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Date **March 7, 1988**
ABSTRACT:

The approach of this enquiry is to describe and analyze the processes and interactions which occur when Indo-Fijian women seek health care from their medical system made up of traditional beliefs and practices, combined with alternative sources of healing such as the Biomedical system, and some Fijian practices. Throughout, I have been concerned with discovering the strategic choices and decisions which Indo-Fijians employ in their transactions with a number of traditional types of healers such as pandits, pujaris, maulvis, orjahs and dals, as well as doctors and nurses in the biomedical sector.

I have used the concept of process as basic to this enquiry and I have paid attention to those processes which display social behaviour in empirical events or situations, and thus on emergent medical systems. Thus, the approach chosen for this study is particularly suitable in the case of Indo-Fijians who arrived in Fiji as indentured labourers, and have had to adapt, to regularize their lives through situational adjustment.

The methods used for data collection were participant-observation in two Indo-Fijian settlements and in a Western Biomedical hospital, in health centres and district nursing stations; as well as the use of archival and library materials.

The enquiry, the first of its kind on health strategies of Indo-Fijian women, concludes with a chapter which discusses the interactions and processes between all medical care domains used by Indo-Fijians. Indo-Fijians do not distinguish between medical systems; their medical system is Indian in its ideology but lacks the practice of the therapies of professionalized Indian medical systems; it has retained religious healing, reconstructed and synthesized folk healing traditions from many parts of India, as well as adding elements from Fijian healing. While it is also Western in its use of professional therapies, it lacks the ideological foundations of biomedicine.
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To my family, a special thanks for bearing with me, through my endeavours. Jim McIntosh, a very important person in my life is always mentioned last, but I owe him the most for always keeping the home front secure in spite of my distractions.

I acknowledge errors and omissions in the work, as my own.
ORTHOGRAPHY:

Fijian orthography:

b is pronounced as mb in number

c is pronounced as th in then

d is pronounced as nd in end

g is pronounced as ng in sing

q is pronounced as ng in finger
The Research Question:

The question which this research addresses is the following: What are the interactions and processes with regard to the phenomena of illness, disease and therapy within and between a) the Traditional Medical System, and b) the Western Biomedical System, in the lives of Indo-Fijians in contemporary Fiji?

The purpose of the enquiry is to examine, describe and analyze the health-related behaviour of Indo-Fijians and from this description to construct the explanatory framework of their medical beliefs and practices or in sum, an Indo-Fijian socio-medical theory. The enquiry
should elucidate our understanding of how Indo-Fijians employ their various health strategies to maintain wellness, and of how decisions and choices are made to select healers and the therapies to cure illness and disease, in one pluralistic medical system. Some questions of this enquiry are: What recurring social problems are revealed? What conditioned them? What roles are present? With whom does the person experiencing symptoms of illness first interact to communicate about those symptoms? Who diagnoses and legitimates the role of the sick person, and by what process? Who interacts to decide on therapy; and how do people decide and choose? What are the alternative strategies and procedures that exist in seeking health care? What qualifying conditions help to establish alternative goals? What factors external to and/or internal to the therapy management group influence the choice of healing system used? How does the settlement (community) influence the strategies and choices? What are the general practical and interpretive implications of all of the above questions?

The interactions within each medical system are important in this analysis, but an examination of the interaction between the two medical systems provides the basis for constructing the explanatory socio-medical model of health care used by Indo-Fijians.

I examine how people in a situation of rapid social change attempt to achieve and maintain good health. Of special interest in studies where pluralistic therapy systems exist, is the degree to which people are willing to change their behaviour to embrace new healing systems. I ask how do people use new therapy systems, and what factors in the life situations of individuals constrain or facilitate their decisions and choices? Of interest too is the way in which people respond to the availability of use of the health care system, to access to information, to exchange in interactions (cooperation and competition). What values do people hold, what interactions and transactions do they undertake in situations where they must resolve conflicting values?
The approach of the enquiry is to elucidate the health care seeking behaviour of Indo-Fijians by describing the processes and interactions which occur. Thus the present work depicts systems of interacting individuals in roles, statuses, ethnic and gender relations; as well as interactions between a number of systems of medical practice.

"Social interaction" as the term is used here is defined as "...the mutual influences that individuals and groups have upon one another in their attempts to solve problems and in their striving towards goals. Social interaction discloses the concrete results of striving behaviour upon roles, statuses, and moral norms" (Green, 1976:183-86).

The idea of context is important. Throughout, I have attempted to describe the social reality or the situation as defined by the actors in order to transcend my own categories and to clearly see how people make choices or act upon decisions related to health care. I focus on processes of people interacting, displaying social behaviour in empirical events (or sequences) or situations, and thus on ongoing and emergent medical systems. As Barth states, "We must struggle to ascertain the dynamics of cultures and societies in time as ongoing systems and through time as emergent sequences" (1981:6).

Barth defines transactions as "those sequences of interaction which are systematically governed by reciprocity". And later he says "...a clear concept of transaction, leads us to a recognition of a very fundamental social process: the process which results where parties in the course of their interactions systematically try to assure that the value gained for them is greater or equal to the value lost" (Ibid:38). The model is useful for its ability to show how people make strategic choices under conditions of constraints on choice, to maximize their values and minimize loss in them.

Barth's notion of values is that "They are views about significance, worthwhileness, preferences in/for things and actions. I have represented them as being initial to items and sequences of behaviour--they are the criteria by reference to which alternative actions are
evaluated, and on the basis of which choice is exercised: (Ibid:49). He conceives values as empirical facts which are available for study by close attention to the social activities of people, whereby they are compared and revised in the light of people’s striving for consistency and sensemaking. The result is standardized behaviour patterns (Ibid:48–49). He includes “saying and doing” in his analytical model stating, “Most clearly in the last pair of concepts, we recognize two fundamentally different ways in which acts are connected: as symbols or constituents of symbols of a communicative code, and as physical events in a material world” [my emphasis] (Ibid:81).

Barth explains transactions as follows:

The concept of transaction, by helping us to isolate a basic social process, is a simple but powerful tool when applied systematically. It depicts the strategic limitations imposed on persons who engage in social activity with a view to obtaining something of value; simultaneously it shows the compounded effects which multiple independent actors, each seeking to pursue the transactionally optimal course of behaviour, have on each other, and thereby the gross frequentative patterns of behaviour which will tend to emerge in such situations (Ibid:47).

In this work I point out various exchanges throughout as forms of transactions. The process of transactions has explanatory power as one process amongst many others. It is one aspect of the descriptions encompassed in this work. However I do not rely solely on the transactional mode of analysis; in terms of theory the reader will not find the conceptual supports of that perspective alone. I believe Kapferer’s (1976) concern with the ‘individualistic’ character of social exchange and transactional models is an important one. As he stresses, “...the various elements occurring in an environment stand in such a relation to each other that they might organize behaviour and establish frequency patterns independently of the choices and decisions of actors...there were many unintended consequences of individual choice behaviour which could be accounted for only by the way various elements stood in a structural relationship to each other” (Kapferer, 1976:15).
My main focus is on processes, and on interactions within them. In Parts II and III, I often focus on individual actors in interaction, not as dyads, but usually as parts of family or other small groups. In some sections of the thesis, I discuss interactions and processes in institutions and in generative structures. Barth’s idea of generative models is that they provide explanations of a different order than some other types of anthropological models. They show how social reality is the result of empirical factors which affect, and are the epiphenomena “...of other equally empirical circumstances and features—i.e. how some forms are ‘generated’” (lbid:77).

In this enquiry I have used the idea of process as an analytic unit. It has been used by a number of writers in a variety of ways. The general concept of process has been utilized by Barth, who states it is “...essential to my analytical focus on generative models” (lbid:78). As he says: “I wish to argue that much analytical power can be gained by using it in a strict sense, for a generalizable set of linked events which keep recurring, the necessary interconnections of which, and the consequences of which, can be clearly described” (lbid:78).

Firth (1951, [Beacon Press edition, 1967:2]) states:

Social process means the operation of the social life, the manner in which the actions and very existence of each living being affect those of other individuals with which it has relations...In considering social process, the magnitude of a society, the scale of the relations involved is significant; so also is the sequence of those relations in time.

Moore (1978:43-53), provides a comparative analysis of the various ways in which the term ‘process’ has been used by anthropologists such as Firth, Nadel and Barth.3 She states:

What is useful in these various writings is that taken together they suggest certain gross classifications of processual studies. They seem to divide roughly between the study of regular repetitive events having to do with the circulation of persons, power, goods, and information, and the study of events specifically having to do with processes of changing social and cultural regularities.

She finds the studying of transactions provides a wealth of information about how

“...regular circulatory and redistributive mechanisms that change the lot of individuals may be understood, as well as the conditions of interaction that permit
the introduction of or adjustment to certain kinds of change in the rules of the game.

*Changes in the relative positions of individuals and changes in social regularities are connected though not coextensive phenomena. It is this connection which certain structural models have deliberately ignored.*

In this thesis I use Moore's (ibid:48-53) analytic framework for the study of interactions and processes. She suggests it be used for the study of social processes “in terms of the inter-relationship of three components: the processes of regularization, the processes of situational adjustment, and the factor of indeterminacy” (ibid:39). In the first component people struggle to “...fix social reality, to harden it, to give it form and order and predictability”. The second component relates to how “...people arrange their immediate situations...by exploiting the indeterminacies, or by reinterpreting or redefining the rules or relationships”. By ‘indeterminate’, I understand her to refer to social life which is partially unordered or unpatterned by culture and social relationships (ibid:49). Therefore there is an ongoing dynamic relationship between form or structure, and "the sea of indeterminacy" in social life. And indeterminacy may arise from ambiguities and from sociocultural contradictions (i.e. changing kinship rules, conflicting loyalties, etc.).

She suggests there is a "qualitative complication" and distinguishes between "symbol and form as opposed to content", stating that symbol and form may appear to have regularity all the while concealing mutable elements of content, while content may appear indeterminate but conceal the invariable (ibid:48-50). Moore reiterates however that the study of cultural regularities alone hides the discordant “fit” between symbolic and content levels and the way people negotiate within real situations, as well as "the multiplicity of alternatives and meaning within each, which may accommodate a range of manipulation, interpretation, and choice...."

The approach appeals to me inasmuch as it arises out of law as process. As Moore explains, an institution such as law (or medicine) develops slowly, instance by instance, and out of sets of values which have changed over time as well as place. Law and medicine both are continually modified. For example medicine changes through scientific advances, legislation,
policy, and interpretation, as well as application. Other similarities are in the concern with ethics, and in one group being jurally responsible for the wellbeing (legal welfare, health) of clients or patients. In the case of physicians (and the biomedical system in general), the practice of retaining custody of individuals in therapeutic situations has widespread implications (and sometimes, consequences). Custodialism is just one of the many troublesome assumptions for those people who are making the transition from other medical traditions to the use of the biomedical model. Thus the analogy with a people's change from traditional types of jural practices to the use of Common law seems to me, appropriate.

Her perspective is especially suitable for this study of Indo-Fijian medical beliefs and practices in a situation of rapid social change. People attempt to fix a social reality which has rules as well as ambiguous elements, situations of conflict, and contradiction (hierarchy and equality, purity and pollution), and which are in constant flux; and through interpretation, choice and transactions, to order it.

The study of values is important in any study of interaction, transaction or exchange. Belshaw (1959:555-62) presents an ideal scheme in which he shows "...the steps necessary to identify values and the difficulties of this as an empirical procedure". After considering four approaches, he states:

The approaches so far considered have centered upon characteristics of individuals or cultures. Sometimes they are expressed verbally, sometimes they are inferred from casual or manipulated behaviour, and sometimes they are inferred from or stimulated by custom. One cannot conceive of a value without an expression of the goal envisaged. Thus a moral precept, for example, is important because it expresses a goal; if it did not relate to behaviour in this way, it would have no significance as a value. Thus a significant element in the anthropological treatment of value so far is that it purports to elucidate goals. Whether an author sets out to present a "value system" or to analyze the customs, culture, or social structure of a particular people, the end result is a statement of goals.

And later he says that he does not mean that objectivity can only be achieved through counting and measurement:
Some problems are beyond our reach; for other problems an undue stress on counting and measurement may be unnecessary or dangerously misleading. And the study of values is the study of some quantitative aspects of cultural qualities. Value implies worthwhileness, which implies degree, which implies scale, which is compounded of quantity and measurement. Furthermore, statements about the characteristics of a population are essentially quantitative, for they imply that the appropriate proportion of the population shares the characteristics.

Essentially, the problems of quantification are so difficult that we are left with subjective inference.

He states that cost is important to the analysis, and time "...can be regarded as a universal cost element in valuation...". Although ideally these elements should be considered, their measurement is very difficult. "We simply do not have available the techniques which would enable us to measure units of cost and consumption in such fields as religion and aesthetics, let alone responsiveness to changes in time-price". He concludes:

In straightforward conventional field-work analysis we imply values but do not describe them....

In the future, field work should pay more attention than hitherto to costs of achievement of existing goals and to responsiveness on the part of groups to alterations in costs, for these are essential elements in a concept of value.

The study of values may be the central factor which will elucidate the interaction between the Traditional Medical system of the Indo-Fijians and the Western Biomedical model. As Romanucci-Ross, Moerman, Tancredi, et al (1983-4) state, "...exactly what determines the ultimate outcome of the interaction of medical systems is not yet clear. However, it is clear that this interaction is a complex and difficult one, not susceptible to facile prediction".

One further term which is used in a multitude of ways in the anthropological literature is "systems". Turner (1979:62) and Moore (1978:36-), amongst others, have discussed social systems (or social fields) and have entered into polemical discussions of disillusionment with anthropological studies which focus their interpretations on congruence or on the fit of
Ideology to social organization. Both have conducted studies which rather than focusing on regularity or congruence and consistency, have questioned the relationship of ideology and social action.

Turner (1979:62), perhaps more systematically than others has focused on processual analysis of social dramas as aharmonic or disharmonic units, usually situationally located in conflict situations or crises. Moore (1978:32) however has asked the pertinent questions in a broader context than that of Turner. She wants to know:

When discrepancies exist between ideology and social reality what do people do? What happens when a community that idealizes communal harmony is faced with internal conflicts and contradictions?...It is not that there is anything new about recognizing the existence of such inconsistencies. It is that attention to the ways in which they are resolved raises basic theoretical issues. One of these is the question, What is the relationship between ideology and action?

And still later (Ibid:37), she summarizes her questions in a more general one:

The question repeatedly raised in the last two or three decades is, whether a focus on regularity and consistency should not be replaced by a focus on change, on process over time, and on paradox, conflict, inconsistency, contradiction, multiplicity, and manipulability in social life? (See Firth 1964:59; Barth 1966; Mitchell 1964:v-xiv; Leach 1962:13; Turner 1957; van Velsen 1967).

Finally, she finds her support too, in the work of Murphy in the *Dialectics of Social Life*, in which he suggests that "Social life is indeed a series of contradictions" (Ibid:37). With reference to his dialectical method, she quotes him as stating that "it requires us to also look for paradox as much as complementarity, for opposition as much as accommodation. It portrays a universe of dissonance underlying apparent order and seeks deeper orders beyond the dissonance" (Murphy:1971:117, quoted in Ibid:38).

The model Moore proposes allows one to use complex sets of data, which differentiate between the ideal and the actual social reality in terms of congruence as in the past, as well as seeing the lack of "fit" or contradiction between ideology and social life (Moore, 1978:51). It is most appropriate for this work too, in which the materials "show a marked discrepancy between expressed ideals of community harmony and a more complex social reality" (Ibid:51).
Moore's framework is perhaps as close as any anthropological work to my ideas of an adequate approach which will allow one to analyze the greatest range of empirical data, to allow for emergence of new social forms and yet explain the retention of the old values. It seems to be an appropriate paradigm for the depiction of social change in the case of Indo-Fijians studied in this research.

Moore's view of "process" is important for this thesis. She departs from the usual stance of Barth (who relates it to social change), and Firth (in terms of structure and social organization). Her insightful theoretical perspectives incorporate the way repetitive processes and those which produce continuities lead to the fixing of social reality.

Throughout this thesis I describe systems of people in interaction. After Barth (1981:5) I believe that "...by insisting on events and interaction as central features of our object of study we are compelled to confront a far broader and more diverse segment of reality".

This thesis focuses on an interactional system, that is on social behaviour in contexts of particular situations, the incentives and the constraints on it, and the strategies and behavioural modifications which people undergo with respect to cultural values and their relationship to medical beliefs and practices. But it does more, inasmuch as the interrelationships, many of which occur as systems, take into account a range wider than individual behaviour, that of organizations and institutions. It also examines the codifications people use in their transactions, the symbolic meanings they draw on, use and modify from the cultural context.

