Article Feature:

- Communicable & Neglected Diseases - The Narrative
- The 1875 Measles Epidemic in Fiji
- Leprosy, Colonization and the Makogai Solution

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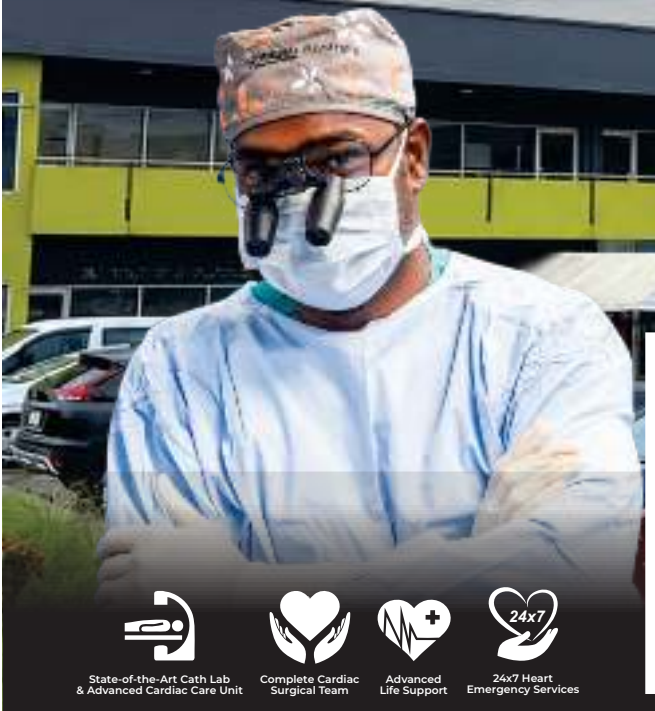

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Contents

Editorial

Communicable & Neglected Diseases - The Narrative

Author: *Dr. Neil Sharma*

This journal issue, dives deep into the nexus of Fijian history & politics with its inherent healthcare challenges. Noting the healthcare road-bumps during the nascent colonial era, and with current eradication of some, resurgence patterns of other communicable (CD) & neglected diseases into the 21st century a review is in order. The late 19th century recorded high incidence of communicable disease. Today's Non-Communicable Disease (NCD) were simply not recorded.

Intertwined with historical & political events with the end of global slavery in 1865, Blackbirding to Fiji, of Solomon Islanders and NiVanuatu natives is on record. The newly formed Colonial Sugar Refinery Company (CSR) in 1855, based in Sydney, also redirected a small Chinese group to Fiji to work in the fledging Cotton & Sugar industry from Australia. These Chinese were escaping the atrocities of their "Era of Humiliation". The beneficiaries to this labor, were the European free-traders preceding the cession of 1874.

Following the Measles outbreak in 1875, so called docile Indians were recruited, 481 on board the "Leonidas" arriving in May 1879, based on the previous governance experience of Fiji's First Governor-General, Sir Arthur Gordon who had previously served in Mauritius and Seychelle Islands. The paradox was to save the native Fijian from further morbidity and mortality when a third of its population, inclusive of six signatories of the Deed, died. Politically, the Council of Chiefs was formed to assist in the administration the Colonial hierarchy in light of the power & resistance of the "Kai-Colo" natives to Cession & Christianity with inherent loss of traditional practices.

Unfortunately, the 1875 Measles outbreak was followed by repeated outbreaks of Dysentery (1915-16 et 1929-30), the Spanish Flu (1918) ravaging the indigenous population and the mix of migrants (Europeans, Chinese, Solomon and NiVanuatu Islanders and Indians). The solution to this complex politico-social and health tragedy's, the Chief Medical Officer in 1888, painstakingly, sought clearances from British Governance by way of a "Health Ordinance" to formally train an initial eight Native Medical Practitioners (NMP) over a three-year period.

Basic skills, as in vaccine administration, dressing wounds with progressive escalating financial remuneration on graduation was offered. This remained a hands-on, hospital-based system. Smallpox was successfully gated as a result.

We deep-dive into the ancient, esoteric communicable diseases (19th-20th century) with professional curiosity, noting the extinction of some neglected diseases yet the resurgence of others associated with novel, new entities HIV-AIDS taking root. Let's establish recognition of newer Vector borne diseases, as in Dengue, Zika and Chikungunya of the 21st century as possible guardrails for expanding one's skillsets. What healthcare inspirations can one, in the 21st century obtain from previous challenges remains a personal matter but can it be collectively constructed as a learning tool for our progressive younger General Practitioner (GP) community?

We target the new practitioners to understand evolution of disease patterns / trends yet take need to take cognition of ongoing political forces, the needs of grassroot health & fiscal challenges with the current corporatization of healthcare in the region and Fiji, specifically. History is a teacher, without an incisive review of our heritage, we remain ignorant to the calculus of developing a future matrix of strategy, policy, planning and program delivery with real-time monitoring/evaluation & learning. Least one forgets, COVID-19 did teach all a lesson in public health delivery not unlike the Measles outbreak of 1875.

The future health impacts of Climate Change are very real with rising sea-levels, increased water salination, reduced crop yield, new evolving vector borne and bacterial diseases with the compounding rising temperatures causing heat stress to humans and plants. Water and sanitation measures to address these changes remain paramount learning points for the younger GP, aligning past experience to innovation in future.

We review selected topics of historical and healthcare interest in Measles, Tuberculosis, Yaws and the "success narrative" of Leprosy eradication in the Region, thanks to the regional "Makogai" experiment. Further topics of interest in Dysentery, Filariasis, Polio, Scabies and Smallpox will follow in subsequent journals.

We pay homage to all our professional predecessors. The Late Dr. James Jioniku of Batinikama, Labasa (the second Indian graduate of 1927) and the Late Dr. Indu Sinha-Prasad of Valalevu, Ba (first Indian Female graduate of 1957, FSM) have profiles in this journal. I sincerely thank son Dr. Daniel Jhinku and daughter MS Evia Prasad respectively for providing legacy notes on their parent.

The shift in disease patterns from CD to NCD in the early 21st century within our diversity, with inherent increasing secentary lifestyles, consumption of ultra-

processed food and beverages with the 80% of premature deaths needs urgent healthcare attention. The "Whole of Society" focus needs gross changes to positive parenting, educational, nutritional and health screening measures to establish the current gaps.
The current Health Bureaucrats in Fiji, continue downstream salvage, oblivious to the shifting upstream challenges. In fact, we are transforming strategic Bilateral & Multilateral organizational infrastructures without clear consciousness to the first base of health and wellness- Prevention!

A major refocused approach to increased Physicality, addressing "Sin goods" with taxations and a shift to addressing the "Commercial Health determinants" are long overdue. A scoping exercise to understand societal knowledge gaps, review the consumption patterns of *White Rice, Normal Flour* products inclusive of "Noodles" and wholesale use of "Palm oil" in the manufacturing process has remained unaddressed to seek solutions to the NCD tsunami.

The Challenge is simple, can the "*Fiji College of General Practitioners*" advocate organic food and nourishment, do away with daily consumption of sweetened sugary beverages. Become the lead advocate of healthy living at a national level?

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Review Article

The 1875 Measles Epidemic in Fiji: Catastrophe, Control and the Forging of Colonial Governance

Authors: *Dr. Neil Sharma, Dr. Josefa Koroivueta*

Introduction

The 1875 measles epidemic in Fiji stands as one of the most devastating demographic catastrophes of the nineteenth-century Pacific, killing approximately one-quarter to one-third of the indigenous Fijian population within a few months. Beyond its immediate human toll, the epidemic fundamentally reshaped British colonial policy, immigration strategies and the governance of indigenous populations. The disaster exposed the lethal consequences of epidemiological ignorance, triggered political crises and ultimately provided the colonial administration with a rationale for restructuring Fijian society under British control.

The Arrival of the Disease: The Dido Incident

The epidemic originated from a seemingly mundane event. In early 1875, HMS *Dido*, a British naval vessel on the Australian station arrived in Levuka, Fiji's nascent colonial port, carrying crew members suffering from measles. The ship had recently transported returned emigrants from Sydney and the disease, considered a trivial childhood illness by Europeans, was not taken seriously by the ship's officers or the colonial authorities. The failure of quarantine protocol was immediately apparent. The captain and medical officer of the *Dido* informed the Administrator, Mr. Layard, of the measles outbreak upon his arrival aboard the ship. However, no yellow flag was flown—a standard warning signal for infectious disease—and neither the naval nor colonial officials appreciated the catastrophic vulnerability of the Fijian population to this introduced pathogen.

A subsequent British parliamentary inquiry revealed deep disagreement over responsibility. The Colonial Secretary, Lord Carnarvon, held the naval officers primarily accountable for failing to provide adequate warning, while the Admiralty contended that the greater portion of responsibility rested with the colonial authorities who failed to implement quarantine measures. As the First Lord of the Admiralty, Mr. Hunt, observed:

"The mischief seemed to have arisen in a great degree from ignorance rather than intervention or neglect."(Great Britain. Parliament. 1876)

The Demographic Catastrophe

The consequences were immediate and apocalyptic. The Fijian population possessed no immunological defence against measles the disease spread with extraordinary rapidity across the archipelago. Contemporary accounts estimated the mortality at approximately 40,000 people—a figure representing one-quarter to one-third of the entire indigenous population.

The epidemiological dynamics were compounded by behavioural responses that proved fatal. Fijian sufferers, experiencing intense fever and skin eruptions, sought relief by immersing themselves in streams and the sea. This practice, intended to alleviate the torment of the rash, produced acute dysentery and pneumonia which became the actual causes of death for many victims. One contemporary report noted:

'Pneumonia resulting from lying under trees was a leading cause of death in Fiji.' (Otago Witness, 1875)

The mortality extended to the highest levels of Fijian society, many paramount chiefs perished, including Tui Levuka and Ratu Saveroka, while Ratu Cakobau himself contracted the disease but survived.

The epidemic generated profound social dislocation. Levuka, the main European settlement, became 'quite deserted,' and the absence of natives from towns produced 'almost a famine, so far as native products are concerned' (*Otago Witness*, 1875). The Fijian population, already reeling from the recent cession of their islands to Britain in 1874, interpreted the catastrophe through multiple frameworks. Some viewed it as a judgment for surrendering their country to foreign rule, while others—reflecting deeper suspicions of colonial intentions—believed the disease had been 'designedly introduced to kill them off' (Halter et al., 2023).

Colonial Responses and Their Limitations

The British colonial administration's response revealed both the capacities and profound limitations of early imperial public health. Medical personnel and supplies were ordered from Sydney, but the fundamental challenge lay in persuading a traumatized and suspicious population to accept treatment. The Fijians 'refused to take medicine,' and no effective power existed 'to compel the natives to use either' doctors or medicines.

However, one notable exception demonstrates the potential for intervention. The native constabulary, who remained under colonial discipline,

'Have been compelled to submit to proper treatment, and none of them have died.' (Otago Witness, 1875)

This striking contrast—zero mortality among the disciplined constabulary versus catastrophic losses in the general population—was not lost on colonial administrators. It suggested that coercive public health measures could be effective and provided a template for future governance.

Contemporary observers noted the political implications of the mortality pattern. 'All the best of the old chiefs are going and the political effect will be great,' reported the *Otago Witness* in June 1875. The decimation of traditional leadership created a power vacuum that the colonial administration was positioned to fill. The arrival of Fiji's first Governor, Sir Arthur Gordon, was 'anxiously expected' precisely as the epidemic reached its peak.

The Political Strategy: Governing Through Chiefs

Sir Arthur Gordon, who assumed office later in 1875, faced a colony in demographic and political crisis. His response to the epidemic's aftermath established the foundational principles of British colonial governance in Fiji for the next century. Rather than imposing direct rule, Gordon pursued a strategy of indirect governance that paradoxically strengthened indigenous chiefly authority while subordinating it to British imperial control.

