koroivueta for his support in research and publication.

We print the study on Ischaemic Heart Disease in Fiji. Annual Conference:2020 is not on the agenda this year: The college has undertaken its first online survey: Mental Health and Wellbeing Study of Fijian GP's, with reports and interventions to follow after this study.

Jesus arose from death in 3days and his spirit lives on and so will we, after this COV19 crisis. God Bless.

NEIL SHARMA

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## **Fijian Disability Gaps: An Independent Gap Analysis (2019)**

Fiji's Disability Policy 2008 – 2018 defines disability as:

***“People with disabilities are persons with long term physical, mental, learning, intellectual and sensory impairments and whose participation in everyday life as well as enjoyment of human rights are limited, due to socio-economic, environmental and attitudinal barriers.”***

The United Nations Convention on the Rights of Persons with Disability (UNCPRD), The 2014 Fijian Constitution and the National Council of Disabled Persons (FNCDF) Act 1994 are the three

seminal documents governing the Fijian Disability legal framework.

Recently, the FNCDF Act of December 1994 was repealed and the Rights of Persons with Disability Act 2018 endorsed and assented by the President of Fiji (16/03/2018).

This independent analysis of the Disability Policy 2008 – 2018 aims to highlight gaps in strategic healthcare delivery under the previous Act 1994 and aims to provide alignment to the new Rights of Persons with Disability Act 2018 under its twelve pillars. With enhanced scope for closer evidence-based monitoring / evaluation within the National Strategy and the Regional Biwako Millennium framework for Asia – Pacific and United Nations Convention reporting schedules.

### **Epidemiological Background:**

The 2017 Population Census provides minimal data on disabilities in Fiji without the necessary desegregation of the population. No analysis on incidence, prevalence, life span trends are forthcoming consequentially. The Census reports as follows:

Functioning Challenge (Disability). A total of 113,595 persons aged 3 and above were reported to have at least one functioning challenge. The number equates to a rate

of 13.7% which is close to the International benchmark of 15%.”

In the absence of any recent disabilities surveys the need for a formal review of 2008-2018 policy direction under the new act of 2018 is mandatory. The new act needs traction, alignment and refocus based on real time, current evidence. A baseline disability survey conducted by the FNCDF (September 2010) on disabled women is now outdated and overdue. Such a survey needs to include a wider assessment of all disabilities.

### **Importance:**

The National Council of Disability Act 1994 repeal and replacement at the end of its 10-year annual tenure with the Rights of the Persons with disability ACT 2018 is timeliest. The current Act 2018 reaffirms the establishment and continuation of the National Council for Persons with Disabilities. The objectives and function well aligned to United Nation's Convention on the Rights of Persons with Disability but lack timelines for proactivity: action spanning prevention to rehabilitation of disability. By way of example, **PART (2) 5 (1) b** refers to the formulation of a national policy, action plans with a reporting timeline due in September 2018. An extension to reporting to the Minister in question was granted and no such report has been tabled apart from a ministerial statement in Parliament that the new act was in place and progress with developing a strategic plan will take place shortly.

**Part (2) 5(h)** targets review of the National Policy and plan of action yet review of two of the FNCDF annual report (2016) and subsequent draft annual report 2017-2018 remain rather wanting of statistics, cursory and of substandard reporting capability. No reference to the incidence, prevalence, chronologic lifespan trends in National disabilities is demonstrated. No reference to the Population Census 2017 is available in the 2017 – 2018 Draft, nor in either of the three-year reports: 2016 – 2018.

### **Policy Review:**

The 2008 – 2018 Disability Policy needs an urgent retrospective review and a fresh set of evidence-based de-

cisions made, based on real-time monitoring and evaluation of disability plans and programs with raw data, already collated at grass root divisional level, aligning that with the new act No. 4 of 2018. In the absence of inability to review the previous performances, based on the superfluous annual reports a return to the national drawing board is essential. The new act must be nurtured with respect, especially with proactive time lining as it has a shorter half-life and annual reports. Due to its shorter life no mid-term review, independent or otherwise is now possible. The new 2018 Act stipulates the need to formulate a 5-year Strategic plan.

- Further-more a strategic plan or a revision was to be submitted to the responsible minister within six (6) months (by Sept 2018) after the commencement of that Act. The National Council is falling behind on this already and sought an extension.
- An annual review of the Strategic plan was also ratified under the Act, 17(1) b and approved and is shortly due March 2019.

## The 12 Strategic Pillars:

The 12 Strategic Policy Areas of the 2018 Act carry forward the 1994 ACT alignment. These twelve pillars require an all of governmental multi-sectoral and multi-level approach to completely address disability in Fiji. Pillars 1,2,3,4,8 and 12 have a distinct health focus and will be center of focus for this independent disability policy gap analysis and review.

### Pillar 1: Advocacy, Awareness, Empowerment and STATISTICS

#### Objectives:

*Strengthen and empower organizations of people with disabilities (DPOs) to advocate for and create greater awareness of disability issues at the national, district and community levels.*

- **The 1996 Census** had minimal data collection

and analysis for persons with disability. It had a rather timid non-representative pilot survey in Macuata province as a means to provide an index for the whole of Fiji.

- **Population Census 2017.** A public document of monumental importance in national planning for the first time issued only segregated data, failing to address the ethnicity and culturally sensitive data in the various provinces and districts. Desegregated data was absent; hence population sensitive information is totally eclipsed. Contrary to noncompliance to International Private, Public Partnership (PPP) and World Health Organization (WHO) analytical requirements and reporting, the Fiji government has created a major stumbling block to aid support, planning and program delivery.
- **Age,** incidence, prevalence data, trends, types of disabilities are not evaluated in the population dataset. Programs, outcomes, monitoring, evaluation will remain problematic for STATE et International Partnership Funding Support.

## Recommendation:

1. In the absence of adequate Statistical data advocacy, awareness and empowerment remain problematic and almost impossible to address. All programs become empirical. An urgent solution must be forthcoming otherwise the drifting continues.
2. Focusing on the absence of Statistics in the Population Census data an urgent **SWOT** or other relevant analysis, is in order to obtain an improved perspective of the geographic location, incidence, prevalence and grassroots needs in the communities must be undertaken. Centralization of any divisional or national data readily available would assist to expedite the process further.
3. Future Population Census and other surveys such as Household, Poverty and specific Disability Surveys must have senior personnel from the FNCPD provide a key role in design of questionnaires and meaning-



ful collation of dataset to obtain valuable statistics on the disabled communities. Such key information to the political leadership and the public at large is essential to leave no one behind as an SDG agenda item. Incorporating essential data into annual reports to Minister responsible is also valuable.