Definitions:

I have defined the Fiji-Hindi words at the first occurrence of each one. Some of the terms which do require prior definition however are those English words which carry special meanings according to the researcher's theoretical stance. The following short commentary
explains the usage of the main words in the research question. As well, two frameworks, Kleinman’s (1978, 1983) and that of Frankenberg (1976, 1980), are discussed here briefly, for comparative purposes, as two poles along the continuum of models of medical systems proposed in recent years for the comparative study of medical systems. (I think it is important to show I have made a choice on the basis of comparison with other systems and find Frankenberg’s work close to my ideas, although not the same as, my work.)

Although I have not used his entire framework in this thesis, I find the definitions provided by Frankenberg (1980), as well as his perspective, clear and intellectually appealing. He employs a three phase model in studying medical care processes. By disease, he means "...a biological or pathological state of the organism whether or not it is socially or culturally recognized, and whether or not the patient and his/her advisers, lay or professional are aware of its existence". By illness, he means "...the patient’s consciousness that there is something wrong" (Frankenberg, 1980:199).

He explains the "making social of disease" in Western curative medicine, as "...predicated on the sequence—being diseased, feeling ill, involving healers in the legitimation and creation of sickness as a social state" (Ibid: 199).

Kleinman takes a slightly different approach to terminology than Frankenberg, and explicitly includes psychological processes in his definition of disease. He states: "Disease refers to a malfunctioning of biological and/or psychological processes..." (Kleinman, 1980:72). They differ however in their meaning of "illness". Kleinman (Ibid: 72–73) states:

"...Illness refers to the psychosocial experience and meaning of perceived disease. Illness includes secondary personal and social responses to a primary malfunctioning (disease) in the individual’s physiological or psychological status (or both). Illness involves processes of attention, perception, affective response, cognition, and valuation directed at the disease and its manifestations (i.e. symptoms, role impairment, etc.). But also included in the idea of illness are communication and interpersonal interaction, particularly within the context of the
family and social network. Viewed from this perspective, illness is the shaping of disease into behaviour and experience. It is created by personal, social, and cultural reactions to disease. Constructing illness from disease is a central function of health care systems (a coping function) and the first stage of healing.

Frankenberg and Leeson (1976) proposed a three phase model in which the making of disease is a crucial aspect:

...becoming sick is a social process. Implied in it is not only a physical unwellness, but the recognition by significant others that all is not well and the consequent readjustment of patterns of behaviour and expectations. The first stage of sickness as a social phenomenon is, therefore, the communication of the fact to another, or others, by voluntary or involuntary, verbal or non-verbal, signs. Once the symptoms and the sickness have become social property, the now established social fact will disturb previously existing social relations in some way or other.

Frankenberg (1980:199) states:

If, ...we restrict illness (my emphasis) to the making individual of disease by bringing it into consciousness we can use sickness (my emphasis) to apply to the total social process in which disease is inserted. This will force us to include in the same social process of social interaction and historical development the totality of healers, lay and professional, and the totality of distressed.

Thus, the illness must be legitimated (given an acceptable social explanation) and that is achieved according to the society's value system.

Young's work is important, inasmuch as he states: "But sickness episodes may also contribute to the orderliness of social life, since they are a useful vehicle for communicating and legitimizing changes in how social relations are distributed within a community" (1976:12). He treats the sickness and subsequent healing episodes as contests or games which are played out according to specific rules, in particular arenas of action.

His argument is:

(1) People maintain their medical traditions because they affect undesirable biological states in expected ways, and because they are effective ways for dealing with disruptive events that cannot be allowed to persist. (2) A consequence of these meanings is that some kinds of sickness episodes also perform an ontological role--communicating and confirming important ideas about the real world--analogous to the one which Durkheim (1915:387), Geertz (1966:29-34), Turner (1967:27-29), and others have attributed to religious belief and ritual (1976:5).
Frankenberg (1980:200) paraphrases Young (1976), when he states:

...sickness episodes have what he calls ontological importance as dramaturgical contests which reaffirm and legitimate other aspects of the society's value system especially because, (a) sickness is always there and is relatively indiscriminate in the categories it attacks; (b) the onset of a sickness episode compels people to initiate or participate in it and in turn compels them to reflect on their social order; and finally (c) since etiologies are socially constructed but out of pre-given cultural elements it forces them to recreate and reinforce their culture.

I believe that one of the primary differences between Frankenberg's and Kleinman's definitions is that Frankenberg emphasizes the process of the legitimization of illness (after the making social of disease) as a distinct phase in the health care process. This highlights the process of negotiating or transacting of the sick role - that it is communicated to others who decide if the sick role can or will be legitimated. This is the first step in the unfolding of the social process of seeking and managing therapy.

Additionally, Frankenberg's model allows for the contingency of the sick person withholding the "making social of disease" in situations where it is disruptive of ongoing social relations, or in political processes if it is in the best interests of an individual not to take the sick role, and to withhold disclosure of illness.

The appeal of Frankenberg's work is also that he is concerned with the political economy of health care, and locates health care in the development process which he believes influences health behaviour. This is an interesting aspect of health care but unfortunately cannot be encompassed in this research.

Lolas (1985:1358), defines diagnosis as a process which is repeatable, which is based on a medical theory, a classification of illnesses and established rules. It is purposive and has "...some intention or practical orientation for action, attached to it".

Diagnosis involves interaction during which communication is transacted. It takes into account the affective content of verbalization and symbolic content of movement and gesture.
Values are also important in the diagnosis of an illness and have meaning for therapeutic measures and outcomes.

Lastly, by therapy I mean simply "remedial treatment of bodily disorder...an agency (as treatment) designed or serving to bring about social adjustment" (Webster's Seventh New Collegiate Dictionary, 1970:916). Janzen (1978:4), in a study of therapy among the Kongo society in Zaire, refers to the network of family and friends who come into action during illness or other crises, as a "therapy managing group". They are the group who interact with a patient, and with whom a patient transacts or negotiates the legitimacy of taking the patient role. A therapy managing group often accompanies the patient to healers, and in some cases consults healers on behalf of the patient. The idea is particularly suitable in cultures which do not turn over custody of a family member to a healer or to an institution for healing. South Asian and Asian cultures are noted for retaining custody of a family member, of accompanying them to seek therapy and staying with them whenever possible, if they are hospitalized.

These are some of the primary concepts and ideas with which I am concerned and which I use. Others appear throughout the work, many of them in Fij-Hindi. For ease of understanding they are explained at the time of their first occurrence.

Methodology and Data Collection

The fieldwork on which this enquiry is based was conducted on the island of Viti Levu, Fiji Islands, in the year from June, 1985 to June, 1986.

On my arrival in Fiji, I located my fieldwork site almost immediately. The choice was between three areas. The first, Lautoka, is a large industrial town in the Western Division of Fiji. There are Sugar Cane refineries with shipping facilities nearby, ship building factories, garment industries and many other small commercial enterprises. The town has a large central
market place and serves a vast area. There is a large modern 200-bed hospital with a Crippled Children's organization on the grounds. This hospital is a Divisional one in the health care hierarchy (see Table 11-1, Chapter 11).

The second choice was a small town between Nadi and Suva, close to Indian settlements with mixed economies, one vegetable growing and the other sugar cane growing, each with neighbouring Fijian villages. The Sub-Divisional Hospital (56 beds) in the town was the center from which a Medical Centre and eleven District Nursing Stations were supervised. The third choice was a small town close to Suva, with a small maternity unit.

Prior to my arrival in Fiji I had already read geographic, demographic and economic literature on Fiji. So when I took a taxi from Nadi to Lautoka I knew the general characteristics of the town from the literature, but wanted to see the ambience. Then I returned to my hotel in Nadi and packed to leave for Suva where I planned to obtain my permission to conduct research from the Immigration department, to go to the Department of Lands, Mines and Surveys to obtain the necessary maps, to do initial archival research in the Ministry of Health and at the Bureau of Statistics. Enroute to Suva, I would view the other two potential fieldwork sites. I engaged a car and driver in Nadi and within an hour of leaving, arrived in the small township, at the mouth of one of the major rivers. The driver knew the area well; he pointed out the hospital, and later the market in the center of town. I asked him to drive up river, into the area of the settlements and villages. I did not have to look further. From the gravel road which meanders up to a viewpoint on the hillside, I could see the Fijian villages nestled in the valley below and in the distance, the Indian households in the dispersed settlements. It appeared the perfect setting and although I had yet to see the last of the three potential sites, I had already decided to remain in this location.
I was heavily influenced in my choice of research site, by the fact that many years before, my fieldwork supervisor Dr. C. S. Belshaw, his wife and two small children had spent a year in the same area, studying the native Fijians on the coast as well as in the interior of the river valley. He had recommended Fiji, and this area, to me for my research once I had decided on Fiji.

I did not spend more time considering other fieldwork sites but went on to Suva where I obtained the letter giving permission to conduct research in Fiji from the Immigration department. It had been applied for months earlier, had been approved by the Ministry of Health and the Ministry of Education. A copy of the permission was taken to the University of the South Pacific where I was given research associate status in the department of Social Science and Economic Development (S.S.E.D.). I spent some time working at the University library over the next several days.

At the same time, I made my appointments to introduce myself to the Permanent Secretary for Health (who was away but was replaced by the Director of Preventive Medical Services, Dr. M. V. Mataitoga), and the Minister responsible for Hospitals, a paediatrician, Dr. K. D. Sharma. They knew of my research, both had read the research proposal which the Ministry of Health had approved, before sending it on to the Ministry of Education for their approval. They phoned the sub-divisional medical officer (SDMO) in the small township to ask him to allow me to work in the hospital. In addition they forwarded a letter to that effect to him. Then, I asked to work in the Ministry of Health Statistics department and they made it possible for me to do so by phoning Mr. Saimoni Vuatalevu, who assisted me. In the days that followed, I obtained my maps from the Department of Lands, Mines and Surveys, and went to the Government Statistics offices for demographic information. Within five days I had completed my archival research in Suva and was ready to go to the fieldwork location.
For the first two weeks, while I arranged living accommodation in my fieldwork area, I stayed at the rural home of the mother of an Indo-Fijian colleague who was then studying at the University of British Columbia in Vancouver. Initially, I had planned to stay in a settlement once I met the people there. Because of the logistics of conducting research in three areas, it turned out to be more feasible to stay in a flat in the small township which was at the center between the two settlements and the hospital and to travel by local bus to the area in which I was working.

Participant-observation in two Indo-Fijian settlements and in a Western Biomedical hospital and the analysis of these activities provide the major data of this research. I interviewed the 44 households in Nasavu, a market vegetable growing settlement first, and later added the 41 households in Solevu, a sugar cane growing settlement. I have used fictitious place names for the settlements and initials for proper names of people. Both settlements had Fijian villages adjoining them and the peoples in both lived in a symbiotic relationship to each other. I describe this below.

I started out with eliciting information on genealogies, household surveys of the types of houses, water supplies, and general health information. I also took notes on economic activities, such as the crops grown, the acreage under cultivation for each crop, and the cropping patterns in the various seasons. My interest in women's work (referred to as "shadow work" in the literature), led me to document a day in the life of many of the women I interviewed.

I began to list home remedies almost immediately, for this provided me with a way to immediately begin eliciting information on health care beliefs and practices. When people in the first few households found out my research interest was the health care of Indo-Fijians rather than a general survey for the government, they were quite willing to talk to me. Later in my research, one of my assistants told me that at first the settlement people thought I was one more person surveying the area, just as they do in Fiji after each hurricane or flood. The people have
an extremely negative attitude towards these surveys. They feel that in the end no material aid was provided to them during the crises of the past five years.

I began some work in the hospital at the same time as I worked in Nasavu settlement, but the logistics of travel in the heat and humidity, the bus schedules, as well as the rigors of documentation, meant that I could usually not combine work in the two areas on the same day. I decided to spend most of the early fieldwork months (May to October, 1985) in the rural work, sometimes visiting the District Nursing Station which services the area. At the end of October, 1985, I began to work more intensively in the hospital. Later, I added work in Solevu settlement. I usually tried to spend some time each week in the settlements even when I worked at the hospital. Any important event in the settlements usually was signaled by an invitation for me to attend. Often, after a day in Nasavu or Solevu, I walked the 1-1/2 miles to the hospital in the evening so that I did not lose touch with the events of the day there.

At the hospital, I was fortunate to work with a young Muslim woman Gynaecologist/Obstetrician. Because the Ministry of Health had kindly provided me with almost unrestricted permission, I worked alongside the doctors in all areas of the hospital. I am not a nurse by training, and the only previous hospital work I had worked at was as a nursing unit clerk in the oncology ward in the Children's Hospital, and in the Emergency Department of a major hospital in Vancouver. The first day of work started with my accompanying the surgeon on rounds in the Men's Ward in the morning. The first patients on rounds that morning were recent amputees. Their wounds were unwrapped and checked by the surgeon and the nurse as I accompanied them. The second patient was an elderly blind Indian man whose toes had been amputated because he had developed gangrene due to diabetes. I was told that while his family were in the fields, the rats, attracted by the smell of the sugar, had chewed at his wounds. (A medical doctor has informed me that this information was a part of the folklore—the rat would have been attracted by bodily secretions.) The patient's wife was attending him in the hospital.
Later in the morning, I accompanied the Obstetrician on rounds. Sometimes I went on rounds with another woman doctor (an Anesthetist), who was responsible for the Women’s Ward. After the first week or so, I worked mostly with the Obstetrician in the Ante-natal, Post-natal, and Gynaecological Clinics; and in the Labour, Delivery and Obstetrics Wards. On the days when she was assigned to Outpatient’s Department, I accompanied her. I was also able to observe in the Operating Theatre. And on one occasion I found myself called upon to intervene in an emergency situation when I worked as the non-sterile nurse, something I had read about prior to going to the field, fortunately.

There were many other cases during the first weeks which were difficult for a person new to medical interventions to observe. There is a vast literature on the sociology of medicine which deals with how doctors learn to cope with the realities of illnesses, surgery, and of deaths. As a social scientist, I was not trained to intervene as a medical practitioner, but I found myself in the emotional circumstances which doctors face. I found that I could distance myself enough to be objective and to express “detached concern”.

I believe it is important to note that at no time did I jeopardize the confidentiality of the patients. I was introduced to patients as a Ph.D. student in anthropology, with an interest in medical beliefs and practices of Indo-Fijians, but not as a medical doctor. Few people probably understood the differences however, since I did “hands on work” or what we refer to as “intervention” in the hospital. I came to terms with the amount of intervention I allowed myself, since in the setting of a hospital I felt it was unethical not to assist to the limited extent that I could, when called upon. On the other hand, I did not intervene beyond my own capability. Since I accompanied a doctor at all times, I observed most of the work she performed as an Obstetrician and Gynaecologist: examinations, birthing, family planning, discussions, morning rounds, clinical work, tubal ligations in the Operating Theatre, and work in the Outpatient’s
use the same space. As a consequence, I was allowed to observe the surgeon as he conducted the surgical clinic, attending to small wounds, broken arms or legs, as well as other such procedures.

The SDMO invited me to attend the doctor's seminars usually held on Friday mid-day, as well as the seminars held every month by the SDMO for nurses from the Medical Centres and the District Nursing Stations.

I sometimes travelled with the medical team by jeep and by van when they went on trips to the District Nursing Stations in the interior of Fiji. On these trips I observed and noted the work. At the District Nursing Station in my own fieldwork area, I interacted often with the nurse, sometimes going by bus to the clinic she held and consulting with her about every household in my settlement area.

The main techniques used for obtaining data were participant-observation, open-ended interviews, and a very few taped interviews which were later transcribed while I was still in Fiji. I also used unpublished information sources obtained from the hospitals and published archival materials, and Ministry of Health Statistics, as well as information from the Bureau of Statistics in Suva. The main libraries used were the Library at the University of the South Pacific where I had staff privileges, the Fiji Archives, the medical library at Hoodless House, and the Fiji School of Medicine Library at Tamavua, Suva. I also conducted archival research at Macquarie University, Australia, where I spent one day in the archives studying the Dr. Chandra Jayawardena documents on Fiji which are deposited there. I spent another day at the Australian National University in Canberra. The National Library in Canberra was kind enough to do computer searches of the literature on Fiji and health care of Indians (from India) for me.