Gordon believed that:
'If separated from their land the race will die out and that would be a violation of the express conditions on which alone we took possession.' (cited in Ofcansky, 1984)

This conviction reflected both humanitarian concern and pragmatic calculation. The epidemic had demonstrated that Fijian population survival required protection from the destructive forces of colonial contact. Gordon's solution was to preserve and formalize the hierarchical social system of Fijian chieftainship as an instrument of colonial administration.

In 1876, one year after the epidemic, Gordon created the **Great Council of Chiefs** (***Bose Levu Vakaturaga***), an advisory body of hereditary Fijian leaders that would mediate between the colonial state and the indigenous population. This institution, while appearing to preserve traditional authority, effectively subordinated Fijian governance to British oversight. As a recent historical analysis argues,

'Official responses to disease in Fiji were underscored by assumptions of European superiority and power that ignored how non-Europeans viewed Western medicine with suspicion and colonial rules as contradictory.' (Halter et al., 2023, p. 52)

The Migration Solution: Indian Indenture

The most consequential colonial policy emerging from the epidemic was the decision to import indentured laborers from India. The massive population loss created acute labor shortages on European-owned plantations, particularly the emerging sugar industry. The epidemic had removed a substantial portion of the potential indigenous workforce, and the surviving Fijian population was deemed insufficient to meet colonial economic demands.

Governor Gordon, drawing on established imperial precedents from Mauritius and the West Indies, proposed recruiting workers from British India. The first shipment of 498 Indian indentured workers arrived in Fiji in 1879, inaugurating a system that would transport approximately 62,000 Indians to the colony over the next 37 years (ANZ, n.d.). These workers, recruited under a five-year indenture contract with promised return passage, were subjected to quarantine upon arrival in Levuka—colonial authorities having learned, belatedly, the importance of disease control.

This policy fundamentally transformed Fiji's demographic and political landscape. By 1963, Indo-Fijians numbered 205,000 and threatened to outnumber the indigenous population, generating 'a general Fijian fear of domination by sheer weight of numbers' (*The Fiji Times*, 2023). The epidemic of 1875 thus set in motion a migration strategy that would create Fiji's characteristic multiethnic society with all its attendant tensions and complexities.

Imperial Epidemiological Thinking

The 1875 epidemic occurred within broader imperial discourses about disease and racial susceptibility. Contemporary observers explicitly framed the catastrophe in racial terms.

"As usual when an inferior race catches an infectious disease from a superior one, its virulence was intensified." (The Spectator, 1875)

This racialized understanding of disease—that 'superior' European populations carried pathogens to which 'inferior' races had no resistance—became a self-serving justification for colonial expansion and population displacement.

The Spectator, reporting on the epidemic in June 1875, articulated this logic with brutal frankness:

"The first result of annexing the Fiji Islands to Great Britain is the death of a third of the population... the result will be really a gain in the world, since the dead natives will be speedily filled by English emigrants, who will make a new Australia out of the Fiji Islands." (1875)

Such commentary reveals how epidemiological catastrophe was rationalized within colonial frameworks as an unfortunate but ultimately progressive process.

Conclusion

The 1875 measles epidemic in Fiji represents a watershed moment in Pacific colonial history. The demographic catastrophe—40,000 deaths, one-quarter to one-third of the indigenous population—resulted directly from imperial expansion and the movement of British naval vessels through Pacific waters. Yet the colonial response to this disaster was not simply reactive. Governor Gordon's policies of indirect rule through the Great Council of Chiefs and the importation of Indian indentured labourers transformed the epidemic from a crisis of indigenous depopulation into an opportunity for restructuring Fijian society under colonial control.

The epidemic demonstrated the lethal consequences of epidemiological ignorance while simultaneously providing the colonial state with rationales for expanded authority. The pattern established in 1875—that disease introduction, population decline, and colonial intervention formed a linked sequence—would repeat across the colonized Pacific throughout the nineteenth century. For Fiji, the measles epidemic of 1875 was not merely a medical catastrophe but the crucible in which modern colonial governance was forged.

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Review Article

Tuberculosis in Fiji: From Colonial Introduction to Modern Resurgence

Authors: Dr. Neil Sharma & Dr. Scott Leuliger

Introduction

The introduction of Tuberculosis (TB) into the South Pacific, particularly Fiji, represents a significant epidemiological turning point. Historical records indicate that TB was largely absent from the islands before the 19th century. Its subsequent establishment was a direct consequence of colonialism, and its evolution—from an acute sanatorium-managed crisis to a community-controlled outpatient system—illustrates the shifting challenges of public health. Today, this trajectory faces a dangerous new complication: the intersection of the disease with rising intravenous drug use and HIV/AIDS.

1. Historical Backdrop: Introduction by Colonial Settlers

Prior to sustained European contact, the isolated populations of the South Pacific had no exposure to *Mycobacterium tuberculosis*. This lack of prior exposure meant indigenous Fijians possessed no natural immunity, making them highly susceptible to the "tubercular taint" brought by outsiders.

The introduction occurred through two primary vectors during the colonial era.

- **Immigrant Populations:** Labourers and settlers, particularly Europeans and Indians, brought the bacillus into the port towns.
- **Missionaries and 'Civilisation':** Contemporary 19th-century reports explicitly blame the "introduction by Europeans of the tubercular virus." Observers noted that the "evils wrought by civilisation"—including changes in clothing, housing, and the gathering of people into villages and churches—created perfect conditions for the airborne bacillus to spread among a non-immune population.

By the early 20th century, the impact was devastating. Colonial medical officers noted that TB was reported as the cause of 25% to 30% of deaths in hospitals. Tuberculin tests from that era revealed that over 90% of Fijians were infected by early adulthood.

2. Evolution of Public Health Control Measures

Fiji's response to the TB crisis evolved through distinct phases, moving from strict isolation to community-based treatment.

a. The Sanatorium Era (Mid 20th Century)

The peak of the epidemic occurred just after World War II. In response, the colonial government established the TB control program in 1951. The cornerstone of this strategy was the F. J. Twomey Hospital (later the National TB Hospital), which functioned as a sanatorium. Patients were isolated and treated in a hospital setting, with a heavy reliance on mass chest X-ray screening campaigns to find and contain cases.

b. The Shift to Outpatient DOTS (1997–Present)

As effective antibiotic therapies became available, the approach shifted from isolation to cure. In 1997, Fiji adopted the global Directly Observed Treatment, Short-course (DOTS) strategy.

- **The Strategy:** DOTS moves away from long hospital stays. Instead, a health worker or community member watches the patient swallow their pills to ensure adherence.
- **Domiciliary Management:** The government actively supports "community models of care," allowing patients to complete treatment at home rather than in a hospital bed, reducing the burden on facilities like the Twomey Hospital.
- **Success:** This shift has been largely successful. As of recent reports, Fiji is currently categorized as a **low-burden country**, with a treatment success rate of 81%.

3. Current Resurgence and the Drug-HIV Nexus

While the DOTS strategy lowered general caseloads, recent epidemiological data reveals a concerning resurgence driven by specific high-risk behaviours. A 2025 report highlights an "urgent" health crisis. **injecting drug use is causing an increase in HIV, hepatitis C, and tuberculosis cases.**

This "syndemic" (synergistic epidemic) operates in Fiji through the following mechanism.

The Mechanism ("Blue-whiting"): The term "blue toothing" refers to the sharing of drug injection equipment. When users share needles, they bypass the body's first line of defence.

HIV Activation: Sharing needles dramatically increases the transmission of **HIV.**

Immunosuppression: HIV destroys the immune system (CD4 cells). A person with latent TB (inactive bacteria) who contracts HIV is at extreme risk of developing **active TB.**

Airborne Spread: Once a user develops active pulmonary TB, they spread the bacteria through the air back into the general community and vulnerable prison populations.

4. Clinical and Epidemiological Associations
To fully understand the risk, we must look at the specific clinical data and high-risk groups identified by the Fiji Ministry of Health.

- **The HIV-TB Co-epidemic:** People Living with HIV (PLHIV) are the highest priority group for TB screening. Because HIV destroys immunity, TB is the leading killer of people with AIDS. The Ministry of Health explicitly intensifies screening campaigns for PLHIV to catch TB early.
- **The Diabetes Connection:** Beyond drugs, Fiji faces a diabetes co-epidemic. Research modelling from 2019 warned that while TB is declining, the effectiveness of TB control could be easily derailed by moderate increases in the diabetes burden.[1] High blood sugar weakens immune response, mirroring the risk profile of HIV.
- **Other High-Risk Groups:** Public health data identifies specific pockets of transmission that intersect with the drug crisis, including prisoners (due to overcrowding and potential drug use) and young adults aged 25–44 years (the demographic most associated with substance abuse).

Conclusion
Fiji has successfully navigated the transition from the sanatorium era to effective outpatient DOTS therapy, dramatically reducing its historical burden. However, the current resurgence is not a failure of the TB program itself, but rather a spillover consequence of the raging intravenous drug use epidemic. The sharing of needles ("blue-whirling") fuels HIV, and HIV fuels TB. Consequently, Fiji's modern TB strategy is no longer just about finding coughs; it is deeply integrated with HIV management, harm reduction, and the control of non-communicable diseases like diabetes.

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Review Article

The Pacific Crucible: Leprosy, Colonization, and the Makogai Solution:

Disease Patterns in the Late 19th Century South Pacific

Authors: *Dr. Neil Sharma, Dr. Rajeshwar Sharma*

Introduction
The late nineteenth century in the South Pacific witnessed a dramatic transformation of disease patterns, driven by the converging forces of European colonization, labor trafficking, and maritime mobility. Among the most feared afflictions to emerge during this period was leprosy—a disease that would catalyze one of the colonial era's most ambitious and complex public health experiments. Central to this narrative is the Fijian island of Makogai, which became the region's premier leprosarium, administered by a French religious order and serving as a medical clearinghouse for Pacific peoples from Samoa, the Cook Islands, New Zealand, and beyond.

1. The Pre-Colonial Disease Landscape and the Hawaiian Introduction
Prior to intensive Western contact, the South Pacific islands were not disease-free, but their epidemiological profile was relatively circumscribed. Yaws—a bacterial infection closely related to the syphilis spirochete—was endemic throughout much of Polynesia and Melanesia, causing disfiguring skin lesions but remaining non-venereal and primarily affecting children. The arrival of European explorers, traders, beachcombers, and eventually colonists introduced a cascade of novel pathogens: tuberculosis, dysentery, influenza, and sexually transmitted infections, against which island populations had no acquired immunity.

Leprosy, however, occupied a unique position in this emerging disease ecology. Caused by *Mycobacterium leprae*, the disease had an exceptionally long incubation period—often five to twenty years—and low infectivity, requiring prolonged close contact for transmission. This meant that leprosy did not produce the explosive epidemics characteristic of smallpox or measles, but rather established itself gradually, silently, and terrifyingly.

The consensus among medical historians, supported by late nineteenth-century colonial physicians, is that leprosy was introduced to the Hawaiian Islands around 1850. The precise origin remains debated, but Chinese laborers and Hawaiian sailors traveling along Pacific maritime routes are considered the most likely vectors. What is certain is that the disease's emergence in Hawaii coincided with profound social disruption: the collapse of the native population from 300,000 at Captain Cook's arrival in 1778 to approximately 70,000 by 1850, the overthrow of traditional kapu systems, and the transformation of Hawaiian society by American missionary influence and sugar capitalism.

Hawaii's response to leprosy became infamous. The 1865 'Act to Prevent the Spread of Leprosy' authorized the Board of Health to arrest, examine, and forcibly isolate suspected lepers. By 1866, the remote Kalaupapa peninsula on Molokai Island had been designated a 'leper settlement' where over 5,000 Native Hawaiians—90% of all patients—would be exiled over the next thirty-four years. It was here that Father Damien de Veuster, a Belgian Catholic missionary, arrived in 1873 to minister to the isolated population, eventually contracting and dying from the disease himself.