## **Pillar 2: Prevention, Early Detection, Identification, Intervention, Rehabilitation and Health:**

### **Objectives:**

- **Develop and strengthen an integrated approach between the FNCDP, Government, NGOs and other stakeholders.**

Early detection and diagnosis of persons with disability are pivotal to address healthcare needs, healthcare interventions and rehabilitation services. Unfortunately, no progressive advancements or developments have been highlighted over the last four-years. Rather, the Fijian government were notified of their stance by the 2015 global UNICEF meeting.

Health is enshrined as a basic human right under **Article 25** of the United Nations Declaration of Human Rights and **Section 38** of the Constitution of the Republic of Fiji 2013. The vision of the Ministry of Health proposes a patient focused health delivery system endorsing the right to health and human dignity.

**Article 23** of the Convention on the Rights of the Child: (Children with Disabilities) “Children who have any kind of disability have the right to special care and support, as well as all the rights in the Convention, so that they can live full and independent lives.”

To date there has been major discussion within the Health Sector Administration and Clinical services and appropriate liaison with the Ministry of Social Welfare to address the “Challenged Child”, yet there is no sign of progress in sight.

Children born with “high risk- Medical and Social disabilities, need to be followed up by Medical and Social Welfare including Education, to optimize earlier diagnosis with Screening and treatment in a holistic approach.

Preterm, sick neonates, at risk of development delays,

ones at risk with hearing or visual, physical anomalies need to be picked up, tagged early and screened by the Primary Health Teams-Zone and district nurses, Staff at baby clinics, Area medical officers and in early kindergartens by preschool teachers and community health and education personnel. The delay in diagnosis leads to difficulties in mainstreaming these children and loss of equal rights to these children with disabilities.

### **Recommendation:**

This area remains unaddressed up to the current stage despite several attempts at senior health and social welfare level since 2014. Earlier diagnosis of potential disability results in mainlining children and disability is stalled, stalled and reversed in progressing further, where special needs become mandatory. In specific reference to the challenged child the following commentary is essential as part of the recommendations.

1. Upon identification the child is referred to the sub-divisional and pediatricians who conduct sub-divisional visits for clear diagnosis and support organizations: i.e. Early Intervention center, Hilton School for hearing, visual tests.
2. Physiotherapy, auditory, visual tests and the range can extend to Autism and other rehabilitation service providers for earlier diagnosis and interventions.
3. The process and piecemeal work need to be coordinated and brought under a common banner with the State, Community, Public Private Partnerships with Civil Society and International Partners all working towards a state of efficiency so no child is denied the opportunity of quality life in the upcoming Sustainable Development Goal era (SDG: 2015-30).
4. Specifically, there is much scope for Public, Private Partnership (PPP) with service organizations, corporate organizations and the Hilton Special School team who have indicated an interest in this arena. Much dialogue has taken place but the States ministries have not progressed this initiative despite several reminders to the

family unit in Health and to the Permanent Secretary Social Welfare under the pretext that an Inter governmental meeting was to be called late 2014.

5. Internationally and nationally, the political leadership must be harnessed and State machinery greased with Civil society and Donor partner support sought, as we progress in the SDG era (2015-30) so no one is left behind Able and/or Challenged.

## **Pillar 3 & 4:**

### **Pillar 3: Effective Education Services and Programs.**

#### **Objectives:**

**Provide, strengthen, implement and review special and inclusive education services and programs for all children with special needs in schools, homes, communities, and hospitals in accordance with the Constitution.**

### **Pillar 4: Training, Employment and Social Needs**

#### **Objectives:**

**Develop and strengthen skills in people with disabilities to enable higher levels of participation in the workforce and other livelihood opportunities.**

#### **Recommendations:**

1. Interlinking health with education: specific training of special education teachers, community health workers and public health nurses will play a major role in early detection, follow-up and referral to specialist pediatric staff. Additionally, preschool and kindergarten teachers likewise need special training to identify children that require early screening and diagnosis services.

2. Improving populations health literacy must also be addressed and corrected as there is abundant health literature in the community yet the ability of our people to understand health risk is very low. Our four (4) years of primary schooling, without any examination, is utilized as the benchmark of our high national literacy ranking of 99%, is very cruel. Critical analysis of health literature is impossible by our common Fijian. Ministry of Health and

Education need to review national literacy and numeracy abilities to reset the target to where individuals can creatively assess their abilities to apply knowledge to the educational and health needs especially in the ability of disability focus.

3. Increased health and general literacy by disabled individuals and organizations supporting their special need will improve their knowledge-based skills and engagement in employment and the workforce. The State must ensure that representative and proportional employment is reserved for the disabled. That again, begs the question as to the true incidence of disability without meaningful statistics.

### **Pillar 8: Access to Information and Communication Technology**

#### **Objectives:**

**Increasing opportunities for people with disabilities to gain access and have accessibility to information and communications technology.**

#### **Recommendation:**

1. Increasing opportunities to access information and communication for the disabled community. In this liberal, progressive digital era of information and communication technology it is pressing important to provide the essentials to all disabled individuals and their organizations, the essential tools to address their potential into a meaningful lifestyle. Education technology specific in mainlining their potential is the universal goal. In the era of artificial intelligence, robotics and nanotechnology Fiji is being left behind by such global advances. Providing basic educational tools such as computers and internet capabilities can reshape the lives of our disabled children. A high-level white paper needs to be developed to this end soon for necessary commissioning.

#### **2. Technology – Reducing the Disabled gap:**

The extensive discussions with the Government of India and its interested agencies a project Code named “**Disabled to Abled**” has crashed prematurely. Screening of

over 1000 individuals was undertaken, the needs analysis completed. The need for such services was in great need to address quality of life issues. The project proposal has not progressed for intrinsic Donor/ Recipient discord. This proposal was to offer a range of prevention to rehabilitation for our disabled communities. Serious re-evaluation is warranted.

