

graduates of this School were given status of their qualifications — something which has been long over due.

The introduction of seventh forms in Fiji and proposed phasing out of the Preliminary Science Programme will have important implications to the Medical Course. At present the USP conducts the first year i.e. Preliminary II (Medical). While we welcome the introduction of Seventh form in High Schools in Fiji there may be a lot of wisdom in retaining the first year of the Medical Course at U.S.P. after seventh form.

The School staff would soon be deliberating on this important issue which could have far reaching effects if the future directions are not delineated at, this stage. Perhaps we might be able to reduce disturbingly high drop out rate in the second year, if the preclinical component of the course was lengthened by at least six months.

Time has come for review of the Medical Curriculum. We are mindful of the past and present achievements

of this institution. However, these we should not be complacent about it. The Medical School should look forward and not backward in its training programme. We agree with the concept that education and research programmes within the Medical School should be relevant to the Health Care needs and resources of the countries. There have been quite rapid changes in the patterns discussions and environmental conditions and sometimes it happens that there is substantial delay before these changes are reflected in altered education and research programmes. With the progressive growth of scientific knowledge content becomes too large to be comprehended by an individual mind. Hence, it is now important to teach the students how to learn rather than just what to learn. There is a need to improve the educational skills of teachers by establishment of courses in teaching techniques, curriculum planning, instructional design, evaluation and measurement. Hence, it will be necessary to organise in future workshops for teachers in health profession in general education."

PERINATAL MORTALITY IN FIJI

INTRODUCTION

Perinatal Mortality is defined as late foetal deaths or stillbirths plus infant deaths within 7 days after birth. It is customarily expressed as rate per 1000 total births. Early neonatal mortality is death within 7 days after birth and is customarily expressed as rate per 1000 live births. Both indices are sensitive indicators of the quality of antenatal care, delivery service and neonatal care provided by the Country Health Service.

Prior to 1970 perinatal mortality statistics were either non-existent or scarce because of lack of reporting or a system for doing so. Whatever statistics reported were usually from work of interested personnel and through their own effort within their units in the hospital or Division. Such was the case with Dr D.J. Lancaster, Consultant Obstetrician and Gynaecologist at C.W.M. Hospital from 1964-71. While representing Fiji at the VTH Asian Congress of Obstetric and Gynaecology in

Djakarta, Indonesia in 1971 he reported the following Statistics: 1

Combined Stillbirths and Neonatal Death Rates

Year	Fijian	Indian	Total
1965	56.5	99.7	82.2 per 100 births
1970	24.2	50.3	40.8 per 1000 births

In 1971 reporting of Foetal and Neonatal deaths were standardised with the introduction of Consolidated Monthly Returns, Foetal Death registers and Monthly Obstetric Ward returns. These returns ensured wider coverage and consequently the accuracy and reliability of Perinatal Mortality Statistics in Fiji. This paper reviews Perinatal and Early Neonatal Mortality for the period 1974-1978.

FINDINGS

Perinatal Mortality By Race 1974-78

Year	Fijian	Indian	Others	Rate/1000 Total Births
1974	16.9 (134)	43.8 (369)	27.7 (24)	30.9 (527)
1975	19.2 (142)	41.8 (352)	23.4 (20)	30.6 (514)
1976	21.7 (176)	36.2 (321)	14.7 (13)	28.8 (510)
1977	18.4 (159)	33.2 (296)	27.2 (25)	26.2 (480)
1978	15.2 (138)	32.8 (319)	10.9 (11)	23.8 (468)

Figures in parenthesis are absolute number of deaths

The declining trend in all three ethnic groups is notable. The reduction in the rates is most marked in 'Others' group with 60.6%, Indians next with 25.1% and Fijians last with 14.2%.

Fiji's 1978 figures compared well with that of developed countries such as: Australia = 19.2, Israel = 20.9, Austria = 21.2 and Belgium = 19.7 2

Early Neonatal Mortality

Early Neonatal Mortality Rate per 100 Livebirths

Year	Fijian	Indian	Others	Rate/1000 L.B
1974	11.9 (94)	28.1 (233)	18.7 (16)	20.1 (343)
1975	10.1 (77)	27.1 (255)	19.9 (17)	19.1 (319)
1976	14.5 (125)	22.7 (199)	10.2 (9)	18.8 (333)
1977	12.9 (111)	20.1 (178)	19.7 (18)	16.8 (307)
1978	10.6 (96)	21.4 (205)	7.0 (7)	15.7 (308)

Early neonatal mortality is a very sensitive index of the efficiency and quality of care provided during pregnancy and childbirth. It can be safely said that the falling trend amongst the three ethnic groups is a true reflection of rising quality of care provided for mothers and babies in Fiji.

Overall Fiji rate declined by 22.0% during the 5 year period while individual ethnic group declined by 62.6%, 23.8% and 10.9% for 'Others', Fijians and Indians respectively. These figures should be read in relation to the comparatively high incidence of Anaemia amongst Indian mothers as well as the correspondingly high incidence of low birth weight babies amongst them.