When I wrote the fieldwork proposal, I found no literature in medical anthropology on Indo-Fijians at the library, and a computer search revealed only that of Spencer (1966) on the Fijians. I therefore hypothesized that the medical practices of the Indo-Fijians today would be
heavily influenced by the professional medical systems of India. Theoretically, because of this
dearth of literature, I felt, (and commented during my proposal defense at university) that
Glaser’s Grounded Theory approach (1967) offered me ample scope to go to the field, to observe
and to participate, and to constantly renew both my methodology and my perspective in the light
of the emergence of my data and my reflections on it. This proved to be a most appropriate
decision for it allowed me to enter the field without an a priori theoretical perspective. And it
allowed me the option of focusing on one aspect and area of medical practices in the hospital
setting more than on others, as I saw fit. Of necessity, it was more practical in terms of energy
and in the light of where I discovered the greatest potential for observation, interaction and
dialogue with both patients and medical practitioners was going to occur. On the negative side, I
was a complete newcomer to research on pregnancy, birthing and family planning, and the
complications inherent in them. The shortcomings of the work may indeed reflect my initial
ignorance. Had I been a person knowledgeable in these areas I might have posed hypotheses more
quickly and perhaps the data that emerged, and the approach, might have been totally, different.
This has made my approach even more important for as I attended, questioned and learned in
these wards, I re-evaluated that which participant-observation revealed to me, and the data that
I needed.

In order to collect data on interactions and processes in the lives of the people I studied,
I was involved in observing social action at the level of behaviour in situational contexts. I
recorded their interpretations and explanations of how they made their choices and decisions and
of how they viewed their experiences, seeking health care.

The primary domain of research involved how people who were sick cognized their state
of unwellness and made it social by involving others, during the process of seeking health care
within the home and in a pluralistic healing system. The enquiry in this sense focused on
specific locales and particular situations or contexts of interaction, between role holders. It
involved analysis of people using strategies or transacting with others in order to optimize their chances for recovery. Each healing "situation" or "context" (or ‘institution’) had a specific set of role relationships which were brought into interaction in the healing process.

While the larger problem of this thesis is to describe the general processes, there are many specific questions which I ask of the ethnographic data in order to explain the interactions and relationships which lead to them. These questions, too many to present here, appear in the relevant chapters.

An Outsider Insider

The forced psychological exploration of one's cultural self which occurs during field research is perhaps the most difficult part of anthropological fieldwork. Born in Punjab, India and raised as a Sikh (although I do not follow the religious practices very regularly), in Canada, I have received all of my schooling in the Western or European tradition. After the age of about fifteen, it was not augmented to any great extent by socialization into the Indo-Canadian culture (except within my own home but not in the greater Indo-Canadian community). Punjabi was my first language however and remained the language of my parental home.

In Fiji my status was one which produced some dilemmas and anxiety for me, and some negotiation with Indo-Fijians. I arrived in Fiji sometime after the assassination in India of Indira Gandhi by Sikh extremists. Within a week of my arrival I went into the Air India office in Fiji where the staff were in shock about the plane bound from Canada for India which had been bombed, with all lives lost, over Ireland. This disaster too, was attributed to Sikhs. Fiji is a nation of Hindu Indians, some with fairly strong links to India. Soon after, when I began my interviews in the rural settlements, one of the senior males, a Brahmin in the very first household, asked me about my feelings about Indira Gandhi's assassination. I told them that my feelings were probably the same as theirs about Mahatama Gandhi's assassination. We were all
powerless against certain kinds of people who believed in revolutionary tactics, whatever their religious or political background. The subject was dropped in that household, but was raised a few times by others.

A few days later, my assistant told me that one of the women in the settlement had told her children that I was taking down their names and ages and everything because I was a Sikh and that I might be doing that in order to hurt them later. This news was spread in the school by the children, most of whom I often saw on the bus. It was a few weeks before that gossip was stopped by some well meaning families. Meanwhile I had the stress and uncertainty of how people in the settlement might perceive my background as in conflict with the good of the Indo-Fijians, and the concern about how this could have ramifications for my fieldwork.

In the early days of the research I was not certain how my Sikh background would be accepted. Fortunately, the people were very kind and after a rather awkward start, I was slowly accepted by every household in the two fieldwork settlements. I participated in their religious rites and near the end of my fieldwork, I was honoured to be invited as a special guest to raise the flag for the beginning of a Hindu temple building. I am proud to say that by the time of my departure many people in the settlements accepted me as a friend, and continue to write to me.

My research was conducted in both Fiji-Hindi and in English. During the early part of the fieldwork, I had difficulty speaking Fiji-Hindi and in quickly framing questions spontaneously. For this reason I usually had an Indo-Fijian woman research assistant (a North Indian, or one of two South Indians) who spoke Fiji-Hindi, accompany me. These women were in their early twenties.

I took care that my assistant worded the questions as I wanted them worded. In some instances, where careful wording was essential, I would ask them how to word the question and went over it beforehand with them. I could understand the language and could in fact correct my research assistant's interpretations pointing out the nuances of something to her when she
erred, or when she gave me her own interpretation of what someone said, instead of what they did say. It was my impression that Indo-Fijians easily understood the questions we asked of them. Many understood English and spoke it fluently, while others understood it well, but preferred to speak Fiji-Hindi. Only elderly people, or those in rural areas had difficulty understanding English.

Most Indo-Fijians were enthusiastic and happy that I understood the language, and when I did speak to them (in a mixture of Punjabi and Hindi combined), they said it was sud (pure) Hindi. They call their own language Fiji-bat (Fiji-language) and say it is an inferior one to Punjabi and sud Hindi of India. Fiji-Hindi, the lingua franca of the Indo-Fijians is a unique mixture of North Indian languages and the four major Dravidian languages of South India.

During the fieldwork I took detailed notes in English, noting the Fiji-Hindi concepts of importance to this enquiry. Only a few interviews, those of life histories of elderly women, were taped. My assistant and I transcribed them but the process of transcription and the time involved with taped interviews did not appear very rewarding for the topic considering the inconvenience, length of time and discomfort of transcription, so they were discontinued.

The women whose "stories" I discuss in the following chapters do not represent a formal random selection, but relate to women who were available to talk to me at the times I was exploring a particular topic. In this work I have tried to retain their perspective as they talked to me in Fiji-Hindi, or in English or in both languages. In all cases I noted their age and ethnicity. The 'Interviews' were usually conducted as informal visits during which I introduced the topic I wanted to know about. I was usually accompanied by one of my assistants for I learned that people in the settlements considered it more appropriate for women in the settlements to be accompanied by another woman rather than "move around" alone.
On my first visit and usually on subsequent ones, I took a package of cream-filled biscuits as a small gift for the family. This was usually served to us with tea, and distributed to the children as a treat.

The women who assisted me in Nasavu settlement were young women in their early twenties. One was a North Indian woman who was married and had a three year old child. She was introduced to me by the 'main' Pandit family in the settlement, and it was through her that I met my second assistant, an unmarried South Indian woman who was an unemployed pre-school teacher at the time of my research. She had completed high school and had taken a diploma course in teaching (preschool) after which she taught for a season in the schoolhouse in the nearby settlement. At the time that I met her she was helping to manage the large vegetable farm with her parents. In Nasavu, when I worked in the South Indian section of the settlement, I usually took the South Indian woman with me; whereas on the North Indian side, the North Indian woman was more suitable for the work.

Later in my research, a nurse at the hospital introduced me to her unmarried sister who she said would assist me in Solevu settlement. This woman was South Indian and had completed some schooling in the senior high school. Her family were well known in the settlement and she was well liked. She was able to accompany me to the Nepalese and Muslim homes, as well as to the South Indian ones which predominated in Solevu. There were few North Indians in Solevu settlement.

My assistants were paid by the day since I did not know where I would be working at any one time. Often I had no assistant at all, as when I worked at the hospital.

Early in the research, a young pandit woman accompanied me as I interviewed women in the area where the Brahmins live. She was reprimanded by one of her husband's female relatives (a woman who others call nala - meaning crazy) who said "I am going to tell your husband you are going around the settlement with this woman". My assistant told me to
disregard her comments. This was one of the few times that people in the settlements were worrisome to me.

I usually preferred to take the bus when travelling between the settlement and the town or hospital. For a woman to travel alone in a car with a man or men is usually considered poor policy for it gives others a chance to gossip about her, and some men revel in being seen alone with a woman. I learned that unrelated men and women do not often sit with each other on the buses.

Data taken everyday were typed into field notes every evening. As I left for Fiji, my fieldwork supervisor, Dr. C. S. Belshaw asked me to write short papers from the field, in draft form, on topics which were my current interest. I found the exercise rigorous and demanding at the time; at the same time that it kept me engaged in a dialectic between my data and the discipline. The comments which I received in return provided me with deeper insight into particular problems.

The questions in Chapters 7 and 8 concerning menarche, pregnancy, and birthing created some initial discomfort for the first women with whom I discussed them. Partly, this was because people were uncertain about me and whether or not I would be judgemental about what they told me. I usually prefaced my questions with personal examples, or examples from the people of my own lineage in India or in Canada. In this way, by divulging intimate details of my own, I was soon able to accomplish a deeper level of interaction than I might otherwise have done. This was not difficult to do in the context of these all-women gatherings, and indeed gave me cause and opportunity for reflection myself. At first, and then for the duration of my fieldwork in Fiji, I was both surprised and gladdened by the empathy with which my informants heard 'my stories' and shared the intimate details of their own. I noted they were intensely interested in anything I divulged of my personal life.
The order in which the description is arranged is necessarily in a linear array of four main parts, each with a number of chapters. It is an heuristic necessity to present the empirical data on the sociomedical theory of Indo-Fijians, as if it were about two distinct systems, one Traditional and the other the Western Biomedical. I emphasize at the outset that the medical system of the Indo-Fijians as they conceive of it, and as I will present it in the final summary chapter, is one system of health care composed of many types of healing. From the perspective of the anthropologist however it is possible to describe the pluralisitic types of healing or sub-systems as they are utilized in particular healing episodes. This style of presentation allowed me to present my approach in the sharpest relief.
Footnotes:

1 This view appears to be close to that of Nadel as explained by C.S. Belshaw, in his paper, "The Identification of Values in Anthropology, in The American Journal of Sociology, Vol. LXIV, May 1959, Number 6. Belshaw (p.555), states that the essence, "as expressed with great clarity by Nadel\(^2\) is that values are ideas about worthwhileness. As Nadel states, the conceptual index may vary [using scales such as "good-bad," "desired-not desired"]. Such values are significant because of a relationship to action or potential action".

2 I have not placed emphasis on Kapferer's (1976) work on transactional analysis, for it appears mainly to be a critique of Barth and has long since received attention by Barth.

3 In Moore's framework, sociocultural elements are not static and in fact are continuously being transformed through interpretation and decisions and choices of individuals, acting in arenas and through networks to produce order and harmony. And she states that the study of transactions is par excellence, "so often very revelatory".

4 Moore proposes that sociocultural analyses be conducted by the use of three interrelated components: processes of regularization, processes of situational adjustment and the factor of indeterminacy. She defines the first as "...a major category of ongoing activity in society". She states,

'Processes of regularization' include all the ways in which conscious efforts are made to build and/or reproduce durable social and symbolic orders....The continuous making and reiterating of social and symbolic order is seen as an active process, not as something which, once achieved, is fixed. The view is taken that existing orders are endlessly vulnerable to being unmade, remade, and transformed, and that even maintaining and reproducing themselves, staying as they are, should be seen as a process (Ibid:6).

She also states:

....people try to control their situations by struggling against indeterminacy, by trying to fix social reality, to harden it, to give it form and order and predictability....We have called these attempts to crystallize and concretize social reality, to make it determinate and firm, "processes of regularization"...(my emphasis)(Ibid:50).
She defines 'processes of situational adjustment' in the following way.

They [people] use whatever areas there are of inconsistency, contradictions, conflict, ambiguity, or open areas that are normatively indeterminate to achieve immediate situational ends. These strategies continuously reinject elements of indeterminacy into social negotiations, making active use of them and making absolute ordering the more impossible. These processes introduce or maintain the element of plasticity in social arrangements. We have called these 'processes of situational adjustment' (ibid:50).

The model is not static, and when people make situational adjustments these have the potential of becoming regularized as change when repeated in sufficient numbers.

Finally, of the whole model she states that each of these processes has "...within itself the possibility of becoming its schematic opposite" (ibid:51).


The late Dr. Chandra Jayawardena was Foundation Professor of Anthropology at Macquarie University in Australia. He conducted research in the small township of Sigatoka in Fiji, as well as in the settlement referred to here as "Solevu". His research papers are in the archives at Macquarie University. Mr. Findlay, Acting Registrar at Macquarie and Mrs. LaMaro, clerk in the Office of the Registrar, were kind enough to arrange access for me to consult the Jayawardena papers.

As Young states: "Etiologies are usually worked into narratives that are able to transmit social facts which, although often elaborate, can be easily understood..." (American Anthropologist, No. 78, 1976:13).
Chapter 2

THE BACKGROUND

The present chapter presents the demographic, political and economic background of life in Fiji which conditions the patterns of social structure and organization in settlements and villages. In the second part of the chapter, I provide the background and structure of the present Biomedical or modern health care system in Fiji.

Throughout, I focus research attention on the Area level of health care, in the Nadroga/Navosa province in the Western Division of Fiji, and the Sigatoka town and River Valley (see Figure 2.1, p. 32).

Fiji Islands

The Fiji Islands, in which this research was located, consist of some 320 islands, of which about 150 are permanently populated. Of these, the two main islands Viti Levu and Vanua Levu, make up 87% of the total area. They are situated between 15 degrees south and 22 degrees south (latitude) and 175 degrees east and 177 west (longitude).
EXISTING HEALTH FACILITIES,
WESTERN DIVISION

- One nursing station on Vatulele Island
Derrick (1957:3) states that the aggregate land area is 7023 square miles, of which 4011 square miles are on the island of Viti Levu.

The climate

The climate varies from dry and hot on the leeward (west side, i.e. Lautoka and Labasa) to wet and warm on the windward side (Suva). On the wet side, annual rainfall is from 305 to 325 centimetres, whereas on the dry side the annual rainfall is in the range of 165 to 178 centimetres. The average temperature is 77 degrees F., and seldom rises over 90 degrees F. or falls below 60 degrees. The islands are very humid with the Suva area being the most humid and Lautoka and Labasa increasingly less so. During the hot season, when temperatures can range in the 80's, and humidity in the 90's, the weather is oppressive, hot and sticky. As Derrick states, with a temperature above 85 degrees, humidity over 65 can be "unfavourable...and a humidity of 50 per cent represents a dryness of the air that is welcomed in these islands" (Derrick:1957:110). The hurricane season is from mid-November to mid-April. When hurricanes occur, as they have during the last five or more years, they leave a path of devastation in their wake, from which people do not recover economically for many years. They bring with them disease and accidents, and an increased drain on the resources of the health and welfare system of Fiji.

Viti Levu - The Ecology

The largest island in Fiji, Viti Levu (Figure 2.2, p. 34), the site of this fieldwork, measures eighty-eight miles east-west and sixty-four miles north-south. A high mountain range rises to 4,311 feet and divides the island in the middle on a north/south axis, on either side of which are tracts of highlands. These plateaus flank the watershed and are hundreds of square miles in area. They are intersected by other mountain ranges and are drained by the Sigatoka, Ba and Rewa Rivers.
The prevailing winds cause a heavy precipitation on the east-side or the Wet Zone, leaving the western or Dry Zone sunny, hot and dry. A third plateau is situated at the base of the central mountain range, which forks at the southern coast forming the Navua River Plateau and drainage system.

**The Western Division, Nadroga/Navosa Province, Sigatoka Area.**

The central mountain range has been one of the topographical features which divide the Fijian hill tribes of the East and West of Viti Levu into two distinct cultural groups, each with its own language and traditions. It was in the West that this research was conducted. The plateaus, referred to as Navosa and Colo West are the headwaters of the Sigatoka River (See Figure 2.2. p. 34). In its upper reaches, the river courses through open and well drained flat lands although on its eastern side is the area of steep escarpment falling from the central mountain range. The river flows down steep ravines, some with extensive forestation.

At its southern reaches the ravines broaden and become shallow, forming numerous small valleys with grassland. Broken hills, many of them wooded, rise from the alluvial plains of the middle Sigatoka valley. The flat lands here are extremely fertile, they lie along the bends in the river, some of them high on hillsides above the current river bed. From Naduri village which is situated on a high river-silt bed, one can see the vast flatlands which are quite broad on some river bends. Nasavu settlement, adjoining Naduri village is one such alluvial plain or high silt-bed around which the river winds. The high point of land is at Naduri and from there the alluvial plain which is the settlement slopes southward towards the lowlands. These lands along the river are lush with green vegetation of trees, gardens, acres of passion fruit vines and other plants. Yet along the banks the river cuts deeply into the red soil where the banks are unprotected by plant growth. On either side of these small valleys and plains, rise lower mountain ranges. Most of them are rock, bare and without grass cover to hold soil or water. During flash storms the heavy torrential rains gush down the mountain sides and follow shallow
dry creek beds, becoming swift flowing creeks rushing through gorges to merge with the Sigatoka River. Where the gorges have become treed and overgrown with creepers and vines, the water has no outlet and backs up, flooding the land to depths of fifteen feet or more. The Sigatoka River has no forest cover along its immediate banks so the land is subject to sudden flash floods. The water coursing down to the ocean is red with eroded silt which is lost during every major rain storm in the year.