### 3. Communication skills development.

Sign Language has marginally progressed as a means to communication with our Fijian deaf and speech impaired communities. This must be further extending to abled persons too for mutual communication. The true need for Braille for the visually impaired needs evaluation in the not too distant future as new technologies gains momentum.

### Pillar 12: Policy Monitory, Review and Implementation:

**Objectives:** Develop a strategy and process for the regular monitoring of progress and implementation of the national disability policy.

### Recommendation:

1. Based on the current annual reports this objective is poorly met. The absence of statistics, prevalence, incidence, trends in the life course, aging trends are not captured. There is no subgrouping of types of disability to provide a solid foundation for program development. In the absence of evidential data on disabilities there will be uneven claims for financial and other resources towards universal design.
2. The need for a specific **national disability survey** is long overdue.
3. Periodic report timelines need to be addressed to the United Nations, Government and its relevant ministers and their ministries.
4. Population Census is undertaken at ten-year intervals. In the absence of specific disability data consideration to a national disability survey is warranted to provide that evidential support to refocus national strategic intent. There being 35 civil society organizational affiliates to

the disability national committee, it is imperative to fully engage this set of organizations in the screening, awareness, advocacy and services delivery to the disabled communities on a rotational basis, as only 5 are represented on the national council currently.

5. Identification of areas of future needs especially in the earlier diagnosis of disabilities. An aging population with projections of a doubling in the demographics of the over sixties (60) to 14 % by 2025-30 the needs of the population will increase, based on global data and international studies. The urgent need to plan ahead for the disabled elderly needs foresight and policy and program direction.

### Conclusions:

This independent gap analysis of disability in the arena of healthcare with the new act of 2018, aims to add value to the policy direction by state and its national committee, bridging the gap to program delivery and its real time monitoring. It is not the intention to undermine current efforts in place but to rather provide suggestions that may strengthen current policy and systems in place. By drawing attention to detail in improving statistical data collection, addressing the importance of evidential data as information on disabilities. Population census at 10-year intervals with the cursory details on disability delay proactive changes within policy needs and program redirection. Disabilities are causally related to poverty, marginalization and added health costs when unaddressed. The need for a distinct **Disability Survey** cannot be over-emphasized. Earlier diagnosis in children and re-designing current programs and proactive assessment of the aging populations needs are also mandatory to alignment with the health-related SDG goals 2015-30 where we are signatories at state level. "Leaving no-one behind" is the mantra of that ideal.

The Executive summary at the 2008-2018 policy launch still rings true 11 years down the line in 2019. "The National Disability Policy in its totality aims to provide a framework to address the needs and rights of people with disabilities. Give a voice to people with disability, and is based on their needs as outlined. It relies upon an effective working partnership between government, non-governmental organizations, disabled peoples' organizations and the wider community. The implementa-

tion of this policy will bring about the full inclusion of people with disabilities in the day-to-day activities and decision making of communities throughout Fiji.

## Acknowledgement:

### Dr. Josefa Koroivueta:

Permanent Secretary Women, Children and Poverty Alleviation.

### Dr. Sitiveni Yanuyanutawa:

Executive Director, Fiji National Council for Disabled Persons.

For their kind, continued support to undertake this independent Gap Analysis of Fijian disability and their untiring effort in strategic direction and program delivery to date.

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## DO YOU CARE FOR YOURSELF?

Although it's a simple concept in theory, it's something we very often overlook but it is important in life. We may differ in what self-care means. Without self-care, our inherent ability to have a balanced living will fall short. The resilience and delight to cope with work and life will not be achieved.

**What is self-care?** Self-care is any activity that we do deliberately in order to take care of our mental, emotional, spiritual and physical health. Self-care isn't a selfish act either. It is not only about considering our needs; it is rather about knowing what we need to do in order to take care of ourselves, being subsequently, able to take

care of others as well. That is, if I don't take enough care of myself, I won't be in the place to give to my loved ones either.

**The World Health Organization** defines self-care as the ability of individuals, families and communities to promote, maintain health, prevent disease and to cope with illness with or without the support of a health care provider. Self-care encompasses several issues including hygiene, nutrition, lifestyle, environmental and socio economic factors. Promotion of self-care is a means to empower individuals, families and communities for informed health decision-making. It has the potential of improving the efficiency of health systems and contributing towards health equity. In a few words, self-care is the key to living a balanced life:

**Where do you start? Self-care needs to be something you actively plan, rather than something that just happens.** Here is a basic checklist that can be followed by all of us:

- **Diet:** Eat a nutritious, healthy diet based on your level of physical activity.
- **Sleep:** Get enough sleep. Adults usually need 7-8 hours of sleep each night.
- **Exercise.** In contrast to what many people think, exercise is as good for our emotional health as it is for our physical health. It increases serotonin levels, leading to improved mood and energy. In line with the self-care conditions, what's important is that you choose a form of exercise that you like!
- **Medical Care:** Follow-up with medical care. It is not unusual to put off checkups or visits to the doctor.
- Use **relaxation** exercises and/or practice meditation. You can do these exercises at any time of the day.
- **Relationship:** Spend enough time with your loved ones.
- Do at least one **relaxing activity** every day, whether it's taking a walk or spending 30 minutes unwinding.
- Do at least one **pleasurable activity** every day; from going to the cinema, to cooking or meeting with friends.
- **Laugh:** Look for opportunities to laugh!

Add on your own list as you start your selfcare program.

REMEMBER SELF CARE TAKES PRACTICE AND THIS IS FOR YOUR INVESTMENT.



### Ischaemic Heart Disease in Fiji: The emergence, early studies and experiences

This article discusses ischaemic heart disease in Fiji and is largely based on the chapter on Cardiovascular diseases in the Food and Nutrition in Fiji (1), monograph on Cardiovascular Diseases in Fiji, Fiji Medical Journal, Fiji General Practitioner journal, some sections are reproduced and clinical experiences.

#### Summary

Ischemic heart disease (IHD) emerged as the most prevalent, most serious and most rapidly increasing cardiovascular disease in the second half of the twentieth century.