2. Blackbirding, Beachcombers, and the Pacific-Wide Dissemination

From Hawaii, leprosy radiated outward across the Pacific, carried by the same maritime networks that were transforming the region economically and demographically. The most notorious of these was 'blackbirding'—the often-forcible recruitment of Pacific Islanders to labor on Australian, Fijian, and Samoan plantations. Between the 1860s and 1901, thousands of men, women, and children from Vanuatu, the Solomon Islands, New Guinea, Kiribati, and Tuvalu were taken aboard labor vessels, often through outright kidnapping or deception.

The health consequences were catastrophic. Approximately 15% of those blackbirded died during transport from malnutrition and exposure to novel diseases. Survivors were worked in brutal conditions on Queensland sugar plantations and Fijian cotton fields. When their labor contracts expired—or when Australia's White Australia Policy mandated their deportation after 1901—these workers returned to their home islands, carrying not only cultural memories of displacement but also latent infections, including leprosy.

Beachcombers—deserted sailors, escaped convicts, and adventurers who settled on Pacific islands—formed another transmission network. These marginal figures moved between islands, integrated into local communities, and frequently carried diseases acquired during their maritime wanderings. Colonial medical officers consistently noted that early leprosy cases in previously unaffected islands often appeared in individuals with histories of travel or contact with outsiders.

Chinese indentured labor, introduced to Samoa in 1903 and already present in Fiji and Tahiti, provided another vector. By 1915, the first cases of leprosy among Chinese laborers in Samoa were recorded, and Chinese nationals would constitute nearly a quarter of all identified leprosy cases in the territory between 1892 and 1923.

3. Fiji's Cession and the Birth of a Regional Health Strategy

When Fiji was ceded to Great Britain in 1874, the new colonial administration inherited a population already experiencing significant epidemiological transition. The sugar economy, introduced by Australian planters, required a large and mobile workforce—Indian indentured laborers began arriving in 1879, joining existing Fijian, Polynesian, and Melanesian populations. Leprosy, imported through multiple channels, began appearing with increasing frequency.

The colonial response, however, did not crystallize immediately. Early leprosy cases in Fiji were managed through local isolation or simply left untreated. But as the disease's prevalence became more apparent—and as neighboring colonies struggled with their own leprosy problems—the British colonial administration recognized the need for a coordinated, region-wide approach.

The German leprosarium at Ali, Samoa, established during that territory's period of German control (1900–1914), demonstrated both the necessity and the limitations of local isolation. By 1918, the Ali station was deemed unsuitable: patients escaped easily, and facilities for expansion were inadequate. The leprosy station was relocated to Nu'utele Island off Upolu's eastern coast—but this, too, proved problematic. The isolated location made it 'impossible to give them the treatment necessary for the cure or alleviation of their condition'. All that could be provided were the 'praiseworthy ministrations of a Sister of the Society of Mary and the Roman Catholic priest on the mainland opposite the island'.

4. Makogai: The Nucleus of Regional Leprosy Control

In 1911, four years before the Nu'utele experiment in Samoa, the Fijian colonial government established a leprosarium on Makogai Island in the Lomaiviti Archipelago. The island, covering 6.1 square kilometers with two central peaks rising to 267 meters, was visible from Ovalau and had been known to European navigators since Captain Bligh passed between Makogai and Koro in 1789.

Makogai's development as a leprosarium was neither haphazard nor purely punitive. The facility was deliberately designed as a *regional* resource, intended to serve not merely Fiji but the entire British Pacific—and eventually New Zealand territories as well. This vision of regional centralization represented a significant departure from earlier approaches, which had emphasized local isolation on small, often inadequately resourced islands.

The colonial government partnered with the Missionary Sisters of the Society of Mary, a French Catholic religious

order, to administer the facility. This arrangement was not coincidental. Catholic orders had gained extensive experience in leprosy care through their work at Molokai, where Father Damien and later Mother Marianne Cope (who arrived in 1883) had established nursing protocols and community structures for leprosy patients. The Sisters brought this expertise—and their distinctive white habits—to Makogai, where they would remain until the colony's closure in the 1960s.

Mother Mary Agnes, who served as superior of the leper colony from 1916 until 1950, became the institution's guiding hand. Under her direction, Makogai evolved from a rudimentary isolation camp into what contemporaries described as a "beautifully situated and splendidly equipped station". By 1918, the patient population exceeded 300; by 1950, it had grown to 700.

5. Life and Hierarchy in the Leprosarium

Makogai's organization reflected both the humanitarian aspirations of its religious administrators and the racial hierarchies of British colonialism. Patients not confined to the hospital were housed in villages organized by ethnicity—a system that allowed different communities to maintain their own traditions, languages, and religious practices. Fijians lived separately from Samoans, Chinese, Indians, Europeans, and Maori. Each village was expected to be self-sufficient: patients grew food, fished, tended cattle, and engaged in craft work as occupational therapy.

The colonial government's financing model explicitly racialized the institution's operations. Accommodation fees charged to various governments sending leprosy patients were scaled according to the patient's race: highest for whites, lower for Chinese, Indians, and Maori, and substantially lower for Pacific Islanders. White patients received more generous rations than non-white patients. This racial hierarchy was imposed by the Fijian government, not the Sisters, and reflected broader colonial assumptions about differential needs and worth.

Yet despite these inequities, Makogai acquired an international reputation as a "model of discipline and social peace". Patients had access to services that would have been unavailable in most Pacific villages: schooling for children, postal and banking services, film screenings, and even a photographic darkroom. The Sisters provided skilled nursing care at a time when effective medical treatment for leprosy did not exist. (Chaulmoogra oil, derived from Hydnocarpus seeds and the only pre-sulfone treatment, was used at Makogai but had limited efficacy.)

6. The Makogai Solution: Regional Consolidation, 1922–1925

The true flowering of Makogai as a regional center occurred in the early 1920s, driven by New Zealand's assumption of administrative responsibilities for Western Samoa (formerly German Samoa) and the Cook Islands.

In 1914, New Zealand military forces occupied German Samoa. Among the assets they inherited was the leprosy station at Ali'i, which then housed twelve patients. By 1918, these patients had been transferred to Nu'utele Island, but conditions remained inadequate. The New Zealand administration faced a difficult choice: invest in building a proper leprosarium within Samoa, or seek an alternative solution.

The alternative was Makogai. In July and August 1922, thirteen leprosy patients from Samoa—including one from American Samoa—were transported to Fiji and admitted to Makogai. In May 1923, six more were sent. The "Makogai solution" was born. New Zealand would pay for the care of its territorial patients at the Fijian facility, eliminating the need for separate leprosaria in Samoa or the Cook Islands.

The Cook Islands followed a similar trajectory. Leprosy had been reported on Penrhyn Island in 1890, and subsequent cases appeared throughout the northern archipelago. Early responses emphasized isolation on designated islets within each island group—a fragmented and inefficient system. After the Cook Islands came under New Zealand administration in 1900, the colonial government grew dissatisfied with this arrangement. Beginning in 1925, Cook Islands leprosy sufferers were also sent to Makogai.

Quail Island, New Zealand's own leprosy settlement near Lyttelton, was closed in 1925, and its remaining residents transferred to Makogai. The logic was inexorable: centralization at Makogai offered economies of scale, specialized nursing care, and—perhaps most importantly—removal of leprosy patients from metropolitan territories where their presence might alarm European settlers and indigenous populations alike.

7. Achievements and Limitations of Control

What did "control" of leprosy mean in this context? The term requires careful unpacking. Before the introduction of sulfone drugs in the 1940s and 1950s, leprosy was incurable. Isolation could interrupt transmission, but only if implemented thoroughly and sustained over decades—given the disease's long incubation period, new cases would continue to appear long after transmission had theoretically ceased.

The colonial record on leprosy control was mixed. Makogai's system of ethnic villages and self-sufficiency represented a relatively humane form of isolation, particularly when compared to the forced segregation and police enforcement that characterized the early years of Kalaupapa in Hawaii. Patients at Makogai were not prisoners in the same sense that early Molokai exiles had been. They could write letters, receive visitors, maintain cultural practices, and in some cases, return home if cured or rendered non-infectious.

However, the very existence of Makogai—and the enthusiasm with which colonial administrations embraced the "Makogai solution"—reflected a public health strategy driven as much by anxiety as by epidemiology. The fear of leprosy in European settler societies and colonial capitals vastly exceeded the disease's actual threat. Isolation at Makogai removed the visible reminder of disease from metropolitan centers, allowing colonial governments to claim that their territories were being "cleansed".

The patients themselves experienced isolation as exile. Samoan oral histories, preserved in song, record the grief of families separated when loved ones were sent to Makogai. For Cook Islanders, removal to Fiji meant permanent displacement from their small island communities. The 'haunting' of those left behind—the incomplete mourning, the ambiguous status of the exiled—persisted for decades.

8. Medical Transitions and Final Closure

The introduction of dapsone in the 1940s marked the beginning of effective ambulatory treatment for leprosy. Patients could now be cured, or at least rendered non-infectious, without indefinite isolation. This pharmacological revolution gradually undermined the rationale for large-scale leprosaria like Makogai.

Nonetheless, the Makogai colony continued operating into the 1960s. The inertia of institutional investment, the lack of alternative community-based treatment infrastructure in many Pacific islands, and the persistent social stigma surrounding leprosy all contributed to the facility's longevity. By the 1960s, however, the global leprosy control paradigm had shifted decisively toward outpatient treatment and integration.

Makogai's closure in the 1960s was not accompanied by the dramatic ceremonies that had marked its opening. The last patients were discharged or transferred, the Sisters departed, the buildings gradually fell into disrepair. Today, Makogai is remembered primarily through archival records and the oral histories of families whose relatives were exiled there.

9. Conclusion

The trajectory of leprosy in the late nineteenth- and early twentieth-century Pacific illustrates the intimate connection between disease patterns and colonial power. Leprosy was not a traditional Pacific disease: it arrived through the same maritime networks that brought blackbirders, beachcombers, Chinese laborers, and colonial administrators. The Hawaiian introduction around 1850, the subsequent Pacific-wide dissemination, and the eventual consolidation of regional leprosy control at Makogai all reflected the transformative—and often destructive—impact of European and American expansion.

Makogai itself was an ambivalent institution: a place of exile and segregation, certainly, but also a site where Pacific peoples from dozens of islands created communities, maintained cultural traditions, and received care from dedicated religious sisters. The 'achievement of control' that Makogai represented was partial and contingent—dependent on isolation rather than cure, on colonial hierarchies rather than medical equity, on the removal of the diseased from sight rather than their integration into society.

Yet within the constraints of pre-antibiotic medicine, Makogai offered a more humane alternative than the penal colony at Kalaupapa or the neglected islets of earlier Pacific isolation policies. The French Sisters who ran the facility, the colonial administrators who funded it, and the patients who inhabited it all contributed to a complex legacy—one that continues to shape how Pacific peoples remember and understand leprosy's place in their shared colonial history.

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Review Article

Yaws: A Time-lined Narrative of Its Causative Microbe, Differential Diagnosis, Treatment to Current Status

Author: *Dr. Neil Sharma*

Introduction

Yaws is a chronic, non-venereal treponemal infection caused by *Treponema pallidum subspecies pertenue*. Endemic in the 19th-century South Pacific, it was often confused with syphilis and leprosy. A structured narrative of its microbiology, clinical distinction from syphilis, treatment history, public health control strategies and current near-eradication status is discussed.

1. The Causative Microbe and Timeline

Causative agent: *Treponema pallidum* subspecies *pertenue*– a spiral-shaped bacterium (spirochete).

1905: Discovered by physician Aldo Castellani, who initially named it *Spirochaeta pertenuis*[1].

1905–Present: Renamed *Treponema pallidum* subspecies *pertenue*, confirmed as a near-identical cousin to the syphilis bacterium, sharing microscopic appearance and serological response[1].

2. Differential Diagnosis: Distinguishing Yaws from Syphilis

Yaws and syphilis cannot be distinguished by standard serological tests alone. Differential diagnosis relies on clinical and epidemiological features[1].