There is no delta at the mouth of the Sigatoka River; a heavy surf breaks and goes up the river for some distance during high tide. Here the coastal lands are marked with very high sand dunes, some covered with scrub are stable, and others bare and shifting. To the West, the land is a heavy limestone deposit with light vegetation. The eastern side of the mouth of the river has silt beds and it is here that the cane fields of Solevu are grown. The land goes from sea level up a gradual incline to an elevation of from 200 to 400 feet, in softly rolling hills covered with cane fields, and settlement houses.

The Sigatoka valley area is an important economic area which grows market vegetables for cities such as Nadi, Lautoka and Suva. Although it is situated on the western side, it is not as dry as the Nadi area, but neither does it have the steady rainfall of the Suva area.

Although they are generally rare, during the last five years or so Fiji has been struck by a number of devastating hurricanes. The area of this research has been hard hit and it has also been flooded repeatedly in recent years. But given the semi-tropical climate, the damage is quickly covered by new foliage and the fast growth of plant crops.

Population

The total population of Fiji is estimated as 690,681 of which 345,148 are Indo-Fijians, 312,121 are Fijians and 33,412 are other races. The population in the 0-14 age group is 253,224 or approximately 37%.
The economically active population, in the 15 to 65 age range is 337,325 or approximately 49% of the total.¹

In 1984, the estimated population of Indo-Fijians was 345,156 (173,358 males and 171,790 females). Indo-Fijians make up 50% of the population of Fiji (ibid:4). The Indian population has increased substantially since the first shipload of 464 Indian immigrants arrived as indentured labour in May, 1879.² Population growth is due primarily to natural increase, but immigration has also been an important factor.

The population in 1976, of Suva, the capital city, both within the city and the periurban areas was 117,827, Lautoka had 28,847 people. The population in Sigatoka, the township of this study, in the Western Division of Fiji was estimated in 1976 as 3,635 (Current Economic Statistics, 1986:5, Table 2.3).

Politics

Politically, Fiji was a British colony from 1874 until 1970 when it became an independent member of the British Commonwealth.

It was governed under a system of local and central government. The Fijian population was governed by a Fijian administration, the Fijian Affairs Board. The Minister of Fijian Affairs and Rural Development was the official representative. Sixty members of the Great Council of Chiefs, attend to all affairs which affect Fijians. They were represented in the senate by eight members; and by two members appointed to the Fijian Affairs Board.

At the time of this fieldwork there were two major parties, the Alliance party, and the National Federation Party (NFP). In 1985 the Labour party was still in the throes of emerging as a party from a group of trade union and other organizations and individuals. Through 1985 and 1986, it quickly captured the attention of a large sector of both Indo-Fijians and Fijians to emerge as a strong contender in the 1987 elections during which it formed a coalition government with the NFP.
The people of Fiji received the franchise in 1963, and vote on the basis of a communal/common voting system. Macnaught (1982:158) states that as well as the Indo-Fijians, there are:

"...three communal electoral rolls, with the Chinese and other non-islander minorities being counted in with the Europeans on the 'General' roll, and the Pacific Islanders with the Fijians. A new system of cross-voting allowed voters of all races to vote together for a member from each race for 'national' seats, in addition to voting for a communal seat, so that each elector voted for four candidates. Ministerial government followed in 1967."

He states that later, the relative weight of the 'General' representatives was reduced "...to eight of the fifty-two members (twelve Fijians, twelve Indians and three 'General' elected on communal rolls, ten Fijians, ten Indians, and five 'General' elected on national rolls through cross-voting)" (Ibid:158).

Fiji is divided into fourteen provinces, each with a number of tikina or subdivisions. Since 1967, provincial councils under the leadership of the Roko Tui (government title of head of province) administer the affairs of each province through directly elected majorities (Macnaught, 1982:157). The basic unit is the village or koro which has as its head and as representative to the provincial council level a turanga-ni-koro (usually an appointed representative). The provincial organization is primarily for the governing of the Fijian peoples and their concerns.

The province of this research, Nadroga and Navosa, has six such divisions (Malolo and Vatulele which are islands) and the tikinas of Cuvu, Malomalo, Sigatoka and Baravi (Belshaw, 1964). This research focused on Nasigatoka, which I believe refers to the area referred to previously as Sigatoka.

Fiji is also divided into four Divisions, each with a District Commissioner representing the Central Government, who administers all of the rural affairs, including the Fijian.
Administrative responsibility for Indo-Fijians and all other ethnic groups is under the central government and the District Commissioners.

The Western Division (see Figure 2.1, p. 32), based at Lautoka encompasses Ba, Nadroga-Navosa and Ra, as well as the Yasawa Islands group offshore. The administration of municipalities such as Sigatoka town is through locally elected town councils, which levy rates in order to provide the necessary amenities. This research was based in the Western Division, the province of Nadroga-Navosa, the old tikina of Nasigatoka and the municipality of Sigatoka town.

Legislature

At the time of this research, Fiji's Parliament consisted of two chambers; the House of Representatives with 52 elected members and the Senate with 22 appointed members, of which eight are nominated by the Great Council of Chiefs. Of the remainder, the Prime Minister nominates seven, the Leader of the Opposition, six, and one is nominated by the Council of Rotuma. The Senate has the ultimate voice in all matters affecting native land.\(^3\)

Since independence Fiji has been governed by the Fijian-backed Alliance party. At the time of this writing, Fiji is politically unstable. During the elections in the Spring of 1987, a coalition government made up of the new Labour Party and the National Federation Party, both strongly backed by Indo-Fijians and labour unions with both Fijians and Indo-Fijians, elected Dr. Timoci Bavadra as Prime Minister, with J. Ram Reddy as Attorney-General. The new government was overthrown during May, 1987 by a coup led by a Fijian. Fiji has since been declared a republic. The Governor General was suspended, and a new Constitution is being written to safeguard Fijian interests in view of perceived threat from the Indo-Fijians who form the majority population.

Economy

The economy of Fiji was based on four major sources of revenue, sugar cane, tourism,
tobacco; and copra and coconut oil production, to list a few. All of these fluctuate subject to international market prices, and to internal factors such as political instability and sometimes poor weather conditions such as hurricane seasons.

The major part of the commercial agriculture for export and domestic markets was carried out by Indo-Fijians. Market vegetables are grown primarily by Indo-Fijians in the Sigatoka valley. Other commercial crops grown include rice, and maize. Fiji was not self-sufficient in domestic rice needs and the government was promoting increased paddy production. In the area of this research farmers grew both a three month variety for quick harvest and home use, and a six month variety. As yet the farming techniques were primitive. Meat, poultry and dairy products are also economically important commercial enterprises, with farmers attempting to intensify their production.

For export markets, sugar cane was the primary agricultural product grown by Indo-Fijians. More recently, Fijians were also growing cane as a commercial enterprise. Other export agricultural products were coconut, ginger, cocoa nuts, and tropical fruits such as pineapple, mango, passion fruit and avocados. Fiji also had a growing forestry industry.

Land

The history of land tenure in Fiji has been documented by many writers (Belshaw, 1964; Spate, 1959; Ward, 1965, Gillon, 1977, Maonaught, 1982, Prem Prasad, n.d.; Farrell, 1977 and Farrell and Murphy, 1978; Mayer, 1961, 1963; amongst others.) The pattern of land tenure was fixed at the time of Cession to Britain. In 1875, the Native Land Ordinance prohibited alienation of native land, except for the period 1905-1908 when 104,232 acres of land were alienated. Of this only 332 acres were purchased by Indo-Fijians. The issue of land use is of primary importance to an understanding of the complexity of the multicultural state of Fiji. It is not the topic of this thesis however so I provide just the basic information needed to understand the issues discussed.
Land ownership is divided into **Crown land** which forms 293,424 acres or 6.4% of the total lands of Fiji and is used primarily by Indian tenants. **Freehold lands** (including crown freehold) amount to a total of 9.76% (434,014 acres), of which Indians hold 1.7% or 75,830 acres. **Native Customary Tenure** lands make up 3,776,000 acres and 83.84% of the land of Fiji (Prasad, n.d. p.2)

Gillion (1977:189) provides a discussion on the terms of Indian land leases and the discriminatory aspects of Native Lands (Leases) Regulations of 1915 made under the Native Land Ordinance of 1905 which prohibited land use on the Eastern side of Viti Levu, to Indians. The terms and lengths of leases also discriminated against Indo-Fijian land use. In 1940 the Native Land Trust Ordinance was established to negotiate all leases for Fijian owners, taking a surcharge of 25% for administrative purposes, with a percentage going to chiefs and the remainder to the **matagali** (extended family unit). Most Fijians resented the surcharge, and many made informal arrangements of their own. Indians participated in these arrangements, often paying gifts to obtain the leases as well as giving yearly tributes (personal communication). Inspite of various commissions of enquiry, the land laws did not change and they have remained inviolable.

The period of leases was 30 years, and was renewable for two subsequent ten year extensions (Farrell, 1977:127).

According to the Agricultural Landlord and Tenant Ordinance of 1966 (which is unpopular with both Indo-Fijians and Fijians), "...a first or second ten year extension may not be given the tenant if one or more of the owners requires the land for his own use "and [if] greater hardship would be caused by granting an extension than by refusing it" (Farrell, 1977). Often, under the counter deals are made to retain land leases and many Indian farmers have been forced to make deals or to give up the leases due to threats such as "...a disastrous fire
in the lessees cane crop. Some Fijians, informants state, quickly learned the art of extortion" (Farrell 1977:127). These comments apply to the Nasavu and Solevu settlements of this fieldwork.

The land issue in Fiji keeps the Indo-Fijian farmer off balance for he has little incentive to improve the lands, or if he does, and makes them too attractive, the Fijian can and does reclaim the land, is frequently unable to farm it economically, and prefers to hold it even though it reverts to bush.

When an Indo-Fijian leaseholder died, his cane blocks were usually "...passed on to sons as tenants, or to widows to hold for their sons if these were still minors" (Mayer, 1961:174). Indo-Fijians negotiated Land leases not only with the Fijian but also with the Crown (for its freehold lands, and Class A and B lands); the CSR (Colonial Sugar Refining Co.) and from other freeholders.

Prasad (citing Ward, 1965) shows that in 1959 Indo-Fijians leased 23,000 acres of land in the cane belts from the Fijians. From the crown they leased 20,000 acres of freehold and the same amount of Class A and B lands. In the same year they leased 50,000 acres of land from CSR and another 30,000 acres from freeholders.

In other areas, they leased 80,000 acres from Fijians, 33,000 acres from the Crown of Freehold and Class A and B lands; no lands from CSR; and 15,000 acres from other freeholders. These figures give some idea of the quantities of land in question.

Some Indo-Fijians in the settlement area of Nasavu do not have farms large enough to provide them with a subsistence, so they work as farm labourers on the larger farms. The larger farms also employ Fijians from the neighbouring koros (villages). This is a paradoxical situation for the Indo-Fijian farmer in this area leases his land from the Fijian (through the native administration), whom he then hires as a labourer. The rents which the Fijians receive are a very small and negligible percentage of the total rents – as I have mentioned above, the
Native Land Trust and the chiefs receive the largest allotment. It is no wonder the Fijians too, are unhappy with their land situation.

Furthermore, Farrell (ibid:132) states: "Paradoxically, Indians who do not own land certainly occupy the very best land, while Fijians who are touted as having almost all the land have relatively little of high quality". Also many Fijian farmers exist on their own acreages on credit obtained from Indian farmers. The matter of land and its use is not simple for Indo-Fijians are not aliens and both groups are "...de jure, if not de facto, equal" (Ibid:127). However, the proceedings in Fiji during the coup on May 14, 1987 which overthrew the newly elected government have shown how little de jure means. The land issue is crucial to the understanding of the situation of the Indo-Fijian in Fiji, but is too complex to handle here except in passing.

On many Indo-Fijians farms, in the settlements where I conducted research, Fijians formed a large part of the labour force, and both farming techniques and new values with regard to land use diffused to the indigenous owners. At the local levels of the settlement and the community, the two ethnic groups had worked out a symbiotic relationship, enabling them to live at peace with one another for the greater part of the time.

The National Health Care System

The modern health care system was introduced to Fiji by the British who were the colonial administrators of the Fiji Islands beginning in 1874, and has developed in several steps since that time. In 1928 the Rockefeller Foundation gave a grant to start the Central Medical School in Suva. Later, the health system was affected by the co-operative efforts of countries in the South Pacific such as New Zealand and Australia. Since independence, it has been influenced by the efforts of international groups such as the South Pacific Health Service formed in 1946, the South Pacific Commission, and the W.H.O. For these aspects I shall draw upon the work of
Guthrie (1979), Miles (1984), and Gurd (1984), to go into this in greater detail in a later part of the thesis.

The Health Care System in Fiji is the responsibility of the Ministry of Health and Social Welfare. The Minister of Health has the primary responsibility for health policy; and the Permanent Secretary of Health, for implementation. The latter “also advises the Minister on all aspects of health services” (Ministry of Health and Social Welfare, 1986:5, hereafter referred to as MHSW). Health care is provided throughout the islands of Fiji by the central Government. Curative, preventive, primary and public health services are offered in each Division and at various sectors of the sub-divisional medical zones. Curative services are offered in three main divisional hospitals, and in 11 sub-divisional hospitals.

Special diseases are attended to in St. Giles' Hospital (mental disorders), Tamavua Hospital (tuberculosis), and P. J. Twomey Memorial Hospital (leprosy). In addition services are provided in a number of maternity units, area hospitals, health centers and nursing stations. There are two private hospitals, Ba Methodist Hospital and Ra Maternity Hospital which are partially funded by the government (Ibid:9).

A National Diabetes Centre was established in Suva in 1984. Its functions are to "control diabetes in the country by promoting and integrating diabetes care and supplementing care measures. With this function in mind the centre aims to:— "educate the health care professionals...educate the diabetic...be a resource centre...(and) provide guidance, co-ordinate and conduct diseases-related research" (MHSW, 1986:35).

Diagnostic services are provided by the two main Divisional hospitals, one at Lautoka and the other in Suva, as well as by the Wellcome Virus Laboratory in Suva. The latter also conducts epidemiological research (Miles:1984:127). Fiji also relies on special diagnostic services in other countries such as Australia where the WHO collaborating Centre for the
Epidemiology of Diabetes Mellitus is based (Zimmet, et al, 1985).

In 1979, the Executive Board of WHO endorsed the Alma Ata Declaration of 1978, and the report of the International Conference on Primary Health Care. The result was an invitation to member states, of which Fiji is one, to accept Primary Health Care as the basis for future policy and action directed towards achieving "health for all" by the year 2000. Fiji's participation in formulating strategies and programs to achieve national levels of health care in keeping with WHO's regional and global interests, are guided by WHO's regional office in Suva, itself guided by the Western Pacific Regional Office in Manila, Philippines.

This chapter has provided some of the basic facts on Fiji as a whole, including a brief outline of the modern medical system which is an integral part of the services provided by the central government. The biomedical health care system is fully explored in Part III.

The Traditional Indo-Fijian system which is a major part of this research will be discussed in Part II.

Now, in Chapter 3, I discuss the three fieldwork sites, two Indo-Fijian settlements and the Sigatoka District Hospital.
Footnotes:


2. See Vijay Naidu's *The Violence of Indenture in Fiji*, World University Service in association with S.S.E.D., University of the South Pacific, Suva, 1980. Adrian C. Mayer, 1961:1-12, also discusses the indenture system. And R.S. Milne, in *Politics in Ethnically Bipolar States: Guyana, Malaysia, Fiji*, University of British Columbia Press, 1981, provides a recent commentary on the place of indentured labourers and their descendants in these countries.

3. Macnaught (1982:159) writes,

   "The consent of the eight chiefly nominees had to be obtained to enact any legislation affecting certain entrenched measures - previous colonial laws-or new legislation regarding Fijian lands, customs and administration. In short the constitution gave iron-clad security, short of revolution, to the paramountcy of Fijian interests articulated at Cession, defended against Europeans by Gordon and Thurston, weakly maintained by their successors, never threatened by the Indians, and reaffirmed effectively in 1944 by Governor Mitchell and Ratu Sukuna in alliance with the local European elite."

4. Prasad (n.d.: p.2) states the Crown purchased 65,892 acres and the balance went to Europeans (30,039 acres), CSR. Co. (930 acres), Fijians (5,542 acres), Missions (857 acres), Chinese (550 acres).