In 1960 the hospital admission rate for ischaemic heart disease (coronary artery disease) was 31 per 100,000 of the population and with an average annual increase of 31%, reached a marked six-fold rise by 1980 and accounting for 40% of all cardiovascular admissions. This resulted in an increase in myocardial infarction and several studies on this topic. These showed that myocardial studies were a disease of adult Indian males. The male to female ratio varied from 4:1 to 12:1. Almost 60% of those affected were in the 40-59 years age group. The case fatality was 16-19% in later studies compared to 23-38% in the earlier studies. Most of the deaths occurred early within 24 hours after hospitalization of cardiac failure, cardiogenic shock and ventricular arrhythmias. The ethnic ratio Indian/Fijians was generally 11:1 but higher ratio was noted in earlier studies. This high ratio was not noted in the studies of sudden and unexpected deaths.

IHD is largely a risk factor dependent condition and these were common in the patients with myocardial infarction and in the community. Also, the prevalence of possible coronary artery disease in the community (assessed from ECG abnormalities using Minnesota criteria or Rose and Blackburn questionnaire) was 4-17%.

Several control and prevention measures were instituted but only a few were sustained. One major development in 1980's was the development of the National Diabetes Centre, which was developed as the National Training, Education, Resource and Research Centre

#### The Development of Ischaemic Heart Disease

"Following the Second World War and the second half of the twentieth century, islands in the Pacific benefitted from the introduction of medical technology, and drugs, such as antibiotics, improvements in environmental and public health and increasing socio-economic developments. These led to the subsequent relative decline in morbidity from acute infections and communicable diseases. The adoption of western lifestyles and concomitant changes in food and dietary patterns appear to be linked with the current increases in non-communicable, nutrition-related diseases of affluent societies like heart diseases, diabetes and cancers" (1,2,3,4,5).

In 1960 cardiovascular diseases accounted for 5% of all hospital admissions in the country (6). This percentage increased to 8% in 1965, 9% in 1971, 10% in 1975 and 15% in 1980, in which year there were 2715 and in 1984, 3807 admissions. This trend was seen in both major ethnic groups.

Overall, there was a 717% increase in hospital admission for all cardiovascular disease, with the greatest increase being in the ischaemic heart disease and cerebrovascular disease during 1960-1984 (7) (Table. I)

**Table I: Hospital admissions due to cardiovascular disease in Fiji 1960 - 1984**

<i>Disease groups</i>	<i>Year</i>					<i>% change between</i>	
	<i>1960</i>	<i>1964</i>	<i>1969</i>	<i>1974</i>	<i>1980</i>	<i>1984</i>	<i>1960-1984</i>
Rheumatic heart disease	129	169	84	116	234	185	43.0
Hypertensive heart disease	157	119	280	512	699	565	260.0
Cerebrovascular disease	53	75	142	289	328	392	640.0
Ischaemic heart disease	127	144	362	617	1454	1305	928.0
All cardiovascular diseases	466	507	868	1534	2715	3807	717.0

A detailed analysis of hospital admission rates 1960 – 1980 are shown in Table II.

The hospital morbidity was 150/100,000 in 1960 and 559 in 1980, an increase of 280% (8). The greatest increase was for ischaemic heart disease (613%) followed by other heart diseases, cerebrovascular and hypertensive heart disease, with virtually no increase for chronic rheumatic heart disease. For the period (1960 - 1980) as a whole, the average annual increase for ischaemic heart disease was 31%, other heart diseases 17%, cerebrovascular disease 15% and for hypertensive heart disease 9%. Most of these increases had occurred since 1969 – 1970.

**Table II: Hospital morbidity due to cardiovascular diseases in Fiji 1960 - 1980**

Year	Population	Hypertensive Heart Disease		Ischaemic Heart Disease		Chronic Rheumatic Heart Disease		Other Heart Diseases		Cerebrovascular Diseases		Total	
		No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
1960	401018	157	39.2	127	31.7	129	32.2	127	31.7	53	13.2	593	149.9
1961	413872	202	48.8	93	22.5	149	36.0	98	23.7	74	17.9	616	148.8
1964	456390	119	26.0	144	31.6	169	37.0	258	56.5	75	16.4	765	167.6
1965	469934	131	27.9	169	36.0	204	43.4	114	24.3	93	19.8	711	151.3
1969	513717	280	54.5	367	71.4	86	16.7	484	94.2	142	27.6	1359	264.5
1970	524457	269	51.3	440	83.9	84	16.1	566	107.9	226	43.1	1585	302.2
1974	563801	512	90.8	617	109.4	104	18.4	562	99.7	289	51.3	2084	369.6
1975	573100	651	113.6	700	122.2	116	20.2	553	96.5	255	44.5	2275	397.0
1979	627256	887	141.4	1620	258.3	190	30.3	841	134.0	344	54.8	3882	618.9
1980	642450	699	108.8	1454	226.3	234	36.4	878	136.7	328	51.1	3593	559.3
Percentage increase between 1960–1980													
		177.6		613.9		13.0		331.2		287.1		280.3	

\* Rate per 100,000

Also, the pattern of cardiovascular diseases as seen in inpatients had changed in the two decades. In 1960 the main groups of cardiovascular diseases were seen with equal frequency, whereas in 1980 40.4% of all cardiovascular admissions were for ischaemic heart disease indicating an absolute increase in the incidence of this disease.

A detailed analysis of the cases of ischaemic heart disease admitted to hospital in terms of age, sex and race-specific rates for 1960-79, showed a slight increase in admission rate in the Fijians and a marked increase in Indians (9) (Fig. I). The admission rate was higher in males than females in 1973 at the beginning of the study and this was maintained throughout the period. As regards age, an upward trend was noted in the age group over 40 years; the increase in the 15-39 years age group was slight.

The relative change in admission rate in each ethnic group, which compares the situation in the beginning of the period (either 1960 or 1973) with that in the following years using the 1960 rate (or 1973 rate) as a baseline, showed a similar increase in rates in both ethnic groups. The relative changes between 1973 and 1979 in admission rates in each age group were also similar.

#### **Acute Myocardial Infarction**

The usual presentation of ischaemic heart disease is chest pain and/or acute myocardial infarction. The first study of acute myocardial infarction was done by Isoa Bakani, in 1964-65 (10). He studied 100 hospital admissions at the CWM Hospital. Of these 97 were Indians and 3 Fijians. Since then a number of studies were done at the three major hospitals and these are summarized in Table III.