Feature	Yaws (*T. p. pertenue*)	Syphilis (*T. p. pallidum*)
Primary route	Non-venereal, skin-to-skin contact (often children)	Venereal, sexual contact
Initial lesion	"Mother yaw" – painless, raspberry-like sore on limbs or face	Chancre – painless hard ulcer on genitals, anus, or mouth
Neurological/cardiovascular involvement	Extremely rare (normal cerebrospinal fluid in classic studies)	Common in tertiary stage (neurosyphilis, cardiovascular syphilis)
Congenital transmission	Does not occur	Does occur
Late-stage bone damage	Destructive lesions of nose, palate, long bones (periostitis)	Gummas can affect bone, but nasal destruction less characteristic

Key historical finding (1911): In a study of 175 yaws patients, 82% had positive blood tests for syphilis, but all had normal cerebrospinal fluid – a crucial distinguishing feature from neurosyphilis[1].

3. Treatment and Hallmarks of Medical Control

Pre-antibiotic Era

No effective treatment was available[1].

Breakthrough (1940s–1950s)

A single injection of long-acting benzathine penicillin was found to cure yaws[1].

First Global Campaign (1952–1964)

- **Method:** WHO and UNICEF deployed mobile teams for house-to-house mass treatment.
- **Result:** Cases reduced from an estimated 50 million to 2.5 million (a 95% reduction)[1].
- **Hallmark:** The vertical approach – dedicated, single-disease campaigns outside routine health systems.

Setback (1970s onward)

Post-campaign surveillance was integrated into weak general health services, leading to re-emergence in Africa, Asia, and the Pacific[1].

Second Eradication Campaign (2012–present)

- **New tool:** Single-dose **oral azithromycin** – equally effective, no needles required[1].
- **Strategy:** Total community treatment (TCT) of entire at-risk populations.

4. Current Status: Practically Extinct?

- Eradicated in: Americas, most of Asia (India and Ecuador declared yaws-free in 2003)[1].
- Still endemic in: At least 16 countries, primarily:
  - West Africa (Ghana, Côte d'Ivoire)
  - Southeast Asia (Indonesia, Timor-Leste)
  - Western Pacific (Papua New Guinea, Solomon Islands)[1].

Remaining Challenges to Eradication

- **Azithromycin resistance** – Emerging strains limit oral treatment options[1].
- **Zoonotic reservoir** – Non-human primates (baboons, gorillas) in Africa carry similar *T. pertenue* strains, potentially reinfecting humans after elimination[1].
- **Surveillance difficulties** – Remote, impoverished, or conflict-affected regions hinder active case-finding.

WHO target: Global eradication by **2030**[1].

5. Serological Markers and Differential Diagnosis from Syphilis

- **Identical serology:** Both infections produce antibodies against treponemal antigens. Standard tests (VDRL, RPR, TPHA, FTA-ABS) cannot distinguish between yaws and syphilis[1].

- **Differential relies on:**
  - Patient age (yaws: children, syphilis: adults)
  - Lifestyle (non-venereal vs. venereal exposure)
  - Geographic location (yaws endemic zones)
  - Absence of congenital or neurosyphilis signs
  - Cerebrospinal fluid analysis (normal in yaws)

6. Conclusion

Yaws is a near-eradicated disease whose control by the medical profession stands as a public health milestone. The shift from mass penicillin campaigns to targeted oral azithromycin therapy, alongside persistent challenges like resistance and zoonotic reservoirs, defines its current trajectory. Final eradication by 2030 remains feasible but requires sustained political and financial commitment.

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Review Article

Colonial and Post-Colonial Medical Development in Fiji (1855-1937 & beyond)

Author: *Dr. Neil Sharma & Dr. Porshu Rom*

Introduction

This document provides a structured timeline of medical and colonial history in Fiji from 1855 to 1937, with additional sections examining post-1937 developments at the Central Medical School (CMS), the establishment of the South Pacific Health Service (SPHS), the transition to modern regional health organizations, and the role of Native Medical Practitioners (NMPs) in the World Wars. The content is formatted for academic analysis with Vancouver referencing.

Main Timeline: Colonial Fiji & Healthcare (1855–1937)

Table 1: Key Events in Fijian Colonial and Medical History, (1855-1937)

Year	Historical & Political Context	Healthcare & Disease Challenges	Development of Native Medical Practitioners
1855	Cession Offer: King Cakobau offers to cede Fiji to Britain (rejected).		
1874	Colony Established: Fiji ceded as a Crown Colony.		
1875		Measles Epidemic: A devastating outbreak kills approximately one-third of the native Fijian population.	

1878–1879	ndentured Labor Begins: To preserve native Fijian labor, Governor Gordon initiates mportation of ndian laborers; first ship arrives 1879.		
1885			Formal Training Begins: Dr. B. G. Corney (Principal Medical Officer) passes an ordinance allowing native students to enroll as medical practitioners after three years of hospital training.
1888	Capital relocated to Suva (1882).	First Four Graduates: Ratu Fereteriki Temesa (Bau), Jemesa Tunaceke (Rai), Ratu William Lqueque (Bua), followed by Laisian Cadri (Kadavu).	Lecture room and hostel built at Colonial Hospital, Suva. Approximately 20 practitioners registered.
1891			\Mf Enrollment: 20 enrolled, with 8 in the 3rd year of training.
1899			\Mf Sowane Pua Mau: DOB 09/06/1881, Graduated & Received Civilian MSE on 3/05/1924 for Excellence in Services in the Gilbert & Ellice Islands (1905–1951).
1900			Training facilities expand.
1904	Legislative Council established (partially elective).		
1916	End of ndenture system. First ndian member appointed to Legislative Council.	1915–16 Acute outbreak of Bacillary Dysentery.	
1918		nfluenza Pandemic ("Spanish Flu") Arrives in Fiji, killing an estimated 14% of the population within 16 days.	Native Medical Practitioners play a crucial role in response; eight lose their lives fighting the epidemic.
1923		Colonial War Memorial Hospital rebuilt in Suva, becoming the central medical facility and teaching hospital.	
1926			*(See 1923 entry for first mention of Indian origin practitioners, including 1926 cohort)*
1927			*(See 1923 entry for first mention of Indian origin practitioners, including 1927 cohort)*
1928	First flight from Hawaii lands in Suva, increasing global connectivity.		
1929	ndian representation on Legislative Council becomes elective.		
1930s		Rockefeller Foundation involvement begins (Dr. S. M. Lambert partners with Chief Medical Officer Dr. Montague).	
1931			Training duration extended from three years to four years.
1933		Central Medical School Annual Report – Student Population. 3rd Year: 10 students, 2nd Year: 18 students, 1st Year: 7 students. 35 practitioners posted out in Fiji and the region. First Mention of Indian Origin Practitioners.	The first documented inclusion of non-ndigenous Pacific Islanders in the \Mf training and deployment system. Post Graduate Retained @ CWM Hospital: Aseli Tamanitoakula as Dispenser, Pharmacist & Anaesthetist.

	• 1926: Mohd Hanif (Navua), Chura Chandulal (Nadi), Samson Deok (Lautoka) • 1927: James Jhanku (Rakiraki)	
1935		Training of native nurses formally organized on a three-year basis. 30 nurses stationed throughout Fiji.
1936	Colonial Office inquiry into 'Nutrition in the Colonial Empire' highlights concerns about diet and public health, leading to more focus on mother and child welfare.	
1937	Central Medical School (CMS) formally established in Suva with Rockefeller Foundation aid, serving as a regional training hub for the Pacific.	CMS lauded in *Nature* journal as a successful model. 84 practitioners serving approximately 500,000 people across the region.

3. Post-1937 Developments: The Central Medical School

Table 2: Evolution of the Central Medical School/Fiji School of Medicine, 1945–2010.

Year	Event	Significance
1945	Dentistry program introduced.	Expands scope beyond general medicine.
1946	South Pacific Health Service (SPHS) formed.	Coordinates regional health and CMS training.
1949	South Pacific Board of Health established.	Oversees SPHS and CMS.
1953	New Tamavua campus opened by Queen Elizabeth II.	Marks major physical expansion.
1956	Medical program extended to five years.	Increases academic rigor.
1961	Renamed Fiji School of Medicine (FSM).	New institutional identity.
1982	Partnership with USP for MBBS degree. First cohort enrols.	FSM graduates receive a recognized university degree.
1988	100th anniversary of graduation.	Since 1888, 789 graduates produced.
2010	Merged into Fiji National University (FNU) as College of Medicine, Nursing and Health Sciences (CMNHS).	Becomes part of modern national university system.

4. The South Pacific Health Service (SPHS) 1946–1969

- **Established:** September 7, 1946, by agreement between New Zealand, Fiji, and the Western Pacific High Commission.
- **Governance:** South Pacific Board of Health, chaired by Inspector General (always the Director of Medical Services of Fiji). First Inspector General: Dr. J. C. R. Sutherland.
- **Headquarters:** Suva, Fiji.
- **Key Functions:**
  - Medical advisory for member territories.
  - Disease surveillance and standardized quarantine.
  - Training of MMPs and nurses at CMS.
  - "Pool" of Medical Officers deployable across the region.
- **Expiration:** Agreement not renewed after Fiji's independence (1970), expired December 1969.

5. Transition to Modern Regional Health Organizations

Table 3: Successor organizations to the SPHS in the Independent Pacific

Year	Organization	Role & Significance
1947 (renamed 1997)	South Pacific Commission / Pacific Community (SPC)	Non-political technical advisory body; Public Health Division continues disease surveillance and training across 22 Pacific Island Countries and Territories (PICTs).
1986	Pacific Island Health Officers Association (PIHOA)	Member-driven advocacy for US-Affiliated Pacific Islands; runs SHIP field epidemiology training program.
1996	Pacific Public Health Surveillance Network (PPHSN)	Joint SPC/WHO network; launched PacNet email alert system for real-time outbreak communication.

6. Native Medical Practitioners in the World Wars

Table 4: Roles and examples of NMPs during WWI and WWII

War	Role	Notable Example(s)	Outcome/Fate
WWI (1914–1918)	Uniformed medical personnel; field hospitals.	John Fapak William (Rotuma)	Enlisted August 15, 1918; served as medical orderly in Fiji Army.
WWII (1939–1945)	Coastwatchers, Allied medical units, prisoners, forced collaborators.	Gideon Zoleveke (Solomon Is.)	Worked with Allied Coastwatchers on Vella Lavella.
		George Bogesi (Solomon Is.)	Forced by Japanese to interpret; tried for treason post-war, interned, later returned.
		Cuso Piko (Solomon Is.)	Served safely in Santa Cruz, away from Japanese occupation.
		Dr. Arobati Hicking (Gilbert Is.)	Removed by Japanese, forced to work on Kusaie.

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8. Notes for Further Analysis
The Central Medical School as a Model: The CMS was praised in Nature journal (1937) as a successful example of applying Western medicine in tropical colonial contexts. Researchers should examine how its curriculum balanced Western science with local medical traditions.
Non-Indigenous Inclusion (1930): The first documented inclusion of non-indigenous Pacific Islanders (Indo-Fijians) in the NMP training and development system marks a significant demographic and policy shift.
Aseli Tamani Ioakim: His retention at CWM Hospital as Dispenser, Pharmacist & Anaesthetist represents an early example of postgraduate specialization for a Native Medical Practitioner.
The George Bogesi Case: His trial raises important questions about coercion, collaboration, and the limits of loyalty for colonized medical professionals during wartime. Archival records in Australia and the Solomon Islands warrant deeper analysis.
SPHS to PIHOA Transition: Comparing the colonial SPHS "pool" system (centralized, expatriate-led) with the modern SHIP program (decentralized, member-driven) reveals how Pacific nations have asserted ownership over their health workforce development.
Gender Disparity: Note the late inclusion of formal nurse training (1935) and the absence of female NMPs in the early records. Further research should explore when the first women graduated from the CMS/FSM.
Colonial Post Colonial Medical Development Fiji.docx

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Medico-Political Column

Corporate Fijian Healthcare

Author: *Dr. Neil Sharma*

Corporatized healthcare is increasing exponentially into Low- and Middle-Income Countries (LMICs), gravitating into the Pacific theatre. Complimenting the decadent public healthcare systems gracefully, yet devious corporate practices evolve. These corporate practices will contribute to escalating national health inequities.