Prasad's unpublished typescript was kindly given to me by Dr. R. Crocombe, University of the South Pacific, Suva, in 1986.
Chapter 3

THE PEOPLE AND THE SETTING

The people with whom this research is concerned are the Indo-Fijians resident in the south-western portion of Viti Levu in the Fiji Islands. Fiji is not culturally homogenous however, and ethnic diversity is an important factor in its socio-economic development. This diversity is apparent in cultural characteristics such as origins, dress, diet, customs, language, and religion. Since the topic of research is the interactions and processes within and between traditional and modern (Western biomedical) health care systems, I begin this chapter with a brief outline of the heterogenous cultures of Fiji. After a brief outline of the Fijian and other cultures in whose midst the Indo-Fijians of this research live, the chapter focuses on the ethnographic context. I describe the market vegetable growing settlement of Nasavu situated in the Sigatoka River valley, the cane growing coastal settlement of Solevu, and the hospital which were the subject of this enquiry. I discuss the religious, educational, economic, political and ideological forces which shape the socio-cultural world of the Indo-Fijians.

The main significance of this chapter however, is to provide a general discussion as background to the detailed study that follows.
The People

Modern Fiji is composed of two main racial groups, the Fijians of Melanesian and Polynesian origin, and the Indians who came to Fiji as indentured labour.

France (1969:2-9) provides an overview of the various theories regarding, and the cultural composition of, the Fijian people. He states (Ibid:8) that they are inconclusive:

The evidence of physical anthropology is thus neutral on the question of the migrations, but establishes that there is great diversity of physical types in Fiji—corresponding with the cultural variety found by archaeologists and linguists. Fijians in the west of the group are physically like the Melanesians of the New Hebrides and Solomon Islands; the inhabitants of the south and east of Fiji have a closer physical resemblance to the Polynesians of Tonga and Samoa.

France also provides a concise account of the first European contact Fijians had, from that with the beachcombers, to the resident traders, and later the missionaries. The latter two groups began the first commercial agricultural enterprises supplying food and coconut oil to trading ships. Later, the white population grew, bringing with it new notions of real property and other European institutions and problems which accompany colonization.

Cultural groups are registered in the Fiji census as Chinese, Europeans (commonly known throughout Fiji as "expatriates" or "expats"), Fijian, Indian, Part European, Other Pacific Islanders, Rotuman and finally a category called "all others". Because these latter groups are small and played little part in this research they are not discussed.

The Indo-Fijians, from their first arrival into Fiji in 1879, continued to enter Fiji at the rate of about 2000 per year, until 1916. The current population of Indo-Fijians are the descendants of these early immigrants, and of small numbers of new immigrants, many of them South Indian, as well as Gujarati business families. Some of these newer immigrants recruit family members, and marriage partners for sons and daughters, from India and other overseas Indian communities.
The two ethnic groups, the Indo-Fijians and the Fijians, have retained their own cultural ways, thus following the early pattern of segregation set by the protectionist policies of early governments. There is very little intermarriage between them, in spite of common schools and a great deal of interaction. They have separate languages although they share the English language for everyday use in all of the government institutions and in business. In the rural areas especially, each group has grasped enough of the language of the other to carry on a “pidgin” type of commonly understood idiom, made up of Fijian, Hindi and English. “Fiji-bat”, the language of the Indo-Fijians has a low prestige value, similar to regional dialects spoken all over India. In Fiji, Hindi spoken purely, establishes social distance between the speaker and the local people. Thus it serves to emphasize authority and class differences between doctors and lower class Indo-Fijians. Many Indo-Fijians, especially the rural folk, know only the vernacular and cannot function socially with Hindi. The use of Hindi often establishes a one-way pattern of communication as well as a low level of mutual understanding. Thus it reinforces the status and dominance of the educated people such as doctors.

The Fijians in the Nadroga/Navosa region use the Nadroga dialect which is distinctly different, and more difficult for others to master, than the Bau of eastern Fiji. One Fijian Nursing Sister told me that eastern Fijians think the Fijians of the Western Division are difficult and stubborn. The easterners are the elite; however the Fijians of the Western Division have their own status gradations and do not readily give way to the Easterners. This is an important point to remember in terms of staffing, in a country where the professional people are posted to different parts of the island every few years, for the interactions between people of the same ethnic group are also affected by their own status differences. But on the whole, the Western Fijian nurses accepted the fact that the Eastern nurses transferred to the Sub-Divisional hospital were high in the nursing hierarchy as well. There are other major differences as well as those of language, between the Fijian peoples of the East and of the West.
Other cultural differences within and between the Indians and the Fijians which affect interactions and processes arise from the histories of the two groups, one group being indigenous to Fiji; and the other transplanted there, and a minority.

Although I have discussed this in previous chapters, it might be pointed out that all statistics for Fiji, and especially the medical data are compiled separately for the two groups and later consolidated. In the previous chapter I discussed the fact that there is also a communal/common voting system in Fiji.

During the fieldwork year (1985-86), the newspapers in Fiji were discussing whether or not all people of Fiji should be called "Fijians". The editorials on the topic are interesting. My experience is illustrative. While attending the annual meeting of the Obstetrics and Gynaecological Departments in the Western Division, one of the leading Fijian doctors asked me what I was studying. When I told him the topic was the medical beliefs and practices of the Indo-Fijians, he said, "We are all Fijians here, how will you distinguish?" Yet a few minutes later the meeting convened and the entire presentation of the year's major medical events was in terms of a comparison of Fijians with Indo-Fijians. The division is deeply ingrained, as the recent elections and the coup following them has shown.

Indians have not forgotten the 1975 motion proposed by a Fijian member of Parliament (Butedroka), to return all Indo-Fijians to India. The seven days of debate which ensued have remained as a permanent reminder, which today has been reinforced, that the constitution is a fragile one and that inter-ethnic sentiments are volatile even if submerged in daily life. Nor have Indo-Fijians forgotten that it was due to their own inability to join forces and quickly form a government, when they had won the election in 1977, that the Governor General swore in Ratu Sir Kamisese Mara of the Alliance party as Prime Minister.
It is against this background that the processes and interactions of health care seeking by Indo-Fijians in the Western Biomedical sector should be understood. The local institution reflects the social organization of the country, culturally and bureaucratically.

The Indo-Fijians

The Indian population is divided according to their place of origin in India into Hindus (North and South Indians, Punjabis, Gujeratis, Nepalese), Sikhs and Muslims. Although some people deny the existence of caste, it exists as an organizing principle even though it does not have the same force as it has in India; and the hierarchical ranking has changed. Occupation in Fiji is not related to caste, consequently there has been at least one major change of function that is readily distinguishable, as well as others. On the other hand these data do not support Brown’s (1978:69) analysis which states, first, “The experience (the boat journey of the indentured people) was shared by everyone; insofar as is ever possible in social life, social differences were eradicated”. And later she states (Ibid:374) “there are not now groups which use purity and pollution as their organizing principle and as the basis for relationship to other groups”. Where people still express caste differences in everyday speech, use caste to distinguish between others and to criticise them, attempt to make the ‘right’ marriage, then caste is viable for them in some transformed sense. The Indo-Fijians of this research sometimes lived in what appear today to be caste-like groups, and observed purity and pollution concepts, although not as rigidly as is done in India. The important fact is that they carried these notions or ideas as part of their ideals, and they used them normatively. I provide these data in the chapters to follow.

While caste has a transformed importance, North and South Indian, Punjabi, Sikh, Muslim and Nepalese are the general categories which are emerging as the the criteria by which people classify themselves.

Indo-Fijians are an economic force in Fiji working in agricultural, industrial and bureaucratic spheres of activity. In the last few years with the strong interest in trade
unionism, there is greater recognition of class as well as of caste, in terms of stratification. In sum, because of rapid social change, the Indo-Fijians show a great deal of flexibility of social organization. The immigrants from India came from many parts of India. First, a large population came from North India, from Bihar and surrounding areas near the eastern part of India. Later, South Indians were recruited as well. Over the years, the many different cultural patterns which Indians from many parts of India brought to Fiji have been adapted, and Indo-Fijians today have become a more culturally integrated group. Through the transformation of their caste system, their languages, adjustments to marriage rules, and many other changes, their culture can be said to be an emergent one, providing them with new structural and organizational forms.

Under the circumstances it can be expected that their health care system too, is a transitional one. In India and shortly after arrival in Fiji probably a very small fraction of Indo-Fijians if any, had experience with biomedical medicine; and relied primarily on the evolution of their own magico-religious traditional beliefs and folk practices. Through their contact with the colonial system they had access to biomedical practices. How they responded to their medical needs given these changed circumstances and opportunities, is the topic of this thesis. Before that however, I describe the fieldwork locations.

The Ethnographic Context:

Two Indo-Fijian settlements and a sub-Divisional hospital (as well as the Medical Center and District Nursing Stations under its jurisdiction) form the ethnographic context for this work. I have changed the names of the settlements to provide anonymity to the people studied. No attempt has been made to change some names however such as those of the towns, hospitals or nursing stations. In a small country such as Fiji these are always very apparent.

The settlements are Nasavu situated on a small alluvial plain in the interior of Viti Levu, along the Sigatoka River, and Solevu, situated across the bridge, and near the mouth of the
Nasavu settlement is an ecological niche, with mountains on one side and the river on the other (Please see Figure 3.1). On the north side the land rises to a winding hill atop of which is situated the Fijian village of Naduri, while on the south side is a ravine virtually hidden from view by the luxuriant vegetation, trees, bushes and creepers which grow wild. The path along the ravine leads to the river, and to the site known locally as *ortha ki ghat* or the secluded bathing (and washing) place of the women of the settlement. It is here that women gather with their infants and children, and wash their family laundry after which they have perhaps their only daily respite from house work and farm labour. From the steep height of the river bank, it is a pleasant and moving sight to see a mother with long gleaming black hair dressed only in her brassiere and sari underskirt, teaching a toddler to swim, or just enjoying the privacy of her own quiet bath. Other women wash their clothes, while laughing and talking with neighbours and relatives. Older women sit together and observe the goings-on, relaxed in the warmth of the morning sun.

Indian men respect the privacy of the women and stay away from here, sending a young child with a message for the mother if need be. Otherwise for this time the women are absent to their menfolk and homes.

The settlement is approximately triangular. It measures approximately 2.5 kilometres along the mountain side and about 3.5 kilometres to its apex at the river. Along its base (north/south axis) the North Indians have settled in compounds of homesteads with from one, to five or six houses.

Most compounds consist of a kinship unit; but frequently households are organized with lineal and collateral kinsmen, affinal kinsmen and fictive kin or close friends. The smallest unit is usually a nuclear family living in one house in a compound. A larger homestead
FIG. 3.1
NASAVU SETTLEMENT
Market Vegetable Growing Area

- Sigatoka Valley Road
- Indian Fields
- Fijian Village
- Fijian Fields
- Sigatoka River

- Ravine
- Women's Ghats
- Indian Households
- Fijian Households
- Mountains (showing elevation)
- Stream Bed

Fijian Buildings:
- a - Church
- b - School
had a lineal-collateral joint family consisting of a man and his wife; one of his sons with his wife and two children; and one nephew with his wife, two children and his mother. There were many other combinations of kinsmen and unrelated friends in the homesteads. In some compounds for instance, a small shack would be compassionately put up to house an elderly single man. In Nasavu, the North Indian compounds are situated along the "valley road" which goes for some 50-60 kilometres into the interior. They are settled with Muslims in the first household cluster, then several compounds (or clusters) of an extended family of Pandits, followed by the Ahir compounds (one of them a large compound with six separate households of one extended family, under the authority of the widowed mother), the Gujeratis, a Fijian family, and finally a wealthy Ahir family. The South Indians are settled along the road going to the point of the triangle, and along the Sigatoka River. They too live in similar compounds of related households.

In this settlement, a shallow trench along the base of the mountains collects the run-off from the frequent rains. Most of the time and in most years the stream is no more than about 60 centimetres wide and only 12-15 centimetres in depth, running through low grasses, along flat open lands edged in places with guava and other small bushes and trees. Though usually a benign little streamlet, it occasionally becomes a roaring waterway. Unable to escape through the narrow tree-and-bush-lined escarpment which is the ravine entrance into the river, it swells and floods the whole plain over the rooftops of homes, sending the people scurrying for shelter at the school in the Fijian village on the hilltop, or to the adjoining home of a wealthy Indo-Fijian widower.

The people stay at these retreats for several days. The flash flood subsides, and people go back to reclaim their farms and their household belongings from under the layers of fine silt, washing what clothing, mosquito nettings and other items can be found and salvaged. After three recent major floods in five years, the families express discouragement. They have lost even the
few tangible items they did have such as family photographs or travel documents from their virtually unknown past. The photographs that do remain, even though mildewed and stained, are hung up on the walls once more.

The two main ethnic groups, the Indo-Fijian and Fijians live in a symbiotic relationship in an area known for its market-oriented economic base. This area is part of the 'valley' known as the "salad bowl" of Fiji, and grows vegetables which are trucked to Suva, Lautoka and Nadi, as well as to the local market town of Sigatoka. The economy in this settlement has changed rapidly in recent years to one of a mixed-type, with some members of a family going to work into the town, or to one of the many resorts along the Coral Coast. Others have taxis, or small or large trucks, which they hire out. Some family members, including elderly men, most women and some of the boys who drop out of school, do agricultural work on small acreages ranging in size from two to five acres. A few larger acreages are also under cultivation.

Women do much of the planting and weeding as well as harvesting on the farms. At the time of this research, the economy was a mixed one, and in my accounts of women's work in families with cane farms, every woman said she works at weeding in the cane fields during the long growing season of about fifteen months. Similarly, in the market vegetable growing area, the labour contributed by women made up such a significant portion that it cannot be discounted. As well, in many if not most households women oversaw the day to day work on the farm as many men worked at other occupations.

Tomatoes have to be picked, ripened on tarpaulins in the compounds and the ripe ones selected daily for shipment to the market. Cucumbers, eggplant and other vegetables such as several varieties of beans, cauliflower and cabbages are all harvested. As well, many people now plant two varieties of dry rice (three month and six month varieties). The methods are very simple, few farms have modern equipment. Women stand ankle deep in water to plant the rice. At harvest, the rice sheaves are cut by hand or by tractor. To extract the rice I observed one
farmer run his tractor over the sheaves repeatedly for about ten minutes, after which he left it for the women to clean by winnowing with large fans.

Just out of town, along the valley road, there is a small broom factory, and many farmers in the many settlements and villages grow broom corn to sell to it. The corn must be dried and stacked, and often the women are in charge of watching over it. If the rains come it must be quickly covered with tarpaulins. This farm work is always in addition to the ordinary household tasks which must be done everyday such as cooking which begins at five in the morning in order to feed the labourers. Then the children must be readied for school, the house swept, the compound cleaned, clothes washed by hand at the river (although recently tap water is available for families who can afford the expense). It is only then that the woman bathes and feeds herself, after which she has time for an hour or so of work in the fields before the noonday meal.

In the late morning and afternoons, most women work in the fields or in agriculturally related activity. They plant seeds, set out the seedlings in the fields, weed and harvest the crop and then select and pack it for shipment. In a few poorer households, women hire themselves out as agricultural labourers on farms. Since several crops are planted and harvested throughout the year, there is a great need for the labour of the women in a family.

One hardy individual, a widow, has her own acreage which she plants, harvests, and sells by marketing in a stall in the town. As is the custom in Fiji, when she was widowed, her husband's land lease was transferred to her to hold for her five sons. Although they all live in separate households in the compound, all but one work at other employment in the town, or as farm labourers. The children in the families sleep in any of the houses as they wish, with their grandmother or cousins.

Several women in the settlement act as "hawkers" (neither has obtained a license) and sell commodities such as vana (dried and powdered root of the shrub Piper methysticum), cigarettes, soft drinks, iced popsicle-like sticks for children, as well as frozen meats, and
tinned corned beef and other meats and fish. They have very small supplies and limited choice, perhaps only five or six items, which they replenish as the stock is sold. One woman purchases *yaqona* root and grinds it into powder which she then packs into small bags and sells to the Fijian people. Many Fijians do not have ready cash and are able to purchase only small amounts of the powder at any one time.

At both ends of the settlement there are small stores which have a more extensive stock. These stocks are mainly for the Fijian people who live in the village on the hilltop as well as for villagers from the *koros* (Fijian villages) across the shallow river.

I have discussed land leases in Chapter 2 so will not go into a further discussion of them in this chapter, other than those more specific details which apply to the two settlements under study.

In Nasavu settlement all lands are leased by Indo-Fijians because of laws which prohibit the alienation of lands in Fiji from the Fijians. In this settlement lands are leased from the J.P. Bayley Trust or from the Native Land Trust Board.\(^{10}\) (In Solevu settlement a few Indo-Fijians have freehold lands.)