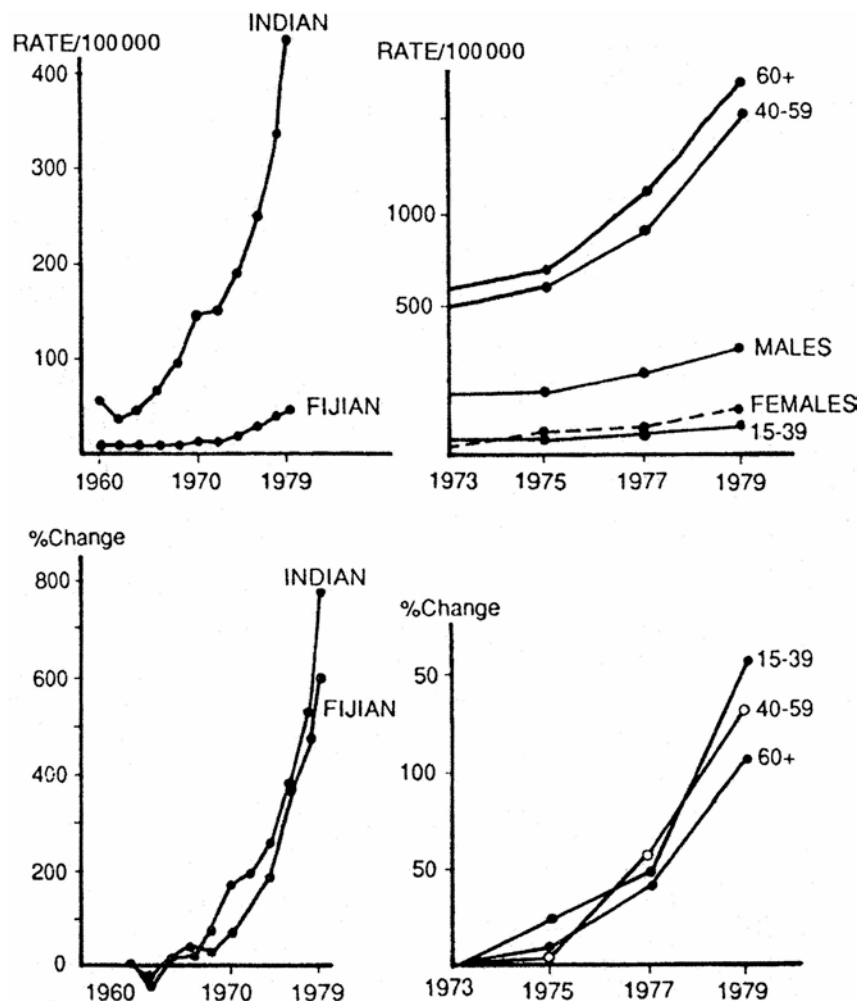


Fig I: Trends in hospital admission rates (per 100,000 population and percentage change) for Ischaemic heart disease in Fiji 1960 – 79 by ethnic group, age and sex (all ethnic groups combined)

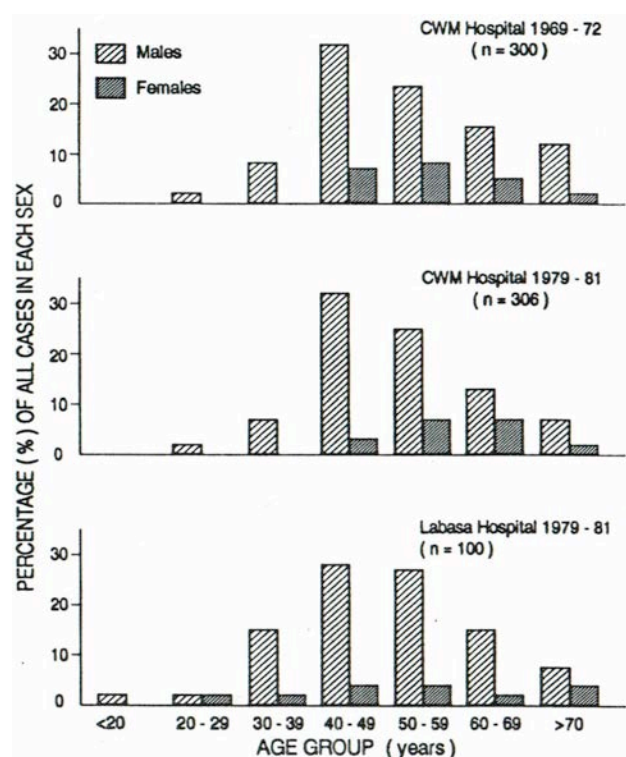


Fig II: Myocardial Infarction: Age and Sex Distribution

The major complications were arrhythmias, cardiac failure and cardiogenic shock. The case fatality in more later studies were 16-19% compared to 24-38% in the earlier studies. There was an increasing case fatality with increasing age.

Most of the deaths occurred early; within an hour to 24 hours after hospitalization. The commonest causes were cardiogenic shock, cardiac failure and ventricular arrhythmia.

The reason for the marked ethnic difference in reported cases of myocardial infarction is unclear. Studies on patients not suffering from symptoms of coronary artery disease showed only small differences between the two ethnic groups (20,21).

**Table III: Myocardial infarction in Fiji 1964-93 – Summary of several studies**

Authors (Year/Place)	Number Studied	Ethnic Groups			Case Fatality
		Indians %	Fijian %	Others %	
BAKANI I. R. (10) (1964-65, SUVA)	100	97	3	0	24
RANDALL G.R. (11) (1968-70, LABASA)	50	94	6	0	38
PATHIK B. RAM P. (12) (1969-71, SUVA)	227	89	5	6	16
SOROKIN M. (13) (1969-71, LAUTOKA)	212	87	5	8	24
PATHIK B. RAM P. (14) (1969-72, SUVA)	300	89	6	5	16
RAM P, NADIU V, NASEROA J. (15) (1979-81, SUVA)	306	90	7	3	17
NAIDU V, NASEROA J, RAM P. (16) (1979-80, SUVA)	28	28	—	—	4
PATEL K. GOKAL, KRISHNA K. E, RAM P. (17) (1981-82, LABASA)	100	93	7	0	19
RAM B, RAM P. (18) (1989-91, SUVA)	342	81	15	4	18
RAM B, RAM P. (19) (1982-93, SUVA)	280	79	16	5	15

These studies showed that acute myocardial infarction was predominately a disease of adult males, especially Indians. The male: female ratio varied from 4:1 to 12:1. The ethnic ratio Indian to Fijian was generally 11:1 although a higher ration was reported in the earlier studies. The age distribution was almost similar in all publications (Fig. II).