The spreadsheets in the boardrooms determine the matrix of the healthcare system deliveries. The subtle direction of healthcare delivery, unethical professional maneuvers determine the type, standard and cost of services. Addressing the exclusive corporate financial blueprints for profit only, results. Financial Groups via their Health Insurance subsidiaries or affiliates, provide dualities in private health services.

The fiscal spreadsheets are becoming lucrative but the cost of services provided remains ethically questionable without appropriate legislative and policy control. The corporatized healthcare business model results in financial groups getting all the fiscal gains at the detriment of enhancing national health-equity. Corporatization includes private hospitals, diagnostic & day-care centers, large group practices and more recently a private sector owned rural health center in Fiji.

With current corporatization, with minimal policy legislation, under limited and sparse health insurance schemes nationally, a fuller range of clinical services provision of in-house and/or directed diagnostic services, with corporatized pharmaceutical services, the concept of the "one stop shop" arises to the client's greatest relief. However, is the fiscal cost appropriate for even the insured client, more so for the uninsured "Joe Blow" remains the question?

This presentation provides a brief contextual narrative of Fiji's evolving healthcare corporatization with a deficient& deteriorating public healthcare system. A positively evolving private healthcare sector but without adequate regulatory policy and unfortunately in a nation with major health strife with a worsening Non-Communicable-Disease's burden (1). In the absence of a national healthcare scheme inequities will worsen. A significantly high number of SDA targets reviewing current trends, will never be achieved.

The Silent Takeover
The corporatization of healthcare isn't just a policy shift:it's a cultural and ethical recalibration and it's spreading to Low- and Middle-Income Countries (LMICs) with the ferocity of a pandemic. **Terminology Changes:** "Patient care" slowly morphs into "patient throughout," "lives saved" into "bed turnover," and "community health" into "market capture."

The U.S. model s perfected within hospital systems, once anchored by religious orders or municipalities, transform nto vast, vertically integrated "health delivery networks." The goal s no longer s mply to heal, but to secure captive revenue streams. Reviewing the Diagnostic spiral, large non-profit hospital systems aggressively acquired ndependent imaging centers and physician practices. Suddenly, referral patterns shifted nternally. A patient with lower back pain at a clin c owned by the system was far more likely to get an MRI at the establishments imag ng center, regardless of whether a less costly conservative approach was ind cated first.

The insurance product offered by the parent corporation subtly incentivized using this internal 'value chain.' This sn t just vertical integration, it's a closed financial ecosystem where the patient's c inical need becomes secondary to revenue maximization. The ethical marker of 'necessity' s compromised by fiscal design. Health nequities w den because this model thrives in affluent, well-nsured zip codes, systematically divesting from poorer neighborhoods where 'throughput' metrics are less favorable.

Further, the nsurance Pivot between payer and provider has vaporized. The discussions are chilling: "What is the risk pool of this primary care practice we're acquiring?" "How can we adjust premiums or narrow networks to select for healthier populations?" **The mission is to manage financial risk, not population health.** The ethical conflict is absolute. The corporat on's fiduciary duty to shareholders is to minimize care expenditure, while its clinical duty s to optimize care provision.

You cannot serve two masters. The result is pr or authorization labyr nths designed to deter costly care, and provider networks so narrow they exclude the very specialists needed for complex, expensive conditions. The fiscal ga ns are staggering with record profits for insurers and massive CEO compensation, while medical debt remains the leading cause of personal bankruptcy in the U.S.

The European Adaptation: The Stealth Model.
Europe thought t was immune, protected by strong publ c pillars. One notes the slow, strategic creep of corporatization through **public-private partnerships** (PPPs) and outsourcing.

The British NHS and the Private Finance Initiative (PFI)
Under the banner of Healthcare "efficiency" becomes an nteresting case study. PFI focuses to build hospitals locked nto 30-year contracts with private enterprises and NHS trusts. The upfront capital remains private, but the repayments, bloated with shareholder profit now consume up to 10-15% of a trust's annual budget. This isn't a loan, it's a long-term extraction of public health funds nto private hands. To meet these fixed, crushing payments, trusts cut staff, reduce beds and outsource more services vis a vis cleaning to diagnostics, often to other private firms, creating a cascade of fragmentation. The 'provider' becomes a contract manager, not a healer. Health nequities are baked in as struggling trusts in deprived areas have less ability to meet these financial covenants, leading to a downward spiral of underfunding and poorer outcomes.

The German Diagnostic Factory.
n Germany's statutorily insured system, the rise of massive, privately-held chains of diagnost c centers (MRT, CT) and specialized surgical clinics. They are funded by public ins. rance funds but run for profit. Their business model depends on high volume. The insidious pressure is on referring physicians—often themselves under financial pressure to prescribe more scans and procedures. This drives up system-wide costs without improving popu ation health outcomes. It creates a two-tiered mentality w thin a supposedly universal system, the 'fast track' for profitable elective procedures in private clinics, and the overburdened public hospitals left with complex, unprofitable cases and training the next generation of doctors. The fiscal gain is siphoned off by the corporate groups; the health equity loss is borne by the public system's resilience.

The LMIC Frontier and the SDA Mirage
This is the model now being exported. With promises of 'modernization' and 'investment,' multinational hospital chains and insurance conglomerates are entering LMICs. They talk of 'Universal Health Coverage' but practice 'profitable patient selection.' They build gleaming hospitals in urban centers for the emerging middle class and expatriates, drawing the best doctors away from the public sector with higher salaries—a catastrophic brain-drain.

The Sustainable Development Goals (SDGs), particularly Target 3.8 for UHC, will not be met this way. Corporatization is structurally antithetical to equity. Its algorithms are designed to avoid the sick and the poor, not to embrace them. It views health not as a human right, but as a **market segment.**

Extrapolation to the Pacific Arena: The Quiet Wave of Corporatization
The Pacific arena presents a potent and often tragic case study of corporatization, where global models are superimposed on fragile, small-scale health systems with devastating consequences. The narrative here is one of imported vulnerability and ethical exploitation, magnified by geographical isolation, limited regulatory capacity, and acute health workforce shortages.

The Pacific Context: A Perfect Storm for Extraction
Pacific Small Island Countries and Territories (PSIDS) face a triple burden: high rates of communicable diseases, a rapidly growing epidemic of NCDs, diabetes, heart disease and the existential threat of climate change. Their public health systems are modest, donor-dependent, and stretched thin. Into this space step two primary corporate vectors: Multinational Private Hospital/Clinic Chains and Transnational Health Insurance/Managed Care Companies, often with metropolitan Australian, New Zealand and Asian origins.

Fiji: The Two-Tiered Citadel

In Suva, foreign-owned private hospitals arise—as 'centers of excellence.' It is advertised to the region's expatriates, tourists and the local elite. As a public hospital administrator, one observes as the most skilled nurses and specialists are poached with salaries the public sector will never match. The private facilities focus on lucrative elective surgeries, diagnostics, and specialist consultations. It has no infectious disease wing, no mass casualty unit and handles few complex emergencies. That burden remains squarely and now with a depleted staff on the dysfunctional public system.

The Fiscal Gain & Ethical Compromise. The corporate group's profits are repatriated. The public system, funded by taxpayers and aid, becomes the de facto subsidizer of this private venture: it trains the workforce, often at great cost through overseas funded scholarships only to see them lured away, and it handles the complex, unprofitable cases. Health equity widens into a chasm, quality care for those who can pay; a struggling public safety net for the vast majority. The Sustainable Development Agenda's call for 'leaving no one behind' is rendered absurd in this landscape. Unfortunately, the mix of the experiences of USA, UK & Europe, now fine tuned into the Fijian scene. Corporatization is throttling the traditional general practitioner cadre. Over 60% of Fijian General Practitioners worked for the corporatized healthcare system in 2025, an intergenerational landmark.

Vanuatu and Samoa: The "Medical Tourism" Drain

If you are a doctor in Asia or Port Vila. A patient with a complicated cardiac condition needs a specialist intervention unavailable locally. The public system, through aid partnerships, might have a pathway for referral to a major public hospital in New Zealand. But now, a slick brochure from a corporate healthcare group in another country promotes a faster, 'all-inclusive' package. It requires upfront payment or a specific insurance product. Middle-class families sell assets or take crippling loans to access this perceived better care. The financial toxicity is immediate and catastrophic for households.

The Fiscal Gain & Ethical Compromise. The revenue is extracted from some of the world's most vulnerable economies. The patient is often a medical and financial outsider in a foreign system with little continuity of care upon return. The local health system is further undermined, as community trust in its capabilities erodes. The corporate model exploits the lack of a robust public system as its core market opportunity.

The Insidious Role of Private Health Insurance (PHI):

In capital cities across the Pacific, aggressive marketing by subsidiaries of global insurers promotes PHI as a marker of modernity and responsibility. They sell primarily to formal sector employees, civil servants, and the wealthy. From a policy perspective, you see the creation of a parallel financing stream that seduces the healthiest and wealthiest out of the communal risk pool.

The Fiscal Gain & Ethical Compromise. This is the ultimate cherry-picking. The insurance model is mathematically unsustainable in small populations unless it excludes high-risk individuals. It draws vital financial contributions away from the public system that must serve everyone. It creates a political constituency (the insured middle class) with less interest in advocating for improvements to the public system they no longer rely on. The ethical marker of solidarity is completely discarded for risk segregation. The corporations win by managing a profitable, low-risk portfolio; the public system loses the resources and political will to function equitably.

The Diagnostic Services "Partnership":

Your ministry is approached by a multinational diagnostics corporation. They offer a **"PPP"** to modernize the national laboratory or imaging services. The deal is complex, but the allure is strong: new equipment, no upfront capital. The fine print, however, reveals a per-test fee that is above global market rates, a long-term contract that locks the government in, and proprietary technology that makes the state dependent on a single supplier for reagents and maintenance.

The Fiscal Gain & Ethical Compromise. This is fiscal colonization. Scarce public health funds are funneled for years to a foreign entity for a core service. The corporation's duty is to its shareholders to maximize test volume and profit margin, not to advocate for the most clinically appropriate, cost-effective testing regimen. Public health priorities like screening programs can become distorted by what is profitable to provide.

The Pacific-Specific Tragic Irony:

The greatest corruption is not always a bribe (though that exists), but the normalized, spreadsheet-sanctioned diversion of resources from health need to financial return. We have allowed the logic of the market, with its requisite of winners and losers, to infiltrate a realm that must be governed by a logic of solidarity. The fiscal gains are concrete, reportable, and flow to a small financial class. The loss is measured in foregone care, bankrupt families, and eroded trust—it remains diffuse, borne by the population, and devastating to the very idea of a healthy society. The system is no longer failing, it is functioning exactly as designed, viz a viz to generate wealth, not health. And until we name this as a hijacking and rebuild our systems on the principle that healthcare is a common, not a commodity, the prognosis will remain grim.

The very countries most in need of resilient, equitable, publicly-governed health systems to withstand climate-induced health crises (from dengue outbreaks to mental health trauma from displacement) are being steered toward fragmented, profit-driven models that are inherently brittle and inequitable. These models fail spectacularly under the collective stress that defines a public health emergency.

From this contextual prism, the corporatization in the Pacific feels less like an economic trend now and more like a form of systemic predation. It leverages vulnerability, extracts limited financial resources and human capital, and leaves populations more exposed. Whether as an Australian Aid funded health ministry advisor, a clinician in

a public hospital or a representative of a regional health body, one notes a familiar playbook deployed with even less resistance and greater impact.