There are two main cultural groups of Indians in Nasavu: the North Indian and the South Indian. The North Indians tell me that they have resided in Nasavu since the early 1900's. Most of the South Indian families in Nasavu moved there from the very crowded South Indian settlement across the river within the last two decades. One Fijian family resides in the settlement, across the road from the Fijian village.

Although the dominant ideology in Fiji is that there is no caste system amongst the Indo-Fijians, the settlement is organized spatially according to homesteads of caste-like groups.\(^{11}\)

Nasavu did not have a community organization. Until recently, when it was necessary that the settlement be officially represented, it relied on the "old D.O." (District Officer)\(^{12}\),
an elder in the main Pandit family in the settlement. Several months prior to the end of this fieldwork, a small breakaway group of people decided they wanted to form the Nasavu Balua Mandali, independently of the Pandit family’s leadership. They managed to get together a core group and succeeded in laying the foundation for a temple in the settlement. They had the cooperation of the South Indians in the settlement, and their success may depend on that. At the time of this fieldwork an in-marrying Brahmin man was emerging as the leader. The Brahmin family who since the early 1900s had been the traditional representative of the settlement was in an uncertain and unenviable position — how to join a group which had dispensed with their Brahminical services and did not want them in a leadership role. They acted with dignity and had not reacted to the slight, even though it was hurtful.

Other groups formed in Nasavu settlement but disbanded because of factionalism and internal strife. One of these was a women’s club, and the other a small group trying to organize a bus shelter building. Both failed, leaving bitter feelings and a lack of will to try again.

**Solevu Settlement**

Solevu, the second fieldwork settlement studied for this enquiry, occupies a land of softly rolling hills which rise from sea level directly facing the settlement (Please see Figure 3.2 on the following page). From the vantage point of the ocean, the mouth of the river and the Fijian village are situated to the left of the settlement. The trans-Fiji Queens road which goes to Suva and Nadi cuts through the settlement leaving one group of Indo-Fijian compounds near the sea, and next to a small Fijian Village. The main settlement is situated on rolling hills on the other side of the road. All day long buses, cars, tourist coaches and other transportation move in both directions on this highway.

The lands in this settlement too, are often leased, although there are some which are held as freehold lands, that is, owned by the Indo-Fijians. Other lands, owned by individual Fijians and those held by the matagali have recently been subdivided (as shown in Fig. 3.2) to
FIG. 3.2
SOLEVU SETTLEMENT
A SUGAR CANE GROWING AREA
be sold as lots for housing. Previously, the subdivision was a large acreage which was leased in parcels to the Muslim and Nepalese families who lived on the hillside. During this research the Fijians told some of the Muslim families to move or to purchase the house sites for $1000 each.

There was little interaction between the Fijians in the village and the settlement people in Solevu, perhaps because cane growing requires a more seasonal labour force. The other reason was that the settlement was not along the main travel route as it was in Nasavu. Also, because Solevu was closer to the town, very few of the Indo-Fijians acted as "hawkers", or small establishments which merchandise a few commodities from their homes for sale to the Fijians. On the other hand, I may not have been aware of them because many people did not want to pay to take out hawker's licenses so kept their operations a secret from other people. There were some small commercial operations (such as one retired man who rented out video cassettes from his large library). These were used primarily by Indo-Fijians.

In this settlement, the majority of the Indo-Fijians were either Muslim, South Indian, or Nepalese. The Muslims and the Nepalese households were located along a ridge and in the hills beyond, at the beginning of the settlement. The South Indians have their homes in compounds dispersed throughout the rolling hills with acreages of cane fields around them.

The people of Solevu were a more wealthy group than those of Nasavu, and in fact some are the elite of the township. Here too, many of the men were engaged in work in the town in the shops, and in the tourist resorts. There were some young professionals in the settlement such as teachers, nurses and doctors. Some people owned taxis, or they drove buses or other transport for the resorts or public transport companies. Some of the young women were employed as clerks in the town, as well as in restaurants in the resorts. Nevertheless, it looked like all cane-growing settlements, rural, with few civic amenities.

In this settlement, the main agricultural economic activity was cane farming. Many of the middle-aged and older women, and those who were not skilled enough for outside
employment, worked on the cane farms. Here the work was hard, but it was more seasonal than in the market vegetable growing areas. As well as attending to their daily housework, women worked in planting, and kept the cane fields weeded. Their work was harder than that of women in Nasavu.

Gangs of cane cutters were employed for the season when the cane was harvested. On most farms, in both settlements, where outside labourers were hired, they were paid three dollars (Fijian) per day and given morning tea and some food, as well as a full meal (rice, dal, and vegetable curry) at noon.

There was a large Indian High School in this settlement which, as in the case of most schools in Fiji, was jointly funded by community fees (which covers maintenance and operating expenses) levied on each student; and by the national government (teachers' salaries). By custom, perhaps reminiscent of the Indian panchayat, the school was the responsibility of a community organization made up of a committee of Indo-Fijian men. They hired one young South Indian man as the manager. He was responsible for hiring instructors and for the smooth operation of the school. Maintenance of the school building was a heavy responsibility for the community in a country where hurricanes do substantial damage to buildings.

Additionally, in this settlement there was a mandir (a Hindu temple). The community had appointed a pujari (temple priest) who as well as fulfilling his priestly duties, also acted as resident caretaker. The community organization also helped the needy and was consulted in the case of any major disputes between people in the settlement. In this sense, Solevu was a more cohesive settlement than Nasavu.

Social Relations

The on-going realities of social organization (religion, marriage patterns, etc.) show groups that have a variety of basic value orientations to caste principles; as well as some which they no longer observe (i.e. caste-linked economic and social relations). Empirically, the
caste-like organization or groupings of people are most noticeable in the spatial distribution of the Indians in the settlement, which often show caste clusters of households.

Prior to 1987, on the surface at least, the two peoples, the Indo-Fijians and the Fijians, managed to maintain good relations. Underlying this however, during the time of this fieldwork in the year 1985-1986, was an almost electric undercurrent of antagonism, which was apparently not present a few years ago. Because the topic of this thesis involves interactions and processes between people and with people in institutions I note that ethnic tensions existed to an unprecedented level during the time of this fieldwork.

In the settlements and the township, a few Indo-Fijians and Fijians had firm friendships of long duration. School children also found friendships with each other, but it was not often that one saw a group of Indo-Fijian and Fijian children at play after school hours. In general there was little deeper level interpersonal interaction between the two groups. Although many Indo-Fijian and Fijian men shared vagona at an Indian or a Fijian home together, and worked together in the fields, it was rare for groups of Indians (as whole families for instance) to interact with Fijian families in their villages. To this extent the two groups kept significantly apart.

Inter-marriage was rare, and was frowned upon by each group. When it took place, it was usually an Indo-Fijian man who had married a Fijian woman. I did not know of any Indo-Fijian woman married to a Fijian man in my areas of fieldwork.

In recent years there has been some intermarriage between South Indians and North Indians. Occasionally, a Muslim person may be found married into a North or South Indian family. Intermarriages of this type are usually the result of “love marriage” and are not arrangements made by parents. Initially, the in-marrying person (in patriarchal families, a woman) has difficulty fitting in and being accepted, but after the first child, there is a general acceptance of the situation by the family and the settlement. The adjustment appears to be more
difficult for an Indian woman marrying into a Muslim family, for in some families she must give up her Hindu name for a Muslim one, give up many of the symbols which married Hindu women have, as well as giving up the Hindu religion. In some cases of Hindu/Muslim marriages, the couple resides in the Hindu family, with the couple visiting the man’s parents on occasion. In one case a Muslim woman told me that when she married into a Hindu family, she informed her husband’s family that she and her husband had jointly decided that she would not take on the symbols of Hinduism (i.e. the red sandur colouring in the center part of her hair). These are just a few examples of the kinds of adjustments people in Fiji make when they intermarry.

Another factor which until recently marked the South Indian from the other Indo-Fijian groups was the practice amongst the former of cross-cousin marriage. (And formerly, the marriage of a mother’s younger brother with his niece was prescribed.) These practices have been discontinued since the South Indians now interact closely with North Indians and Muslims to whom the practice is abhorrent in the extreme. The latter groups think of cross-cousins as brother and sister.

Religion

A number of other cultural practices are also quite different among North and South Indians and Sikhs and Muslims. The worship of different gods in the Hindu pantheon and their different names, the performance of weddings and the rituals, the rituals performed at funerals and those concerning infants, were given to me as examples of what the South Indians and North Indians thought of as significant differences between the two groups. (As well, many minor differences exist such as styles of cooking, ornamentation of married women, etc.). The differences between the Hindus and Muslims, although they are both Indo-Fijians, are religious and socio-cultural. Muslim religion is based in Islam. Both religions in Fiji have been divided by sectarian interests (i.e. Arya Samajist/Sanatani Hindus; Sunni/Ahmadiyya Muslims). Sikhs although they have made up a very small minority of the Indo-Fijian group, have strong
followings in Suva and Lautoka where they have major temples. There were no Sikhs in the settlements where I conducted research; in Sigatoka town however there was one Sikh family.

There were no Indo-Fijian/Fijian marriages in the settlements which I studied. But there was one such marriage in the township, between a Fijian woman and a Hindu man. In this case they lived with an Indo-Fijian family, but not with his parents who had ostracized them. He saw his siblings by arranging to meet them in the shops in town.

It is difficult to tell whether, historically, the principle of the settlement pattern was on the basis of caste or whether each original nuclear family, as it leased lands individually from the Fijians, in time became an extended family and added houses in their compound for additional members. These compounds, each consisting of a homestead, usually with an extended lineage group, now appear to be, and are, a caste group located in one area.

My understanding is that very few Pandits (Brahmins) were recruited for indenture. Since they were not agriculturists, recruiters felt they had neither the knowledge nor the stamina to work in the cane fields. Gillion (1962) however shows 16.1% of the emigrants were Brahmins. Many people who came to Fiji did not state their true caste affiliation and some later changed it. Because people came to Fiji as individuals community sanctions did not exist to enforce caste.

After indenture those Pandits who were in Fiji began to reinstate their caste occupation and status as priests and segregated themselves from the other Hindu castes, on religious grounds. The Muslims and Sikhs also continued to each practice their own religions.

I was told that each South Indian name relates to a particular caste and that caste has some importance amongst South Indians (i.e. Pillai’s are scribes or accountants); thus the family names indicate South Indian hierarchical structure to the members of that group.
When talking to women about medical beliefs and practices, I learned that caste was important to them, that until recently, they depended on the midwife, a caste-linked occupation, to remove the pollution of menstruation and childbirth. Many of the traditional beliefs about purity and pollution are made clear during the study of health care. I discuss these in the chapters to follow.

All of these cultural groups interacted much as they did in India, at times sharing in each other's celebrations. But inevitably the differences in their cultural practices with regard to food prohibitions, or other practices, limited their interactions. Many of the South Indians (and the Gujeratis) were late comers to Fiji, did not share the indenture experience and have kept a stronger interest in maintaining their community separate from any of the other Indo-Fijian groups.

Caste remains an organizing principle with regard to marriage and religion, but has lost its potency occupationally. It is also possible and relatively easy for an individual to change caste, and this has been done very often. People in the settlements comment on those families who by changing their names have changed their caste. One informant told me about one example, that of a chamar (leather worker) who after buying some freehold land from a South Indian, changed his name to that of the former owner. Such individual mobility is usually not possible in Indian castes. In India, a whole caste which has become economically successful has been known to change its status over time by taking on the attributes of a higher caste, or by paying genealogists to reconstruct their genealogy showing links with higher castes. Individual mobility in India is rare.

People in the township and the settlements took an active interest in local and national politics. Sigatoka town, situated on the main route from the capital of Suva, is economically important as the center of Fiji's agricultural production. Because of its proximity to the Coral Coast Resort area it has many duty-free shops which cater to tourists. Its geographical location
and its economies mean that there is a strong tie to National politics. At the time of my fieldwork there was a strong resurgence of political activism, with the beginnings of a new Labour Party. The area however has been an Alliance party stronghold (the governing party since Independence). Nevertheless many people were interested and appeared to be weighing options in the light of the declining sugar cane prices, massive layoffs at the resorts (the strong Fijian dollar has badly affected Australian and New Zealand tourism to Fiji) where many people work, which itself leads to layoffs at the duty free shops and in the town generally.14

The Sub-Divisional Hospital

Research at a third fieldwork location in Fiji, was conducted at the Sigatoka Sub-Divisional Hospital. Here I describe the hospital and provide the structure of the hospital organization. Table 3–1 shows the organization of the national Western Biomedical system at the area or local level.

Table 3–1
ORGANIZATION AT THE AREA LEVEL

<table>
<thead>
<tr>
<th>Area Medical Officers</th>
<th>Subordinate staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Centers</td>
<td></td>
</tr>
<tr>
<td>Nursing Station</td>
<td></td>
</tr>
<tr>
<td>District Nurse</td>
<td></td>
</tr>
<tr>
<td>Village/Community</td>
<td></td>
</tr>
</tbody>
</table>

The hospital is on a knoll high above the sea, about 1-1/2 miles from the town. It is pleasantly situated with a circular drive-way around the front of the building. Next to it are two residences, one that of the Sub-divisional Medical Officer and the other that of the Surgeon, each with its lawns in the front and gardens in the back. On the other side is the Nurse's Residence and behind that the house currently occupied by the Dentist. Down the hillside at one end of the knoll are the gardens of the Fijians from the villages between the town and the hospital on one side, and visible at a short distance behind the hospital is an elementary school, situated at the edge of the Fijian village. From the Nurse's residence one can see the sand dunes which reach a height of up to 175 feet. A prehistoric site of great importance in Pacific prehistory, the dunes occur at the mouth of the river and for a distance to the west of it for some three miles.15

The hospital is easily accessible from the center of town by buses which run every half hour from the market and from a number of bus stops along the way. After five o'clock in the evening, they run less frequently, until nine o'clock the following morning. The cost from the town to the hospital, is sixteen cents one way.

At any one time there are 17 staff nurses on duty. I was told that there are seven nurses as 'relievers', some of whom are on leave. There are four senior sisters at the hospital. The hospital operates on three shifts every day. It is the responsibility of the Senior Sister to work out the duty roster. Ethnically, the Senior Sister is Indo-Fijian while the remaining three senior nurses are Fijian (at least one of whom is from one of the chiefly families of the Western Division). In total five of the nurses are Indo-Fijian, and the rest Fijian.

There are four medical doctors in the hospital. The Sub-divisional Medical Officer (always a public health doctor), a surgeon, an obstetrician/gynaecologist, and an anaethetist who also works as a doctor. The hospital has one dental officer, and five staff members who have various levels of training. The dental clinic at the hospital is open everyday from 8 until 4:30 p.m. and
from 8 a.m. to 12:30 p.m. on Saturday. It is closed on Sundays. Two members of the dental staff also go out on school visits with the public health team.

There is one dietician, a nurse who is Indo-Fijian. The X-ray technician is also Indo-Fijian. The two ambulance drivers and the van driver are all Indo-Fijian men. The cook is a male Indo-Fijian and he has at least two Fijian women as aids. The cleaning staff are all Fijian.

The office personnel are under the supervision of an Indo-Fijian man, who has a male Fijian clerk and a Fijian receptionist who assist him. He is responsible for the payroll, medical records and the accounting, and the expenditures for the Nurses residence. The clerk also looks after ordering supplies and for inventory control at the District Nursing Stations, etc.

I describe the patients and their care in later parts of this thesis.

In the chapters in this Part I have presented the research question and background about the setting and the people with which this enquiry is concerned. The Chapters in Part II and Part III of this thesis present the interactions and processes within the Traditional Medical system and the Western Biomedical system respectively. Part IV presents the generalizations about the nature of the interactions and processes in answer to the research question.
Footnotes:

1 In general however on the basis of archaeological evidence France states that "...there appear to be two successive cultures in occupation of Fiji, and possibly three...an early 'Lapita' horizon, with pottery similar to that found in New Caledonia, New Britain and Tonga. Subsequently, a quite independent culture--typified by the use of pottery with relief decoration, for which no close parallels have yet been noted outside Fiji--is in evidence. A third style, the late incised ware, may prove due to the stimulus of European contact".

The linguistic evidence does not allow corroboration of the archaeological evidence. France states that the Bauan dialect of the east "gained its supremacy as a result of the political ascendancy of Bau in the early nineteenth century and the acceptance of the language of the Bauans as the official means of communication by missionaries and government. It is only one among many dialects or possibly languages,* of Fiji several of which remain...as incomprehensible to a Bauan as they were in 1840....Pride is still taken by Fijians in the preservation of their local dialects...."

France states "...the dialects may have differentiated somewhere within the Fiji Group" (Ibid:7).