### **Sudden Deaths**

IHD may present as a sudden and unexpected death (which is defined as death occurring without warning, whether a person is under treatment for some condition which is not considered serious by his medial attendant, or whether he dies suddenly before witnesses or is found dead). Such deaths are not uncommon in the local community. Autopsy studies on sudden and unexpected deaths at the CWM Hospital for 1960-83 period showed that there were 903 such deaths, of which 863 were available for detail analysis (Table. IV).

These studies (21, 22, 23) also showed that IHD was not rare in Fijians. The ethnic ratio was 2:1 (Indian : Fijian) in 1960-69 period, 1.6:1 in 1970-79 and 1.2:1 for 1979-1983 (Table IV.) The age distribution was similar to acute myocardial infraction (Fig. III)

### **Cardiovascular Risk Factors**

All previous studies on myocardial infarction, clinical practice and 1980 national survey, all showed that cardiovascular risk factors were common.

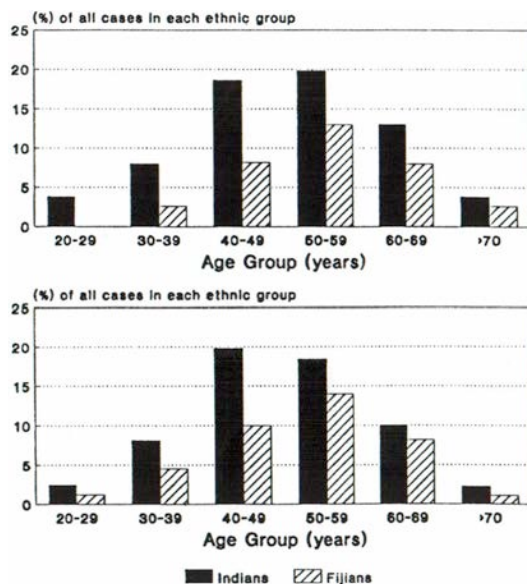
Table V. shows the prevalence of various coronary risk factors in clinical cases of myocardial infarction admitted to hospital in 1969-72 and in 1979-81. Those admitted to the CWM hospital in 1979-81 period had a higher frequency of family history of ischaemic heart disease, hypertension, smoking, diabetes and more sedentary physical activity pattern than those admitted in 1967-72 period. In those above the age of 40 years the major and more frequent risk factors included family history, smoking, raised serum cholesterol and sedentary occupations.

The occurrence of multiple risk factors in patients with myocardial infarction was common. In some studies 50% of all patients with infarction had three or more cardiovascular risk factors. This was equally true for patient below the age of 40 years as well.



Sex	Indian	Fijian	Others	Total (%)
<i>1960-69 period</i>				
Male	112	56	29	197 (87%)
Females	20	4	5	29 (13%)
Total (%)	132 (58%)	60 (27%)	34 (15%)	226 (100%)
<i>1970-79 period</i>				
Male	178	102	37	317 (85%)
Female	26	22	6	54 (15%)
Total (%)	204 (55%)	124 (33%)	43 (12%)	371 (100%)
<i>1979-83 period</i>				
Male	113	93	30	236 (89%)
Females	16	12	2	30 (11%)
Total (%)	129 (49%)	105 (39%)	32 (12%)	266 (100%)

**Table IV: Sudden deaths due to coronary artery disease: sex and ethnic distribution – CWM Hospital 1960 - 1983**



**Fig III: Age distribution of sudden deaths due to coronary artery disease in Fijians and Indians – CWM Hospital 1960 - 1979**

The cardiovascular risk factors were assessed in the 1980 National Diabetes and Cardiovascular Diseases Survey (24). The prevalence of various risk factors were:

Diabetes mellitus 10-11% (1GT 6-11%) (WHO Criteria)

Hypertension 10-11% (SBP  $\geq$  160 and/or DBP  $\geq$  95mm Hg)

Smoking 45% of the population smoked. The prevalence of smoking was higher in Fijians than Indians, in males than females, in rural than urban dwellers and in lower income groups. The prevalence in males was 64% (urban 55% and rural 75%) and in women 28% (urban 22% and rural 35%). The majority smoked on average of less than 20 cigarette/day. It is noted that a local cigarette factory was opened in 1956 and since early 1960's tobacco was grown in two areas in Fiji and was livelihood for 10,000 people.

**Table V: Prevalence of various cardiovascular risk factors in clinical causes of myocardial infarction admitted to hospitals in 1967-72 and 1979-82**

Coronary risk factors	Number of cases in			
	1967-72 (n=300) Suva %	1979-81 (n=306) Suva %	1981-82 (n=100) Labasa %	1979-81 (n=28, < 40 years) Suva %
Family history IHD	7	22	17	39
Hypertension	21	35	22	21
Diabetes mellitus	18	25	19	18
Smoking	56	67	74	86
Serum cholesterol (> 250mg%)	49	36	43	54
Physical Activity				
a) Heavy manual workers	27	10	8	—
b) Light manual workers	13	14	18	—
c) Sedentary workers	27	68	57	46
d) Others	33	8	17	—
Past history of IHD	12	31	26	0

Raised Cholesterol	The male urban Indians had the greatest percentage with elevated cholesterol ( $\geq 270\text{mg}/100\text{ml}$ ) – at least 10% of males in each decade between 35-54 years ago group. Overall, the percentage of people with high plasma cholesterol was lower in females than males and urban males than rural males in both ethnic groups. In another similar study in Nabua and Qamea in 1983 the mean cholesterol and triglyceride level were slightly higher
Obesity	37% (BMI > 27 in males and > 25kg/m <sup>2</sup> in females). It was more in females than males, in Fijians than Indians and in urban than rural dwellers. In males 22% were overweight (Fijians 32% and Indians 12%) and 51% in females (Fijians 64% and Indians 35%)
Physical Activity	In regard to physical activity a higher percentage of urban population were into sedentary and light categories compared to moderate to heavy physical activity status. Males tended to be more physically active than females and Fijian more than Indians

### **Studies in the community**

The prevalence of coronary artery disease was assessed in the 1980 national diabetes and cardiovascular disease survey (25). 391 Indian and 427 Fijian males aged 30-60 years underwent a testing. 12 lead electrocardiographic examination and the electrocardiograms were coded according to the Minnesota criteria. Electrocardiographic abnormalities were grouped into “probable coronary heart disease” (major Q and QS items codes 1.1 and 1.2) and possible coronary heart disease (murmur Q and QS items, ST/T items or LBBB: codes 1.3, 4.1-4, 5.1-3 and 7.1).