The fight here isn't just about health policy; it's about national sovereignty, economic justice, and the right to develop a health system in the image of communal Pacific values, values fundamentally at odds with the corporatized ethos. The challenge is to build regulatory fortresses and regional solidarity to prevent the replication of a model that has, in the USA and Europe, already proven to be a masterful generator of wealth, but a catastrophic failure in fostering genuine health for all.

Reference:

1. https://www.health.gov.fj/wp-content/uploads/2026/02/Fiji-2025-STEPS-Survey-%E2%80%93-Country-Report.pdf

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DR JAMES JHINKU

8th July 1905 – 20th July 1974

Dr. James Jhinku was born in Batanikama, Labasa, on 8th July 1905. His parents were indentured labourers from India. At the age of 8 years he was taken by the Methodist Mission from Labasa to the Dilkusha Orphanage in Nausori, where he grew up. The reason for this move is not recorded.

Dr. James Jhinku qualified as a teacher. In 1924, he joined the Suva Medical School at Suva Hospital (CWM Hospital as it was known then). He graduated from the medical school in 1927. He was the second-ever Indian medical graduate from the school. The first medical graduate was Dr. Samson Decki in 1926. The others I can remember were Dr. Jaheef, Dr. Beg, Dr. James Prasad and Dr. Chandulal, who graduated later.

Following his graduation, Dr. James Jhinku served in the British Colonial Service in various locations, including CWM Hospital, Rakiraki Hospital, Nadi Hospital, Lautoka Hospital, Navua, Labasa Hospital and again at Navua where he served until his retirement in 1953. He continued to live in Navua until 1970.

Dr. James Jhinku moved to Naqumu Point, Lami in 1970, until his death on 20th July, 1974.

by Dr. **Daniel Jhinku**

Dr Indu Sinha- Prasad

Early Years

Dr **Indumati Prasad** (nee Sinha) was born in Sigatoka on the 13th March 1934. Her childhood years were spent in Ba, Fiji with her 5 brothers and 3 sisters.

She spent her high school in Dudley Boarding until she was about 16 years old and left Suva to return to Ba where she had to look after her Mum who was ill and her brothers and sisters. While working at Morris Hedstrom and studying for entrance to medical school. She applied and sat for exams to Fiji Medical School and was successful and accepted representing the Indian female to be accepted to study medicine.

She lived at the nurse's student cottage with 4 other indigenous Fijian women who were also accepted to study medicine. She graduated in 1957 with a Diploma of Medicine & Surgery and her 1st post was at CWM hospital, she was subsequently posted to several islands including the island of Mokogai where she treated patients with leprosy. In 1961 she was posted to Labasa Hospital where she met my Dad Mr. David Prasad who was the Principal of Nagigi Primary School, and they got married 6 months later on the 16th December 1961.

She returned to Ba, Navaga Hospital after marriage and stayed there for several years. She gave birth to her eldest daughter Dawn Ashwini Prasad in Ba on the 7th October 1962 and 2nd daughter Enid Vivienne Prasad at CWM Hospital Suva on the 27th September 1963. (She was briefly in Suva living with her in-laws at 10 miles.) She returned to Ba and gave birth to her 3rd daughter Odette Praveena Prasad on the 30th October 1965.

In the late 60s Both Mum & Dad spent a couple of years in U.K England from 1968-1969 where Mum attended Leeds & Exeter Universities undergoing post graduate studies. My Dad. David Prasad attended Oxford University and was a member on UNESCO. After returning from U.K. they moved to Suva and stayed in Samabula for a few months before buying their home at 16 Stadham Street Suva Point in October 1970.

In July 1971 Mum gave birth to her last child her son in Suva, Edwin Prasad and early 1972 she decided to leave Fiji for Mysore India to do her bridging course and obtain her degree, MBBS. She finished this in 1973 and returned to Fiji. In 1974 she opened a private practice in Fiji at Lumaria Apartments. 265 Waimanu Road. Suva Fiji until 1985.

The family migrated to Melbourne, Australia in July 1985. The daughters had already left Fiji in 1981 and were studying in Sydney, Australia. Mum started private practice (Heidelberg Medical Centre) in Cnr of Waterdale & Southern Rds Heidelberg West, Victoria (101 Southern Road, Heidelberg West, Vic 3081) on the 2nd September 1994. She practiced there till her retirement on 30 August 2017.

After retirement Mum spent her remaining years living with my brother and his family in Narre warren North. She spent considerable time being carer and supporter of my Dad, David Prasad, who by this time needed full-time care. Her pride and joy were her grandchildren William and Tiana Prasad and Aasha Parker. My Mum was passionate about medicine and health and attended numerous conferences in Australia especially regarding Vitamin D deficiencies and mental health. Mum loved her family and loved hosting family dinners and entertaining. Our home was a hub of activity with family and friends from all over the world visiting regularly. Mum also managed social media and loved Facebook and emails. I spent some memorable evenings with my parents watching Bollywood movies and listening to old Bollywood songs.

by **Ms. Enid Prasad.**

THE PRACTICE AND APPRECIATION OF MEDICAL PRACTICE (1961- 2026)

Author: Dr. Parshu Ram

This article discusses some aspects of medical practice and appreciations.

MEDICAL PRACTICE

My 60 years of medica practice have been very varied and ncluded internship, senior medical officer, medical registrar, medical officer, lecturer in the Fiji School of Medic ne, acting consultant physician, j unior consultant, senior consultant physician and Head of the Medical Unit, the Director of the National Diabetes Centre, general practitioner and consultant phys cian in private practice. Only some asoects are dealt w th in detail.

INTERNSHIP

graduated from Otago University Medical School n Dunedin, N.Z., in December 196' and did my nternship at Wellington Hospital and Lower Hutt Hospital. The former, n the capital city, was the largest hospital in the country and had al the specialities. Haemodialysis was just ntroduced.

The internship was a period of supervised practical and clinical app ication of years of largely theoretical training to eq. ip for inoependent practice. We had to do patient discharge summaries and were encouraged to present cases during hospital rounds. When rostered on the Acc dent and Emergency Departments on weekends, we had to do long 24-hour duties.

Like many other interns, I extended my nternship to two years (one year was compulsory). About this time, I decided to concentrate on general medicine and did another year as a Senior Med cal Officer (there was no vacancy for a medical registrar post).

While at Well ngton Hospital, we had the opportunity to attend sessions by three international authorities, i.e. Aubrey Leatham (British pioneer n cardiology), who gave a lecture on cardiac auscultation, T.H. Bothwell on disorders of iron metabolism, and D.W. Beaven on recent advances in diabetes.

ACTING CONSULTANT PHYSICIAN

n 1966, I was a opointed acting consultant physician for six months when the only consultant physician n the country went on six-month leave. This was in colonial days, d. ring which all senior posts were reserved for expatriates.

This a opointment was a major responsibility as I was a fairly junior doctor, being out of medical school four and a half years earlier and having on y one year's practice in Fiji. The duties involved the care of inpatients and outpatients, managing the medical unit, advising on medical matters to other departments, teaching medical students (two lectures and two c inical teaching sessions per week), and orov ding medical coverage for v s ting dignitaries.
The Fiji Medical Association held its n nth annual seminar, and I gave two of the first lectures on Acute Renal Failure and Liver Cell Fa lure.

thought I had carried out the duties of consultant physician well: there were no major mishaps, misdiagnoses, or complaints. A few of the patients later became lead ng politicians.

THE STATUS OF MEDICAL SERVICES IN 1966

At the C.W.M. Hospital, the wards were clean, neat, and tidy, and the compound well kept. The workers (doctors, nurses, paramedics, and support staff) t. rned up on time and did the day's work. Those on roster duties performed well, and those on call were readily available. Absence or lateness at work required an explanation and usually a certificate from the civil servants' clinic.

Senior doctors had offices on the ground floor, and these were not locked at n ght or on weekends. Nothing would go miss ng or stolen. The hospital admin stration was efficient, the serv ce was good, the rep. tation was high, and complaints were rare.

The head office admin stration was hardworking, dedicated, and committed. The best example was Dr. Charles Gurd. He jo ned the Fiji Medical Serv ce in 1951 as a physician specialist at the C.W.M. Hospital. He had a flat on the top floor of the hospital, was available 24 hours a day, and occasionally did additional rounds in the even ng. He started several clinics—medical, diabetic, hypertension, and rheumatic fever (for his studies on rheumatic fever he was awarded an M.D. from Bristol University)—and introduced cardiac catheterisation. He was later promoted to Director of Medical Services and nspector General of So. th Pac fic Health Services.

Ret. rning from overseas duties, arriv ng at Nausori Airport before closing time, he would go to the office, do some work, and then take rest at home and catch up on the backlog (he was doing 25–30 hours per week at home). For his outstanding contribut ons, he was awarded an O.B.E. in 1960 and a C.B.E. in 1969.

The head office was very efficient. Correspondence was replied promptly, and necessary reports were prepared on time. Discipline was strict and expenses well control ed. If you were paid, you were expected to work. f your work

was not up to the required standard, you were advised to leave the service.

Except for in-patients in the paying ward (who had to pay a small amount), all other in-patients, clinics, investigations, and treatments were free. All areas in the country had medical coverage. The service was regarded as good for the available funding.

E.C.G. was introduced several years earlier, peritoneal dialysis in the 1960s, cardiac catheterisation in the 1980s (managed by Dr. Bakani), a two-bed C.C.U. established in 1972 (managed by Drs. Bakani, Naseroa, and Bhagat Ram), and E.E.G. services in 1972. Endoscopies, haemodialysis, cardiac stress tests, and ultrasound investigations were not developed.

THE ADVICE

In 1967 Dr. Gurr had a social gathering of senior doctors at his Domain residence. I was invited and attended. At the end of the meeting, he showed his office at home and said, "***This is the second office of the Director of Medical Services. I spend about 30 hours per week in this office.***"

He also commented about the consultant physician at the C.W.M. Hospital. "***In this position you would be able to keep track of medicine, would be able to advise and influence medical progress. If you were able to devote considerable time, you would be in a position to contribute a lot to the development of medicine in the country.***"

I always remembered his comments and advice and followed them. I was actually doing about 15 hours of work outside office hours and gradually increased to 30 hours per week.

TEACHING

Teaching undergraduates and postgraduates is an important part of medical practice. The undergraduate teaching included lectures in physiology, biochemistry, pharmacology (for the first time organised full subject teaching was introduced; earlier some lectures were given by anaesthetists), internal medicine, ward teaching, tutorials, and setting examinations and assessments.

The postgraduate teaching included almost 500 lectures during seminars and conferences organised by the Fiji Medical Association, both national and regional, the Fiji General Practitioners Association, the Fiji Dental Association, several paramedical associations, and hospital and district meetings. It also included ward rounds, postgraduate lectures, journals, and publications. For postgraduate lectures, one needed to remain updated with recent developments. The library service was inadequate, small, had few books and even fewer journals, mainly from the United Kingdom. There were no other sources of information locally. One depended on personal copies of leading textbooks and personal subscriptions to leading journals.

The textbooks included (authors and titles):
- Brain – Diseases of the Nervous System
- Paul Wood – Diseases of the Heart and Circulation
- Sheila Sherlock – Diseases of the Liver and Biliary System
- Douglas Black – Renal Diseases

The journals included:
- British Medical Journal
- New England Journal of Medicine
- Disease-a-Month
- North American Medical Clinics
- American Journal of Medicine

These were a considerable strain on limited finances.

FORMATION OF THE FIRST POSTGRADUATE COMMITTEE

Between 1960–69, six-month postgraduate sessions in Public Health were conducted by the Fiji School of Medicine, which led to the award of "Certificate in Public Health". There was no postgraduate training before or after the above.

Regular weekly rounds were held at the C.W.M. Hospital since the early 1960s and later at Lautoka Hospital.

In the early days, the number of doctors was small, library services were very limited, and there were rarely teaching aids. In the 1970s and 1980s, there was an increase in the number of doctors, some improvement in library services and teaching aids, and a high failure rate in the Royal Australian College examinations. There was a pressing need for postgraduate teaching.