*France's footnote with reference to whether 'language' or 'dialect' is the appropriate term.

Most Fijians, easterners or those of the Western Division of this research told me that the language of the Nadroga/Navosa province is the most complex of the Fijian languages and is difficult for other Fijian groups to understand.


"Between 1979 and 1919 over 60,000 Indians were brought in under indenture to solve the labour problems of the European sector. Most were encouraged to stay on as free settlers, with remarkably little thought for the demographic repercussions that were to see their descendants outnumber the Fijians themselves by World War II, and embark on a long struggle, never fully realized, to win for themselves the equal place of dignity and power that was their birthright. In the year that Thurston died, however, when this story begins, some 11,000 Indians were isolated under indenture on company estates and only about a thousand time-expired men and their families were beginning to cultivate 1500 acres of land at Rewa and Navua. The success of Indian Labour in developing an export economy, crucial for the expanding revenues of an impoverished government (#74,492 in 1897, #138,167 in 1903), was seen as giving the Fijians the time they
needed - time to absorb the impact of colonial rule, to arrest the steady decrease in their numbers, and to enjoy the unusual institutions that had given them a powerful voice in colonial policy and wholly unprecedented peace and unity.

See Gillon (1977:12-16), for historical details of the circumstances leading to the present Indian/Fijian relations.

Some of these, the result of the colonization of Fiji and the formation of an Eastern elite by the British. (see Simione Durutalo, 1985, Internal Colonialism and Unequal Regional Development: The Case of Western Viti Levu, Fiji). I do not deal comprehensively with the Fijian social organization in this thesis.

For accounts of settlement organization and family structure see Jayawardena (1983) and Mayer (1973).

See C.S. Belshaw's *Under the Ivi Tree* (1964) for a study of the Fijian lifestyle and economy in this area.

In this my data differ from Jayawardena's (1983) account of a similar settlement. He states, "...females almost never work in the canefields, not even in weeding..." (1983:164)

From the field, I wrote a preliminary paper for my fieldwork supervisor and committee, on women's work in Fiji, using ideas from MacCormack and Strathern (1980), Weiner (1976), Illch (1983), and Barrett (1980).

Farrell (1977:126) states that the Native Land Trust Board "...was authorized to use up to twenty five percent of the income for administration purposes. A percentage was distributed to chiefs at different levels and the remainder to mataqali* members". The situation was not one which the Fijian people liked either. They felt that the NLTB should represent them in any dispute with Indians taken to the Agricultural Tribunals. The NLTB did not do so and fell into disfavour with both ethnic groups. Furthermore, as Farrell states (Ibid:128), "The Fijian saw his relationships towards land forcibly changed by the imposition of outsiders, or as France says 'by law established'. The power of chiefs diminished, yet in compensation they derived, and still do, special extra economic benefits from rentals not given to mataqali members".

* A mataqali is a "social unit of second order of inclusiveness; legally a patrilineal descent group and the proprietary unit of most Fijian land" (Macnaught,1982:xiv). Derrick, 1947:8 states that "In Eastern Viti Levu, lands were held in common by members of the mataqali; but elsewhere the landholding unit was the i tokatoka." He defines it as a subdivision of the mataqali, but larger than the family group. The functions of these groups appear to have been different in different parts of Fiji.


This man has served the Indo-Fijians in the Sigatoka area for most of his life, acting as their spokesperson in government affairs, helping them resettle when they lost their leases, and generally looking after their welfare. He was awarded an MBE for service to
his community. Like most people in Fiji he is a monarchist, and has a great admiration for the British Royal Family. His medal and the accompanying certificate have pride of place in the front room of their house.

I thank Dr. R. Crocombe for bringing to my attention the work of Bryan H. Farrell (1977) in Fijian Land: A Basis for Inter-cultural Variance, and H. Farrell and Peter E. Murphy (1978), in Ethnic Attitudes Toward Land in Fiji, both of which are especially illuminating; as well as other works on land tenure in Fiji.

Dr. Crocombe also made available an unpublished paper by Prem Prasad (n.d.), of U.S.P., which states the following five points about Freehold Land:

1. Total area of 9.76 percent of the colony is freehold.
2. For non-Fijians - the most attractive form of tenure because: a, continued occupancy, b, use, c, raising capital.
3. Accessible, high quality - better drained alluvial flats - concentration around Rewa, Navua, Ba and Dreketi River.
4. Freehold land pattern - peripheral transportation.
5. Indians still hold less than 15.5 per cent.


See Archaeological Excavations at Sigatoka Dune Site, Fiji, by Lawrence Birks (with drawings by Winifred Mumford), Bulletin of the FIJI MUSEUM, No.1, 1973:2-3. The area is important for archaeological material, mainly pottery sherds.
PART II
Chapter 4

TRADITIONAL MEDICAL PRACTICES

Any anthropological investigation into social action on the part of human beings is involved with observation of the processes and interactions in which people engage on the one hand; and on the concepts they use to describe and discuss it as real observable phenomena, on the other. The primary goal of this section is to analyze the Traditional Health Care domain of Indo-Fijians in order to understand what the interactions and social processes reveal about the medical system and about other institutions in the culture. Social processes and interactions can be analyzed by examining (a) the factors (or elements or variables) which condition them and (b) the choices, decisions, and the reasons for them, as experienced and described by the people themselves. More simply, I am examining experiences of illness, diagnosis at various levels, choices and decisions about treatment, about the locus of treatment, and type of healer they will use.

Before outlining the structure of Part II, the following brief historical overview of the situation of the Indo-Fijians in Fiji may be helpful. The background assumptions of the Indo-Fijian medical system are based on those of India where a number of professionalized
medical systems (Ayurvedic, Siddhi and Yunani), as well as many folk traditions, and religious and ecstatic healing systems, exist as subsystems and inform the pluralistic practices of Health Care.

In Chapters 2 and 3, I have described the indenture system and the conditions under which the present Indo-Fijian population came to Fiji to live. Briefly, selected as they were for their potentiality to be labourers on the sugar plantations, few if any were literate. Most were uneducated poverty stricken peasant stock from North India. Later, labourers were also recruited from Madras and Kerala in south India. Very few, if any, were learned people or religious specialists, nor were there practitioners of the professional medical systems of India (i.e. vaidyas) among them. In fact, according to my informants there were few people with knowledge of medicine other than ghar-dawai (household medicines from the folk traditions), and no functionaries such as pujaris (temple priests), or pandits (Brahmins), at that time.

Naidu (1979:77) discusses the heritage of the Indo-Fijians:

While the caste system and religion never really disappeared from the midst of the Indians during the indenture period, they no longer played the central role in the lives of the immigrants in Fiji either. What they had, which was not much (including illiterate maulvis, pandits, and sadhus with very little knowledge of the religions) they clung to desperately. Thus the celebrations of 'Holi and 'Tajia', and the singing of bhaajans (hymns) and reading of holy books, where available, continued throughout the Indenture.

However, the essence of the caste system; the deeper philosophies of their religions; the manifestations of these shown by the exemplary living of the elders in the community; the source of wisdom and justice as well as the authority to punish deviant behavior of any member of a caste - the panchayat, was lost to these unfortunate illiterates whose lives had hitherto been governed very largely by these agents of social control.

Therefore there was no continuity of tradition and no one to enforce the values, beliefs and norms of the Indian village community. The Indians in Fiji during the period of indenture and especially during their five years of bondage were a lost people in many ways, and this made them behave in a way unprecedented (sic) in the context of the Indian villages: ...
There is no history of the medical practices of the indentured Indians in Fiji: neither of how they treated their own illnesses, nor of when the pandits and pujaris first began to practice as religious specialists and as healers. From the literature (Lai, 1983; Naidu, 1979), I surmise that it was well after indenture was abolished, when religious groups from India, who knew of the plight of the Indians of Fiji, began to proselytize. Some among the pandits responded and took up their traditional religious obligations. For many, the introduction to the learned textual materials of India, meant that they also took up their traditional roles as prescribed in the texts.

Along with the development of religious interest came the complex associated with it, namely, that of building temples (mandirs) and of appointing temple priests (pujaries) to look after them. These religious functionaries are traditionally involved in the organization and management of ecstatic healing rites at the temples. Other healers such as orijahs (magical healers, sometimes sorcerers) and maulvis (Muslim religious healers) have also been recent additions to the Indo-Fijian medical system. ¹ Orijahs and maulvis provide cures for numerous types of psychosocial illnesses which affect individuals who are alienated from their cultural or social order. They confront the rootlessness Indo-Fijian people suffer, the changes in norms for behaviour which cause disorientation and anxiety. They know the social context of such patients and they can give advice which articulates the world-view (the social, cultural and cosmological realities) with the crises in the person's life.

The traditional health care system of the Indo-Fijians is a fusion of the folk medical practices of India, vestiges of the ayurvedic system of India medicine, borrowings from Fijian traditions, popular over-the-counter methods of self-treatment, Chinese herbal medicines and European folk traditions. Before proceeding to describe and analyze the illness behaviours and the data from the three fieldwork locations, in the following paragraphs I give a brief
description of the way these different traditions are used in the traditional medical system of the Indo-Fijians.

**Traditional Health Care**

Both settlements have a range of folk remedies for the household treatment of minor ailments. Many people are not even conscious of them, and in fact my informants very often denied the use of any type of home remedies. Later, when I mentioned that someone told me about this or that herb or oil used in treatment, they were reflective and would open up and get into animated and interested discussions of the remedies which were handed down in their household, or learned from someone. These cures are discussed in Chapter 5. In conjunction with the first diagnosis of an illness in the home and the remedies used we are confronted with the problem of how illnesses are "made social" and of how and when the sick are taken to healers, and by whom. This process and the interactions involved when people decide and choose from alternative courses of action in seeking healing, and the incentives and constraints they face, are the topic of this enquiry.

**Traditional Healers**

In the settlements there are a number of healers (orjahs) who are specialists in treating the class of illnesses referred to as magico-religious, such as sorcery, witchcraft and possession. The orjahs know how to treat these illnesses which have socio-culturally relevant causes, the agents of which could be human or supernatural. These illnesses require treatment and consideration within the same socio-cultural system as the patient for the causes are embedded within that realm, rising out of antagonisms due to envy, spite, kinship relations, property disputes or other social disorders. Often the illness is diagnosed as hawa (setan or evil wind) or nazir (evil eye). Orjahs have specific treatments for these illnesses. The area of Solevu settlement which I studied does not have an orjah but does have a resident maulyil (Muslim religious healer) who treats many of the same type of illnesses, but with a slight
difference inasmuch as he gives amulets with Islamic verses in them, and is more overtly religious. The Islamic tradition allows for the religious treatment of magical attacks of illness.

Both settlements have religious healers such as pandits (household religious specialists) and pujaris (temple priests). The former treats illnesses (sickness) of a specific type (i.e. "yellow fever" [nerj]), as well as explaining illness (sickness) through readings of the astrological charts that show which grahas (dangers) were present at the time of the misfortune. The treatment is often penance and the performance of puias by the family. The pujaris on the other hand are consulted by patients at the temple. The patient undertakes to become a penitent at the next healing ritual (usually dedicated to the goddess Kali), vowing to undertake the necessary austerities prior to, and during the function. The pujari is responsible for the preparation of the devotees, their fasting, abstinence and proper procedures.

Fijian healers are also used by Indians and Indian healers use the herbology of the Fijians as well as some of their procedures of taking vaoona and propitiating the Fijian god Dakuwaga.²

Traditional healers, including the traditional birth attendants or midwives of which there are a few in each settlement, are not regarded highly by the practitioners of the biomedical system. In fact, the government does not give much credence to them and discourages their use by patients.

Among the traditional healers or practitioners, one of the most important, is the dai, the midwife. Several sections of Part II discuss the role of the dai and the cultural healing practices of women.

The chapters in Part II explore in detail the traditional health care system of the Indo-Fijians. In Chapter 5, the emphasis is on examining the interpersonal, physical (basic hygiene, etc.) and spiritual aspects of life which are encompassed in one overarching concept, tundroosti, which means good health and well-being. Tundroosti codifies the holistic and
preventative outlook which Indo-Fijians have, on health maintenance. Prophylaxis and curing are grounded in this holistic healing tradition; thus ohar dawai or remedies of the household, are usually the first resort to healing. I present them in Chapter 5, in tabular form.

Chapter 6 treats disorders of affect and those with a supernatural aetiology (possession by gods, ghosts and malevolent spirits). Disjunctions in social relationships are frequently expressed in culturally sanctioned ways, as possession by malevolent spirits (i.e. hawa). Sorcery is also practised by some healers in Fiji. How do Indo-Fijians deal with these sorts of health related problems? Chapter 6 examines these critical disjunctions in the psychosocial lives of Indo-Fijians.

The ways in which a community reproduces itself encodes not only medical care and practices, but also aspects of social structure and organization. Chapter 7 therefore examines topics related to menarche and conception, and to changes in how life crises are managed amongst the North Indians, South Indians, Muslims and Nepalese, in Fiji. The complex system of care of the pregnant woman, especially during birthing and in the post-partum phase, is explored in Chapter 8. These two chapters although numbered separately have the captions A and B since they deal with intimately related matters.

Chapter 9, is a conceptual overview of the Chapters in Part II, and presents the analytic findings in a summary form.

Throughout Part II, I raise specific questions in order to focus the work and to make the traditional health care system as explicit as possible. At the present time, there are no comprehensive or systematic studies of the health care system utilized by Indo-Fijians, or of their interactive use of other systems such as the biomedical system or the Fijian system. This section by studying the processes and interactions in the traditional health care sector provides such an analysis. At the same time, many issues of relevance and in need of sound and focused research, but which fell outside the scope of the present work, are raised throughout this thesis.
One of these in particular, that of the history of the involvement of the Indo-Fijians in the elaboration of their own medical system, falls under the concerns of urgent anthropology.

Footnotes:

1 In Chapter 2 I suggested the reasons why people in the religious roles were not recruited during indenture. I believe the orijah role, somewhat similar to that of charismatic healers emerges as a response to stress, and anomie.

2 Derrick (1946:12), states: "Dakuwaga was believed to manifest himself as a great shark who lived in a cave below his bure kalou (god-house or temple, and residence of the priests) on Benau Island, opposite Somosomo Strait, and roamed the adjacent seas". In a footnote on the same page, Derrick says, "The natives of Taveuni believe that Dakuwaga manifests himself in a "basking shark", about forty feet long, which is said to approach the rocks at the north end of the island in order to rub itself against them to remove barnacles adhering to its skin; the natives claim that they scratch its skin with sticks, and feed it".
Chapter 5

THE TRADITIONAL MEDICAL SYSTEM:
Concepts of Good Health, Wellness, and General Illnesses

The intent of this chapter is two-fold. First, I discuss good health as an Indo-Fijian ideal state, examining the background assumptions and processes that are determining factors in the Indo-Fijian culture. Second, I (a) outline the most common ailments people suffer from and which they diagnose within the Indo-Fijian family and (b) show the "ghar dawai" (home remedies) they utilize to treat them. The study is not exhaustive. It represents those illnesses and remedies which I found in two settlements, and in a small town in the Western Division of Viti Levu. Other illnesses and remedies probably exist and further inquiry in this and other areas of Fiji will undoubtedly disclose still others. I am simply concerned here with illnesses of a general nature. Most people have their own household remedies for them and they trust them to bring about abatement of the symptoms and to heal minor afflictions. People usually try home remedies for common ailments before they seek health care in other parts of the system.

The notion of illness presupposes a notion of a state of well-being or good health, from which the ill person is considered to diverge. Therefore, to guide this inquiry, I ask, what are the cultural assumptions about good health? Then, what general illnesses are treated with recourse to diagnosis and treatment within the family context?
In the early days of this research, it was difficult for me to obtain data about home remedies. Some people were reluctant to say they used the old remedies while others although they do use them, do not do so consciously. (This showed that people do not compartmentalize their health seeking behaviour into "modern", "traditional", etc., but seek care by whatever means they can.) I believe that some informants were reluctant to tell me because they thought I would be critical about their practices. I was able to overcome the problem in two ways. First, throughout this research I found that when I could give personal examples (such as a type of tea Punjabi Indians use for relief of abdominal pains), they would then begin to compare and share their own remedies for the illness. Second, instead of asking the question Do you use any home remedies?, I asked a more specific question: What do you do for headaches, backaches, etc.? What do you do when your mother complains of rheumatism? It was fortuitous that one of the first extended interviews was with an older widowed Gujerati woman, who is respected in the community for the way she had managed, alone, to raise her very young family by keeping up the family's little store, and by working her garden fields. One day when a number of us went to visit her, we found that she had some women guests from the settlement. Soon another woman arrived because she saw us going to visit, and she too wanted to join in. Our interview/visit became a time for animated discussion of illnesses, possession by ghosts, exorcism, and an exchange of remedies which a number of women in the settlement employed. The day served to make the anthropologist credible as a researcher in the community, and reinforced feelings in the settlement that women should help with my research since it would be about them, and might help the government to know the needs of Indo-Fijians. The older woman remarked that this was seva (service) to the community and that I had come a long way, leaving my loved ones, to do this work for one year. After this beginning, the research on the topic began to yield some results, as people were no longer reluctant to talk about their beliefs and practices, often laughing at themselves at the same time. In total, I interviewed people in some 42 households in the
vegetable growing settlements, and more than 45 in the cane growing settlement, about traditional medical beliefs and practices.