For both ethnic groups the most common abnormalities in the “possible coronary heart disease” were T-wave inversions or flattening (codes 5.2 and 5.3). ST-T wave abnormalities were more prevalent in urban than rural areas and amongst Indian than Fijians. Greater percentage of subjects with normal ECG were in rural than urban areas in both ethnic groups and both sexes.

The overall age adjusted prevalence of positive ECG findings was 9.1% in Fijians and 17.1% in Indians. There was a tendency for ECG abnormalities suggesting possible and probable coronary heart disease to increase with age.

**Table VI: Frequency of abnormal ECG findings**

ECG coding	Melanesians (n=427)		Indians (n=391)	
	n	(Rate per thousand)	n	(Rate per thousand)
<b>"Probable CHD"</b>				
1.1 Q-waves	9	(21)	10	(25)
1.2 Q-waves	1	( 2)	3	( 8)
	10	(23)	13	(33)
<b>"Possible CHD"</b>				
1.3 Q-waves	0	( 0)	0	( 0)
4.1 S-T depression	0	( 0)	4	(10)
4.2 S-T depression	0	( 0)	11	(28)
4.3 S-T depression	2	( 5)	1	( 3)
4.4 S-T depression	0	( 0)	0	( 0)
5.1 T inversion	0	( 0)	1	( 3)
5.2 T inversion	13	(30)	20	(50)
5.3 T inversion	23	(54)	36	(92)
7.1 Left bundle branch block	0	( 0)	0	( 0)
	38	(89)	72	(184)
<b>Other Findings</b>				
2.1 - 2.5 QRS axis deviation	22	(52)	28	( 72)
3.1 - 3.3 High amplitude R waves	23	(54)	40	(102)
6.1 - 6.8 A-V conduction defect	2	( 5)	1	( 3)
7.2 - 7.6 Ventricular conduction defect	13	(30)	13	( 33)
8.1 - 8.9 Arrhythmias	19	(44)	23	( 59)
9.1 - 9.8 Miscellaneous	16	(37)	13	( 33)
	95	(222)	118	(302)

In Fijians those with positive ECG findings were more obese had higher blood pressure, plasma uric acid, cholesterol and triglyceride levels. In Indians body mass index, systolic blood pressure, diabetes, urban residence and physical inactivity were associated with ECG abnormalities.

Exercise stress test in 221 males showed that ECG abnormalities were more frequent in Indians than Fijians. There were 11 (11%) positive tests in Indians compared to 4 (3%) in Fijians.

In other study of 600 adults (> 16 years) in Nabua and Qamea in 1983, the prevalence of coronary heart disease was assessed (26). The use of Rose and Blackburn questionnaire showed 24 subjects (9 men and 15 women) who had been told they have had coronary heart disease.

It was concluded that there were 24 known cases of coronary heart disease at the time of survey and a further 47 had symptoms suggestive of the disorder.

## Control and Prevention

### i) Primary Prevention

Primary prevention was offered through clinics and various committees. The management of hypertension and diabetes was through the weekly hypertension and diabetic clinics both started first at the CWM Hospital in 1956 by Dr. C. H. Gurd, the physician specialist.

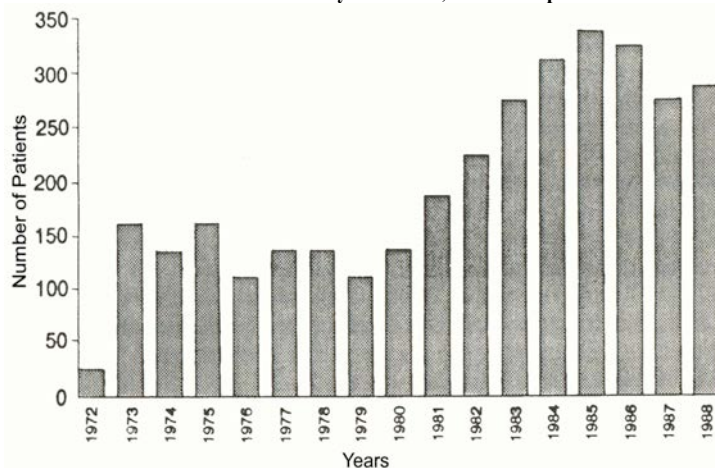
### The National Food and Nutrition Committee

The National Food and Nutrition Committee was established in 1976 in response to the need identified in the Development Plan VII that "Food for adequate nutritional standard must be made in sufficient quantities to every member of the community in order to maintain physical and mental health and to enable people to realize their potential" (27).

The committee had a very wide range of aims to cover all aspects of the nutrition in the country. From 1980 to 1982 the National Food and Nutrition Policy was developed and was adopted by the Government in 1983. In 1987 the Committee produced a well-illustrated 32-page booklet on "Health Guide for Fiji". The booklet contained a wealth of information and advice on healthy living including those important in the prevention of Non-Communicable Diseases such as "Cut down on sugar, Use less salt, Eat less fatty foods, Keep a healthy body weight, Exercise for fitness, Eat more food rich in fiber, Stop smoking and Cut down on alcohol". The booklet also contained a Weight for Height table for desirable body weight for adults.

The Fiji Diabetic Association was formed in 1971 (28). It was very active in educating and increasing awareness in the public and embarked on a nation-wide diabetes detection drive. The activities of the association decreased gradually and ceased completely after ten years.

Fig IV: Patients Admitted to the Coronary Care Unit, CWM Hospital 1972-1988



The Fiji Heart Foundation, established in 1980 (29) was involved in the community awareness and educating about the prevention of heart diseases. After several years it became inactive and virtually ceased to exist.