With the support of all the consultants and the medical superintendent, the first postgraduate committee was formed at the C.W.M. Hospital in 1982. The office bearers were:

- **Patron:** Dr. Ken Lal – the medical superintendent
- **Chairman:** Dr. Parish Ram
- **Vice-chairmen:** Dr. J. Teka and Dr. S. Nandan
- **Secretary:** Dr. S. Mudaliar
- **Treasurer:** Dr. G. Hawley
- **Members:** Consultants and senior registrars

The initial activities included daily lunch hour (1–2 pm) clinical sessions by all departments and 1–2 hour evening sessions once or twice a week in basic science. The visiting specialists contributed to the lunch hour sessions.

The above sessions became very popular, well appreciated, well attended, and especially valuable for registrars and junior doctors.

APPOINTMENT OF SENIOR CONSULTANT PHYSICIAN AND HEAD OF THE MEDICAL UNIT

In 1977, in the 13th year of practice, I was appointed the senior consultant physician and the head of the medical unit of the Colonial War Memorial Hospital, the largest hospital in the country. I was the first local to pass the Physicians Examination of the Royal Australasian College of Physicians and the Royal London College of Physicians and the first to such a position in the early post-independence period. The major responsibilities included:

- The development of medicine
- The management of the medical unit, about 110 inpatients, including a 4-bed CCU and a number of intensive care beds, 5 main clinics and 2 smaller clinics, and preparation of annual reports and estimates for the year
- Providing medical coverage for other units
- Medical coverage of W.H.O personnel, visiting dignitaries, and international meetings
- Contributions to committees and boards of M.O.H, F.S.M. and C.W.M. Hospital, including the Medical Board, Academic Board of F.S.M. Research Committee, Typhoid Committee, and Drug Committee
- The medical unit was the referral centre for medical cases from major parts of the country
- Providing opinions and advice on medical issues
- Providing teaching, encouragement, and guidance for junior doctors
- Teaching, research, and publications
- Lectures to overseas audiences

THE MAJOR DEVELOPMENTS
These were mainly in:

RENAL DISEASES
Introduction of peritoneal dialysis, haemodialysis (both at Lautoka and C.W.M. Hospital), home haemodialysis, renal biopsy, improving urinalysis, follow-up of transplant patients (transplanted in Australia), and teaching.

NEUROLOGICAL DISEASES
Developed gradually and was greatly helped by regular visits of the Sydney Neurological team and three months of attachment to the neurology unit of the Royal Prince Alfred Hospital, Sydney (mainly in E.E.G.), which led to the provision of E.E.G. services in Fiji (E.E.G. machine donated by the Bank of N.S.W. as an independent contribution). A number of rare neurological conditions were diagnosed for the first time in the local population.

NON-COMMUNICABLE DISEASES (mainly CV disease and diabetes)
Hypertension – detection, treatment, and prevention. Major emphasis on lifestyle changes in prevention and treatment.

Ischaemic Heart Disease – detection, education, treatment, and prevention of CV risk factors. Cardiac catheterization, CCU, and stress tests, managed by Drs. Sakai, Naseroa, and B. Ram.

Diabetes Mellitus – increasing awareness, education, detection, treatment, diabetes activities, and establishment of the National Diabetes Centre.

INFECTIVE CONDITIONS
Increasing awareness, diagnosis, treatment, and prevention.
Major diseases – leptospirosis, typhoid fever, amoebiasis.

DIAGNOSIS OF RARE DISEASES
A large number of rare and lesser common conditions were described for the first time in the local population and published (most). These included:

- Cryptococcal meningitis
- Mycosis Fungoides
- Toxic Epidermal Necrolysis (Lyell's syndrome)
- Leptospirosis
- Alkaptonuria
- Pseudohypoparathyroidism
- Eosinophilic meningitis
- Paget's disease of bone
- Neurogenic Pulmonary Oedema
- Marfan's Syndrome
- Epilepsia Arithmetica
- Chromomycosis
- Transient Global Amnesia
- Devic's Syndrome (Neuromyelitis Optica)
- Wilson's Disease (Hepatolenticular degeneration)
- Myasthenia Gravis

MISCELLANEOUS
- Introduction of liver biopsy
- Several other conditions

LECTURES TO OVERSEAS AUDIENCES
Being a senior doctor and in a senior position received a number of invitations from overseas and international meetings and conferences for contributions as a speaker, consultant, temporary advisor, resource person and section chairman.

Due to heavy clinical commitment and financial constraints, I was able to contribute as a speaker in Cambridge – England, New Delhi and Mumbai – India, Townsville, Melbourne and Hobart – Australia, Palmerston North – New Zealand, Kona – Hawaii and a number of lectures to overseas audiences given in Nadi and Sigatoka.

RESEARCH AND PUBLICATION
Research and publications are regarded essential for disease management. Considerable research in the past has been mainly in renal, non-communicable and infective diseases.

MAJOR NATIONAL SURVEY
The most comprehensive epidemiological survey of National Cardiovascular and Metabolic Diseases was conducted by the Ministry of Health and two Melbourne hospitals, Royal Southern Memorial and Royal Melbourne hospitals in 1980 and was partly funded by the World Health Organisation.

I was appointed the national team leader for the survey in 1979. Six weeks survey followed 8 months of planning and involved 21 personnel (five were doctors, 3 seniors). The areas selected were Suva and suburbs, Sigatoka valley and Lakeba to represent both major ethnic groups, the rural urban and island populations. The survey was highly successful and the comments by the senior investigator was:-

"Finally, we would like to thank Dr. Parshu Ram the national team leader for his outstanding contributions for the success of the survey. His account of local arrangements was a major factor in the efficient conduct of the work" – *Professor Paul Zimmet*

The survey showed the prevalence of hypertension (SBP ≥ 160 and /or DPB ≥ 95mm Hg) was 10-11% among urban population of both groups and sexes and rural population was 4-9%. The cardiovascular risk factors were prevalent more in urban than rural populations.

The prevalence of diabetes was 1.7% in rural, 5.4% in urban and 5.7% in Lakeba in Fijians and Indian rates were 11% in rural and 11.8% in urban population. Compared to an earlier study in 1957 these were more than two-fold increase in Indians and several fold increase in Fijians. The need for Diabetes Centre was raised, discussed and considered.

THE ESTABLISHEMENT OF THE NATIONAL DIABETES CENTRE

Following high prevalence of diabetes observed in the National Cardiovascular and Metabolic Diseases Survey in 1980, the attendance at the First W.H.O / I.D.F international seminar in the Epidemiology and Public Health aspect of diabetes in Cambridge England (with exposure to six international diabetologists), in 1981, W.H.O workshop on Diabetes Control in the South Pacific in Suva in 1982, keen interest of the Prime Minister Ratu Sir K. K. T. Mara and the support from Professor Turtle, Sydney led of the National Diabetes Centre in Suva in 1984. It was the first such centre in the developing world.

was appointed the Director of the Centre in 1984, and the staff were trained in Australia. four members trained mainly in Professor Turtles department Royal Prince Alfred Hospital, Sydney and Professor P. Mofft's Diabetic Education and Stabilization Centre, New Castle and a research officer in Professor Zimmet's Diabetic Centre in Melbourne.

nitial aim of the Centre was Training, Education, Resource and Research activities. All centre activities progressed well due to dedicated and commited staff and the great support and encouragement from the community and in particular the National Diabetic Foundation under the guidance of chairman Mr. Manendra Motibhai Pate C.B.E. The centre started triannual eight-page Diabetes Awareness Newsletter in 1987 and in 1990 expended the activities to day long seminars in various part of the country. It also included high schools in the area.

The National Diabetes Centre developed rapidly, and its contributions were greatly appreciated and utilized. It gained internation status and trained health professionals from several South Pacific countries. Some comments about the centre.-

"I would like to avail myself of the opportunity to thank the staff of the centre for their sterling services to the diabetics of Fiji" *– Ratu Sir K. K. T. Mara, Prime Minister of Fiji, 1986*

"The citizens of Suva are very proud of the National Diabetes Centre which has become an important teaching and educational institute for the country and the Soth Pacific. The work of the centre is highly commendable" *– Dr. S. Buadromo, The Lord Mayor of Suva, 1992*

"The National Diabetes Centre in Suva is really a "jewel in the Crown" for diabetes in the Pacific region and it is testament to the endeavours of the staff" *– Professor Paul Zimmet, Director of International Diabetes Institute, Melbourne, 1994*

EPIDEMICS IN 1980's

Fiji experienced two epidemics in 1980's.

EPIDEMIC OF ACUTE GLOMERULONEPHRITIS

An epicemic of acute glomerulonephritis occurred in most part of Fiji between February 1981 and August 1982. Mild cases were treated as outpatients and severe cases were admitted to various hospitals. During the above period 229 cases were admitted to the Colonial War Memorial Hospital. These were studied in detail and results published in F.M.J. Vol. 17 Nos 5 and 6 in 1986.

The disease affected mainly adults of both sexes with the mean age of 33.5 years. Only 15.8% occurred in 0-14 years age group. It also occurred in one ethnic group (ethnic Fijians 91.3%, other ethnic groups 8.79%).

The major clinical features were oedema, proteinuria, haematuria, hypertension and oliguria. The majority had nephritis with raised blood urea, a quarter nephritis-nephrotic syndrome and 10% renal failure. A history of sore throat and skin infection obtained in 62% in the preceding four weeks and a positive throat culture of Beta haemolytic streptococci in 22%.

During this period 25 adults were treated in outpatient in whom detailed history was obtained, 23 had recent sore throat and positive streptococci isolates in 42%.

Due to heavy clinical load renal biopsy was done in only seven patients after working hours. The biopsies were processed at Concord Hospital Sydney and reported by Drs. C. George and R. C. Newland. The finding was those of an immune complex induced proliferative glomerulonephritis with significant glomerular damage. The presence of subepithelial humps suggested post infectious glomerulonephritis.

During the above period there was no evidence of any other bacterial or viral disease that could have caused the epidemic.

The available information suggested post streptococcal glomerulonephritis.

In the four month follow up there were three deaths from renal failure, and a few patients developed renal insufficiency.

EPIDEMIC OF TYPHOID FEVER

Fiji experienced an epidemic of typhoid fever in 1982 and 1983. The investigations, treatment, and prevention were ably guided by the Typhoid Committee of the Ministry of Health, composed of eight senior doctors.

was the team leader of the investigating team. The team visited Moturiki, Ovalau, Levuka Hospital, Tailevu villages, and the Nadi areas. Two centres of infection were Moturiki

(17 cases) and Waya (9 cases) in the Yasawa Group. The majority of cases in Moturiki were directly related to food distribution during family gatherings. From there, it spread to Ovalau, Tailevu villages, and Suva.

Twenty-five patients were treated in eight bed isolation unit at Levuka Hospital in Fiji, which had limited facilities. All cases recovered due to the excellent treatment provided by Dr. Y. Nayaran, the resident doctor, and his staff.

Seventeen cases from the Southern Division were treated in isolation unit at the C.W.M. Hospital. There was one death from enteric perforation. Cases from Waya were treated at Lautoka Hospital.

In 1985, 20 cases were reported, 11 from the Eastern Division and 9 from other Divisions.

The details of the cases were published in F.M.J., Vol. 11, Nos. 9 and 10, 1985.

PUBLICATIONS

I was the founding member of the Fiji Medical Journal, The Fiji General Practitioner and Diabetes Awareness Newsletter (its initial editor), involved in their development and was the major contributor.

I published 270 journal articles:
10 sections in books (the most significant being three sections in the W.H.O publication Guidelines for the Control of Leptospirosis)
2 monographs:
Cardiovascular Disease in Fiji, 1991
Diabetes Mellitus in Fiji, 1991

SUMMARY OF CONTRIBUTIONS AND ACTIVITIES

Patient care of inpatients, outpatients and referrals.
Development of Medicine in Renal, Neurological, NCD and infective diseases and diagnosis of rare diseases for the first time.
The establishment of the National Diabetes Centre
The formation of the First Postgraduate Committee
Provision of EEG services
Contributions, opinion and advice on Medical issues
Training, encouragement and guidance of junior doctors
Teaching, research, journal initiation and publication
Lectures to overseas audiences

COMMENTS AND ENCOURAGEMENTS FROM COLLEAGUES

In the 60 years of medical practice, I received a large number of comments, opinions, appreciations and encouragements from both local and overseas colleagues. A partial list is included.