CAUSES OF EARLY NEONATAL DEATH

A review of early neonatal deaths during the 3 year period 1976-78 showed that the commonest cause of death was Prematurity which was responsible for 52.3% of all Deaths. Details are tabulated below:

FIVE CHIEF CAUSES OF EARLY NEONATAL DEATHS 1976-1978

Causes	Number	Rate %
1. Prematurity/Immunity	496	52.3
2. Anoxic and Hypoxic causes	60	6.3
3. Broncho pneumonia	43	4.5
4. Congenital Heart Anomalies	24	2.5
5. Other Unspecified Congenital Anomalies	18	1.9
	641	67.5

OTHER CAUSES OF DEATH

There were many other causes of death responsible for single or smaller number of Deaths. These totalled 307 or 32.5% of all cases. Five such causes are:

1. Septicaemia
2. Gastro Intestinal Infection
3. Trauma
4. Cardiovascular Causes
5. Tumour or neoplastic Causes.

DISCUSSION

Maternal Anaemia is very common amongst Indian women as reported by Bavadra et al 3 who said "the incidence of Anaemia amongst Indian women in 1975 was 32% higher than whole of Dominion, 89% higher than Fiji women and 172% higher than in 'Other' racial groups. Similar proportion was observed in 1973 and 1974".

In apparently non-pregnant women aged 18-45, Parshu Ram et al 4 found an incidence of anaemia (less than 126% as recommended in W.H.O. Technical report series 1968, p. 405) of 38% which is 38,000 per 100,000.

Bavadra et al found amongst pregnant Indian women 25% or 25,000 per 100,000. It could therefore be said with some confidence that Maternal Anaemia amongst Indian would be one major contributing causes of higher Perinatal and Early Neonatal Mortality amongst Indians

SUMMARY

Fiji's Perinatal and Early Neonatal Mortality rate in the 5 year period 1974-78 has shown a decline of 22.9%. In 1978, by race, Indians had the highest rate with 32.9/1000, then Fijians with 15.2 and 'Others' news 10.9. The high incidence of Anaemia amongst Indian mothers is a major contributing cause of the high perinatal mortality rate amongst Indians. The overall declining trend is a reflection of improving Maternal

and Child Health Care provided by the National Health Services.

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SOME OF THE PATHOLOGICAL EFFECTS OF ALCOHOL ON MAN

Summary of an Address given at Hoodless House, C.W.M.H. on 6/11/79 by

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INTRODUCTION

The use of drug alcohol is part of our Society and has been for a very long time. It was mentioned in the writing of ancient Sumaria 4,000 years ago where it was used as a form of reward for young heroes. The use of alcohol is intricately interwoven with the fabric of our Society. Social attitudes towards its use vary in different cultures and major religions have for the most part made some statement on its use. The short-term effects of taking alcohol are well-known. The marvellous complexity of terms used to describe a person who is under the influence of alcohol are indicative in themselves of the variety of attitudes that we all have towards intoxication. These terms, to mention just a few include intoxicated, drunk, boozed, under the influence, and many others which are peculiar to some areas of the world.

There is a much talked about state of sudden collapse. This is sometimes referred to as "flaking" in New Zealand. This is pathological intoxication caused by taking extremely little alcohol indeed. Behaviour is profoundly modified with great hyperactivity and marked aggression towards other people. The whole syndrome lasts for approximately 15 minutes when the person collapses unconscious. They usually wake later with no memory of the events. It is important to realise that this is a rare condition almost entirely confined to people who are epileptic or have suffered serious head trauma in the past. It is therefore rather more serious than social attitudes indicate.

Some of the long-term effects of alcohol abuse are obvious. For example the death and morbidity from road traffic accidents in New Zealand is an area which has received much attention including legislative attention in the recent past. Financial and social sequelae for members of the family of an alcoholic is a large subject of great importance. The relationship of crimes including assaults and other crimes of violence

to alcohol intake are receiving increasing attention. I do not wish to under-rate the importance of these areas, but the subject of this address does not include these matters.

ALCOHOLISM

Cases in which there are organic changes in the various organ systems of the body are almost confined to persons who may be accurately described as being alcoholic. The definition of an alcoholic is not entirely satisfactory, but one must consider certain points. A person who is accustomed to a high alcohol intake may have an ability to cure various vague feelings of unwellness following bouts of drinking by taking alcohol. The traditional explanations for this are rather mysterious. The phenomena is well known as taking the "hair of the dog". A possible explanation is that it is control of minor withdrawal symptoms by re-introduction of the drug.

The similarity of drug addiction and alcoholism is even more marked if one considers the major withdrawal syndrome known as delerium tremens. Alcoholics may enter the state of delerium tremens by two main ways. Firstly, the well-known syndrome of bout drinking of alcohol followed by exhaustion of financial resources and the development of the withdrawal syndrome because alcohol can no longer be purchased. The alcoholic with extensive financial resources is a somewhat more difficult problem. His alcoholism may not be as apparent and he can afford to continue to buy the drink. If such a person is separated from the supply of alcohol as for example when admitted to hospital for an operation, he may very unexpectedly develop some neurological manifestations which are the onset of delerium tremens.

Delerium tremens is an extraordinary state characterised by gross hyperactivity of the body, the sympathetic nervous system is hyperactive, there is