A similar Heart Foundation was formed in the Western District in 1985-86, it too ceased to exist after 1987.

An Antismoking Program was started in 1986. A committee was formed and supported by the Consumer Council of Fiji. Since early 1987 this program lapsed.

The need for a Non-Communicable Diseases Centre was raised on numerous occasions but no action was taken.

One major development in the 1980's was the establishment of the National Diabetes Centre and was developed as a National Training, Education, Research and Resource Centre for the country.

#### ii) Secondary Prevention

Limited secondary prevention of cardiovascular diseases was through overcrowded hospital and health centre based medical clinics.

A two-bed Coronary Care Unit was opened at the Brown Street end of the Sukuna Ward (Men's Medical Ward), CWM Hospital in 1972 (30). The average annual admission to the CCU increased from 130 in 1972-77 period to 178 for 1978-83 and to 308 in the 1984-88 period (31) (Fig. IV).

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#### Acknowledgements

We are very grateful to Roneel Ram for typing and preparation of this article.

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## Ortho Joke



Your x-ray showed a broken bone, but we fixed it in photoshop.

Sir, please understand, to buy an anti-depressant pill, you need a proper prescription...Simply showing your marriage certificate & wife's picture is not enough...



## Title: COVID 19 – Impacts in a Resource Limited Setting: The South Pacific Small Island States.

**The unprecedented, sudden and devastating global impact on health systems** creates havoc at all 193 world states and within their jurisdictions, despite their different levels of political and health preparedness in service provisions. A rapidly shifting epi-centre questions political wiliness to act early with advocacy, screening and service delivery even in the most developed countries with high Health to GDP ratios. In so much as the epicentric moved within three months from Wuhan, China to Italy, Spain, USA and Brazil. The virulence of this pandemic virus is also in serious question. What catastrophic impacts will result in the Least Developed Countries (LDC) and Low-Middle Level Countries (LMDC), remains to unfold in the southern hemispheres as cooler, winter sets in 2020. South Africa is now in crisis.

All 54 states in Africa remain acutely vulnerable to COVID 19 with shortages of Personnel Protective Equipment (PPE), nursing and medical manpower, ventilatory technology and pharmaceutical and medical-consumable supplies. Africa has the unique service delivery experiences with a wide range of infectious diseases in the recent past (EBOLA), which may assist in some small mitigative manner. Sub-Sahara Africa will not withstand the onslaught of COVID19. Its inability to distance socially, isolate for the mandatory 14 days in urban ghettos will not be possible, where precedence to earning for daily sustenance will outstrip any isolation measure.

The isolated tropical paradise in the South Pacific are no better off and will suffer a major impact without its tourism sector. Without a significant agribusiness or major manufacturing base the dependence on international aid will mount when even developed nations are inward focused themselves. With the ongoing challenges of Climate change and environmental pollution the regional geopolitics looks taxing enough with the “Pacific Reset” and “Vuvale” initiatives being challenges by China’s Road and Belt ambitions taking root, post COVID19. Offers of Chinese Aid assistance have been well received in Africa and the pacific will do likewise with USA” ambience and current health crisis introspection.

### **What human health impacts to social distancing, isolation and lockdowns create in our mind remains yet to unfold.**

The immediate physical, emotional, spiritual and mental impacts of these measures short and long-term need attention. For a healthy mind frame, one needs to focus on physicality in these unusual times, under strange isolated settings. The release of endorphins, enkephalin, serotonin and other neurotransmitters elevate our brains positive functions. Negativities lead one into grief, anxiety, depression self-harm and can lead to domestic violence, as being globally reported. The female gender is notably in the frontline of COVID 19 healthcare management as doctors, nurses, allied health workers and public health experts. The rural women in Africa, India and the vulnerable Pacific face domestic violence when the male partner is not employed, unable to sustainably provide food security and becomes the punching bag of frustration, if she raises her concern. The Fiji statistics on domestic violence demonstrates a six fold increase in the last 3 months in the lockdown period.

Self-harm is already being reported in parts of the globe and counselling very much in need to address the new -normal of distancing, isolation and inability to sustain oneself, families and communities. How we come together as a humanity will matter in this 21st century. Will we revert to the greed and self-centeredness or will human kind change?

The duration of this crisis remains undetermined. Will the Virus evolve like SARS next season and take another potshot at humanity needs consideration? Unemployment and redundancies with Distancing and isolation will invariably lead to increased poverty and impact on food security, child health and education. How will states handle this scenario? Unfortunately, a complex issue to be factored in as the health components are resolved marginally before greater credence is shared elsewhere focusing on the socioeconomic fronts.

Possible benefits of COVID19 need to be considered. A phoenix may arise out of the ashes of “self-centeredness” of the old 20th Century order. How societal values evolve will need the historian’s lens. Now is the hour to decide after all the deaths, joblessness, societal strife, increasing poverty are balanced with the potential gains after recession and possibly a major global economic depression sets in. A new 21st century world order will birth after much laboring pain.

**The economics of national lockdowns in the South Pacific** where isolated states exist, with limited resources need to awaken serious economic strategic thinking by narrow focused politicians, civil society leaders in governance and pragmatic economists. Exotic tourism, some limited commercial fisheries and agribusiness being the mainstay of livelihood, one wonders how communities will survive. These are serious matters to pontificate whilst the equation is compounded by the unabated impacts of climate change and environment pollution. The COVID19 now gels in another important variable in the quest for human survival. Will the “Lockdowns” will give nature recovery time to the devastations of climate change and environmental pollution?

**A new world order** will arise from the ashes of this Pandemic. Much mortality and morbidity are obvious. Much grief and mental health anguish will transpire. Socioeconomic issues can lead to starvation, poverty and social strife inclusive of civil unrest, crime and domestic violence. With China’s recovery, it is demonstrating diligence in its offer of aid and assistance to the rest of the world unlike the USA’s introspection in handling its health calamity.

In the south pacific region pragmatic leadership, governance, networking and global partnerships integrating with in-country groups of NGOs, CSO’s with community engagement and ownership can bring focused global attention. Recession and possible global depression are anticipated if we do not act sufficiently with haste.

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**Meanwhile in Lahore, a terrorist blows up his own house, after the Pakistan Government issued a work from home advisory for its citizens**