FROM LOCAL COLLEAGUES

"Dr. Parshu Ram and his colleagues have spent many years researching the Epidemiology of Leptospirosis in Fiji and have contributed extensively to medical literature both locally and internationally"
Dr T. Mitchell, editor F.M.J. 1985

"The Fiji Medical Journal congratulates him (Dr. Parshu Ram) and his colleagues for their commitment, introduction and the development of acute renal failure in Fiji"
Dr T. Mitchell, editor F.M.J. 1985

"Dr Parshu Ram, I also take this opportunity to thank you for the 21 years of loyal and dedicated service you have given to Government and wish you a happy retirement."
Mr. N. B. Baniga, Secretary, Public Service Commission, 1986

"Dr. Parshu Ram is most deserving of the Queen's honour in view of his outstanding contribution to the medical field in his position as consultant physician. Both his colleagues and patients are said to be appreciative of his dedication and sensitivity. His venture contribution and his role in curtailing the impact of diabetes is well known"
Mr. C. P. Bidesi, OBE, JP, Fiji Ratna, Gold Ratna, 1986
Requested the then Prime Minister to consider him for next years honours.

"Dr. Parshu Ram has a distinguished career in the field of medicine as a physician specialist and has very ably served the people of Fiji in his various capacities and enjoys their confidence and trust"
Mr. Bachu Bhai, FPS, JP, Managing Director, Central Pharmacy Ltd, 1987

"On behalf of Public Service Commission, I wish to extend to you and your staff our thanks and appreciation for the wonderful service that the centre provides to the public and wish you well in future endeavours" (refers to National Diabetic Centre)
Dr. I. R. Bakani, CBE, Chairman, Public Service Commission, 1989

"Dr. Parshu Ram, I wish to thank you and your staff for the good work rendered to the public of Fiji by the National Diabetes Centre through your guidance and leadership"
Dr. A. N. Kamikamica, Minister of Health, Fiji, 1996

"Dr. Parshu Ram has contributed tremendously to medicine both nationally in terms of clinical services, undergraduate and postgraduate teaching at the Fiji School of Medicine and internationally in the field of medical research on topics such as Leptospirosis, Diabetes Mellitus, Renal and Cardiovascular Diseases"
Dr. S. R. Govind, Editor, F.M.J in Fellowship Award, 1990

"As a researcher Dr. Parshu Ram has almost single handedly put Fiji on the international map. Throughout the medical fraternity Dr. Ram is looked upon with great respect and admiration. He can really be called the grand (old) man of Medicine in Fiji"
Dr D. Nandan, President, Fiji Medical Association, 1991

"The FNDF is a very young organization and we are grateful to the Government for its wholehearted support in providing skilled trained personnel headed by Dr. Parshu Ram, a man who is held in high regard both locally and internationally"
Mr. M. M. Patel, CBE, Chairman, Motibhai Ltd.

"Dr. Parshu Ram, the legend, had a distinguished and unparalleled career in Fiji. He was instrumental in the establishment of the National Diabetes Centre and was its first director"
Mr. G. Stephen, Superintendent Radiographer, CWM Hospital and Deputy Editor, Diabetes Awareness Newsletter, 1995

"Dr. Parshu Ram was the first local to pass Physicians Membership Examination, first local appointed Consultant Physician M.O.H and first elected Fellow (Gold Medalist) F.M.A."
Dr. Ram Raju, Editor, Pharmatimes, 2017

"The most eminent Physician Dr. Parshu Ram, the longest and medical journal contributor, our teacher and educator with immense humility who continues to serve these very interests from semiretirement in Melbourne, Australia"

Dr. B.P Ram, Kidney Foundation and Dialysis services in Fiji 2017.

"Dr. Parshu Ram was Fiji's most eminent physician, researcher and medical worker in the 60's and 80's"
Dr. N. Sharma, Doctor Pharmacies, 2021

"Dr. Prashu Ram was well regarded as Grandfather of Renal Medicine in Fiji"
Dr. Amrish Krishnan leader of nephrology in Fiji. F.C.G.P Seminar 2022

"I shall be leaving Fiji very soon and I wish also to take this opportunity to tell you how much I appreciated your kindness and willingness to take care, when necessary, of our WHO colleagues in need"
Dr. J. D. Verdijk, W.H.O Representative and Programme Coordinator

The contributions (in the practice and the development of medicine, teaching, research and publications) was well appreciated by the Fiji Medical Association and awarded the following prizes-

Desai Prize for contributions to medicine in Fiji - 1973
Musadilal Prize for postgraduate education - 1976, 1982, 1983, 1984, 1985
Prakash Mehta Prize for postgraduate education - 1986
Fellowship award of the Fiji Medical Association for contribution of medicine locally and internationally (first award in the long history of FMA - 1990

FROM OVERSEAS COLLEAGUES

"Most important were many discussions of great benefit with Dr. Parshu Ram, to whose knowledge, energy and interest the recognition of leptospirosis as a problem in Fiji must be credited"
Professor S. Faine, Melbourne. W.H.O consultant. 1974

"You are doing tremendous job in Suva"
Dr. R.B.I Morrison, Renal Physician, Wellington, N.Z, 1974

"I thought you were doing an excellent job in the clinical management"
Dr. C. Tasman-Jones. Associate Professor of Medicine, Auckland University. N.Z 1980

"I would like to congratulate you for your most sincere effort for initiating comprehensive activities for care of diabetes in Fiji"
Professor J.S. Bajaj, India, President, International Diabetes Federation. 1986

"Its director is Dr. Parshu Ram, the man who diagnosed me as a diabetic exactly 20 years ago. He is not only a workaholic but one with the ability to infect others with his own enthusiasm"
Mr. G. Rodgers, President, Northland Diabetes Society. N.Z, 1985
Former Minister of Education, Fiji, visited the National Diabetes Centre
"The get up of Fiji Medical Journal Vol. 13. No. 12 1985 is very attractive. The picture of the National Diabetes Centre on the cover speaks for efforts you have put to make people of Fiji aware of diabetes"
Dr. S.S Ajgaonkar, Mumbai. Past President of Diabetic Association of India, 1985

"You have indeed produced excellent posters and pamphlets in all aspects of diabetes which are suitable for adopting elsewhere"
Dr. Quentin Reilly, Secretary for Health, P.N.G, 1987

"You and your team are clearly doing a very good job in the field of diabetes and I hope you will keep up the good work"
Dr. J. Buchanan. Director of Continuing education, R.A.C.P, N.Z, 1987

"Dr. Parshu Ram you are doing a wonderful job in Suva"
Professor M. Viswanathan. Diabetes Research Centre. Chenai, India. 1986

"By any criteria he is an outstanding physician who has done a very great deal to further medical knowledge not just in the Pacific"
Professor H. Lander, Adelaide, letter to the President of R.A.C.P, 1986

"He has the most outstanding record of any physician of Pacific nations and has attained international status in the field of diabetes particularly in respect of diabetes epidemiology"
Professor P. Zimmet, International Diabetes Institute, Melbourne, Australia. 1993

"Dr. Prashu Ram is now known and accepted throughout the Southern Hemisphere for his activities and energetic leadership in diabetes"
Professor D.W.Beaven, Christchurch, N.Z. 1993

"His expertise and knowledge in Leptospirosis, Diabetes and Renal Diseases is quite outstanding and without equal"
Professor H. Lander, Adelaide, letter to the chairman of Asia Pacific Committee of R.A.C.P. 1993

He was elected a Fellow of All India Institute of Diabetes in 1990. This prestigious Institute confers fellowship on distinguished diabetologist throughout the world as a recognition of their contributions directed at improving the quality of life of diabetics. By 1991 this institute had 114 fellows.

ACKNOWLEDGEMENT

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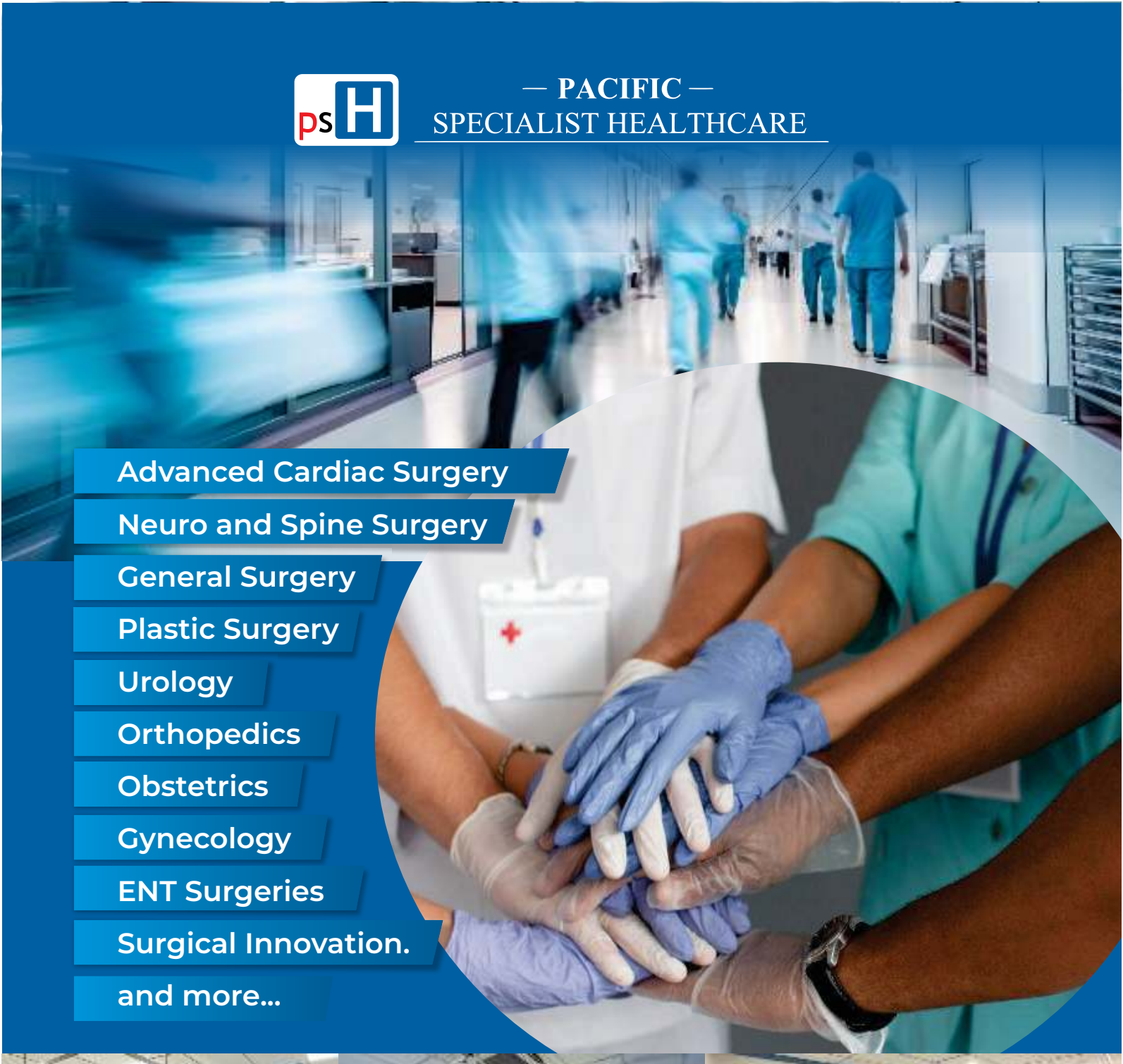

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