Cultural assumptions about illness and healing in the Western Division of Viti Levu, where I conducted this field work, are located in a pan-Indian worldview. In it, beliefs based in religion, ancient medical lore, ethical principles, concepts such as karma (fate or "law of moral consequences"), ahimsa (non-violence), pap (sinfulness acquired through mistreatment of, or by killing living beings), shanti (peace, patience, contentment) and purity and pollution, are combined and demonstrated as precepts and practices for longevity and good health. Other Indian principles such as the hierarchical principles of caste and the four-fold division of lif into stages, are part of the background assumptions which inform the socialization process of every Indo-Fijian individual.1 Ideals of peace, harmonious living, ethical behaviour emphasizing right living to achieve good karma are all intricately woven into a pattern for life. A part of this weaving consists of the notions of fulfilling one's roles in society as a student, a householder and parent, and lastly, the elder or sanyasi (hermit); but equally, of disengaging at the end of each phase. Interest in disengagement is socially motivated, expected and highly rewarded with prestige, honour in the family and community. According to Indian ideals, the end phase of a life has roles and obligations that are highly valued. Some elders become mentors for younger family members, while others serve the community on the panchayat, a committee of village elders who arbitrate in interpersonal problems having to do with caste, land or family problems.

This worldview includes ideas about respect for the body and of following regimens in life with regard to diet, exercise, work, play, rest and stable emotional states to ensure well-being.

Indian medical beliefs are based on the ancient Ayurvedic system which specifies that bodily states must be in balance and that poor health and illnesses are caused by imbalances of
bodily fluids. Medical treatment is concerned with correcting these imbalances. In order to achieve this, **vaidyas** (Ayurvedic physicians) rely on a complicated materia medica.

Basham (in Leslie, 1976:22) states:

Health was believed to be conditioned by the balance of three primary fluids (doses, literally "defects") in the body: wind (vata), gall (pitta), and mucus (kapha). There were five separate "breaths" or "winds" which controlled the main bodily functions. When these vital factors were operating harmoniously, the body—-inhabited by the jiva, the vital soul, as distinct from the inmost soul, or atman—enjoyed health. "Discord...is disease, concord ...is health" (Caraka:1.9.4).

Central to Ayurvedic practices is the idea that foods have certain thermal valences and these can be and are used to balance physiological states of the body. In the same way, emotional states and illnesses also have valences in terms of the hot/cold idiom of the humoral system. Cures can be effected by balancing the three humors with the use of medications and restoring the homeostatic condition of the body.

In Fiji, although ideas from the hot/cold idiom are used, none of my informants gave me a coherent elaboration of the theoretical or philosophical bases of the practices. Nevertheless, notions of good health and well-being based on Ayurveda, ancient yogic traditions and Hindu religious and philosophical systems, are so intricately woven and knotted into the lives of Indians that they are a part of the worldview. As I state in the prologue to this section, Ayurvedic therapeutic practices however are not well known or widely used in Indo-Fijian settlements even though most Indians know they exist as a practice in India.

In Fiji today, many of these ideals remain as background assumptions which have survived the transplantation of the people into a new host country through a system of indenture. Others are more recent, and rather than background assumptions they are based in the "leapfrogging" back, into a past which although it has not been the history for the particular
Individuals, is one which they are now recreating out of the memories of recent immigrants from India.

So it is that concepts, some taken from the traditional world view as it existed for them at the time of indenture, and others recreated now perhaps from other places in India, inform expectations about health care in the settlements. The general term for good health or well-being in Hindi is tundroosti. In order to construct some idea of how good health is conceptualized by Indo-Fijians, I asked the questions, What is tundroosti? How do you get or stay tundroosti? I have consolidated their replies to arrive at an overview of what good health means and how it is thought to be achieved in Fiji.

Most people said (in English) it is "health" or "good health", only a few wavered and said it means feeling good. A few people were unsure of the concept. Most people however, knew the term and clearly related it to good health.

Questions about the components of good health brought forth many ideas. A number of women said "good blood" was a component of tundroosti and was linked to good diet. This fits in with ideas expressed by women concerning menstruation, pregnancy and with notions of purity and pollution in the Indian context. Beliefs such as these have implications for the acceptance or rejection of family planning, and I shall discuss them later.

Blood is not a polluting substance unless it is associated with women and is discharged as menstrual blood or during birthing, at which time it is polluting. In Indian culture, bodily secretions are highly polluting, and those associated with the lower part of the body, especially so. An elaborate ritual structure exists within Hindu culture with regard to how, and who, shall remove the impurity created by these processes. The association of polluting blood and femaleness has deep reverberations in the psyche of Indian women and on how they define "the self". Many of the illnesses to which women are prone have a fundamental association with the cultural construction of the "self" of women and the pressures which some women cannot
withstand and somatize into demonic or possession types of illnesses. (They are dealt with in Chapter 6.) The reasons for these types of existential crises lie in the structural relations concerning the roles of women. Women in Indian culture are at the centre of notions about social exchange and transactions, thus they are a vulnerable point in Indo-Fijian social structure. They can create disjunctions in social relationships and others can use them in this sense to create disharmony. Roles of women make them the focal point in the social structure, which some people use to manipulate and disorder community relations.2

Although the loss of semen is not defiling for men, its loss is associated with loss of energy, strength and power, and many esoteric practices exist which advocate that semen retention is conducive to good health in males.3 Such ideas are so interwoven with Indian cosmic ideas and world views that they are a part of pan-Indian beliefs which seem to intrude in the psyches of Indians, worldwide.4

Breast milk is never defiling and the association with the ties of mother and child are used metaphorically to refer to the strength of ties which bond a person to a parent, family or lineage. Although breast milk discharged during the first three days is called "dirty"5, later it is not polluting and is in fact used in healing sore eyes or reddened eyes. (I discuss this below, under 'home remedies'.) One healer told me "the cleanest thing in the body are the eyes - they should never get dirty and they should never see unclean things". Breast milk is used to heal the cleanest thing in the body, thus must itself have that kind of valence.

The Indians in Fiji think of urine as an ambivalent body fluid but it is rarely thought of as polluting. They use it to heal earache in children. I was told that in order to heal, the urine must be that of an opposite sex child, under five years of age. In some religious practices in India, people believe urine has beneficent properties and they ingest it as part of ritual practices (O'Flaherty, 1980:52).
Saliva is polluting; it can pollute food, dishes, and people. Consequently when someone has eaten a portion of food from a dish, it is rarely shared. People take precautions to prevent contamination by lutu (polluted) food and unclean dishes.

Tears are not polluting in the symbolic sense, and they are cleansing to the eyes.

The principle of pollution from bodily secretions is based on the belief that the upper part of the body is relatively more pure than the lower. Thus, discharges from the upper body are less polluting than those from the lower body. The Indic belief is that semen is produced in the head, consequently it is less polluting than many other secretions (O'Flaherty, 1980).

The people in the settlements studied do not usually reflect on the anatomy of the human body (sairi, badan). Indo-Fijian women believe that there is a main vein (narde) in the abdomen (pate) which is related to the reproductive organs, which becomes misplaced due to heavy work or walking on uneven terrain. The pate is the weak point in female anatomy, a weakness all women suffer from, and it is here that illnesses are thought to manifest themselves most often. The pate is linked to pregnancy, menstrual blood, and other discharges, all of which have to do with pollution and with the natural and potentially crisis producing functions of the female anatomy. I think many interpersonal crises and psychological disorders are first somatized as ailments of the pate. Having said this, I qualify it by saying that the pate area in terms of the Western anatomical model is also the stomach, and in this model it would be realistic to imagine that nervous disorders would manifest themselves in this area. This linkage in Indo-Fijian thought, of the reproductive organs with the stomach, could be a potentially rewarding area of study for obstetricians and nutritionists.

One young married woman told me that a narde-related ailment can also happen to men and that some men are particularly proficient at taking the measurements and doing the massage treatments needed to cure it (see no. 7 below). The cause of the disorder in men is usually heavy work.
The human body is thought of as consisting of similar basic anatomical features as those used today in the Western ideas of anatomy but they are not fully analogous. Some of the differences are encountered in the symptomatology, diagnosis and treatment of illness, which in the Western biomedical model are decided by purely physical manifestations, in the Indian conception on physical, magico-religious and symbolic dimensions.

In the Indo-Fijian conception a greater emphasis is placed on the experiential dimensions of illness and on a system of purity and pollution, with its purificatory agents, rituals and objects. Explanation and meaning of illness are the crucial aspects with which Indo-Fijians are concerned. I discuss this more fully later in this section with regard to female ailments.

I have discussed above many of the basic ideas woven into the tapestry of "good health and well-being" as Indo-Fijians cognize them. These ideas exist in the culture in the form of IDEAL precepts and practices which people in the settlements attempt to follow to achieve and maintain tundroosti. As ideals there is a good deal of divergence from them in the actual practices of today, particularly by young people who adopt new ways which are more functional for their lives. As an example, many young Indian women in Fiji now cut their hair rather than wear it long and plaited. Because of this many of the rules for how to wash, comb, and dress hair, which I discuss below, are no longer relevant.

A. Cleanliness, bodily and in the environment:

Bodily cleanliness includes ideas on how to bathe. I was told that preferably people should bathe early in the morning, prior to making and taking the meals, but after cleaning the house, compound and clothes. Even here, the purity and pollution precepts enter into the method of washing and bathing; there is a proper way which children are socialized to use as the process. After going to the toilet in the morning and washing hands, a person should brush the teeth, then rinse the mouth. Some people also scrape the tongue using datun (a supple twig
grasped at each end and drawn over the tongue.) After that the face is washed. When a person is
bathing, the left hand is used to wash the lower body first, including the feet, and then the
abdomen and shoulders with the right hand. This order shows that the left hand is used for the
parts of the body that are considered polluting. I reiterate that these are ideal forms. Only the
very religious or traditional people who have been socialized in these practices rigidly follow
them. Once these patterns have been learned, however, people follow the practices; they are
hard to disregard. As Kakar (1980:236) notes, a "...central aspect of the Indian body image is
the very high amount of emotional investment in the body".

Hair is symbolically important in many ways and there are rules on its proper care.
When a person bathes, he or she usually first washes the face. Then the hair is washed and
loosely tied up until after the bath is completed. After drying it thoroughly (wet hair leads to
colds), a woman will carefully groom it with oil and then carefully plait it. Indo-Fijians
believe that hair loosened by combing should be carefully collected and burnt, it should never
touch the feet or be flying loose near food. Hair worn loose and unwashed represents sorrow
such as at the death of a family member. If someone has died, no one in the family washes his or
her hair until after the funeral. Older women who do not approve of younger women wearing
their hair short, will jokingly say in admonition that only supernaturals (demonic such as
Churah [the ghost of a woman who has died in childbirth], or dan [witch]) go about with hair
flying loose. In this way they try to enforce the cultural traditions.

Nails should be kept short, neatly pared and the clippings carefully collected and
disposed of by burning them in the fireplace. My research assistant, a young Indo-Fijian woman,
told me people are taught that nail clippings have a very bad odour which increases daily, and
pollutes the house. People in the settlements believe that fallen hair and nail clippings are used
by sorcerers to cast evil spells, and to work their magic against someone to cause illness and
suffering.
Ideas of cleanliness extend to clothing and to the environment. Women wash clothes often, sweep the floors in a house every morning, and clean the compound frequently. Indians think of the natural and "metanatural" environments as in intimate interchange with the human body. As Kakar (1980:235 - 36) notes, they are concerned with the quality of sunlight and air, with animal and bird life, with plants and trees, "the effects of the planetary constellations, earths, magnetic fields, seasonal and daily rhythms, precious stones and metals...". This research shows that this is also true of Indo-Fijians.

As in India, Indo-Fijian women are very particular about the area where foods are prepared. The housewife treats the *chula* (open cooking fire) and surrounding areas with frequent plasterings with water and earth to get rid of pollution and to provide clean surfaces. She gives the whole house a general cleaning at Deepawali (the beginning of the New Year) time every year. Throughout the house everything is cleaned including clothing, bedding, walls, windows, floors, etc. My informants were very particular that they had removed all the cobwebs from the previous year so that the new year could be started in the right way.

Everyone is encouraged to undertake paid work not only for material livelihood, but also because it is good for the psyche, and exercise is good for the body. In the cane growing and vegetable-growing settlements, people work all year around as a matter of course, so they do not have to actively seek other forms of exercise. Young educated women, and men who have sedentary occupations, now join clubs (such as the Hash Harriers for men in one town) and jog or follow other exercise regimen. Many men are also avid soccer players or they take up tennis or other sports.

People value sitting quietly at rest, or lying down in the mid-day. If one visits a family in the settlements the host or hostess will usually allow the visitor to rest after a meal. Similarly, people consider sleep crucial for *tundroost*, and insomnia, and bad dreams are a cause for concern. Many people go to traditional healers to seek meaning and explanation of
nightmares or recurrent dreams. When a woman has a headache, or is emotionally upset, or if she has other minor bodily discomforts such as aches and pains, she may choose to “sleep them away”.

In Nasavu and Solevu, people value emotional balance; one should not be too quick to anger or to become argumentative. In terms of the hot/cold idiom, people relate anger to a “hot” state, (as is any passion) and as such it signifies a body that is out of equilibrium and control. Cheerfulness and steadiness of temperament have a high value for they mean that one can live harmoniously with others.

In attempting to arrive at the meaning of tundroostl, I asked many women what it meant. The term encapsulates such notions as I have mentioned above. Interestingly, in my cultural experience as a North Indian, the term incorporates the idea of shanti (peace, contentment, restraint, patience). In Fiji however, it was not among the first few words informants gave me as meaningful to them. Only later, when I mentioned the term, did my informants agree that it was a part of well-being and good health.

Nevertheless, one young married North Indian woman of about twenty-five years told me “tundroosti is good health, good food, eat on time, do exercises, keep your body clean, rest. Don’t quarrel – shanti.” When I asked her how one achieves shanti, she replied with reference to male-female relationships:

Like don’t talk back. If your husband says something [angry] then you should keep shanti, and don’t answer back as an equal. When our menfolk say something in anger, we womenfolk should stay shanti.

Still another young woman, a South Indian, told me that shanti means:

Stay at peace, don’t think too much so you worry. Shanti gives strength to fight against your worries or problems. Also tagit (strength), for men is important for tundroostl for them so they can do hard work. You do pujas, you say [to God] humari budhi deo (give me knowledge).
Knowledge and wisdom are also important attributes of being *tundroost*, or in good health. The opinions of these two women reflect those of most Indo-Fijian women with whom I talked. Characteristics which Indo-Fijians value highly in the roles of women are peacefulness and controlled emotions; those of men emphasize strength and power.

And finally, Indo-Fijians conceptualize food patterns as important for good health. The hot/cold idiom comes into play most actively during the times of pregnancy, illness or during interpersonal crises. The humoral theory of bodily imbalance and its connectedness to illness, its use as a therapeutic mechanism, is not as well articulated with everyday life as it is in India. It is most explicitly followed in Fiji in the food practices of post-natal women, although some of the elderly women in the settlements have a good knowledge of the food valences and of their use during illness. Other women invoke the knowledge only during pregnancy when it is used to make the *sont* drink to induce lactation and to bring the health of the new mother up to its standard. Some families use the hot/cold food idiom so infrequently that younger people do not know its usage at all. On the whole, although not all younger women have a comprehensive knowledge of the hot/cold idiom, and to some it is a vague knowledge; they are able to recall some aspects of it if necessary, and they ask the advice of their elders.6

I have tried to show thus far that harmony of body with nature, and person with society, is the fundamental leitmotif of Indian and Indo-Fijian life. It is evident in the world view, in everyday practices such as hygiene, and nutrition, states of mind, and in ideas about rest.

I stated at the outset that this chapter is about wellness and good health as they are conceptualized by Indo-Fijians, so as to shed light on cultural assumptions about health care in the chapters to follow. But the chapter is also about common illnesses and their treatment. The list of the general ailments which occurred, and the treatments with many types of *ghar dawai*.
(home remedies) in the two settlements, is presented next. I abstracted them from the data and present them in tabular form for ease of the reader:

Table 5-1

COMMON ILLNESSES AND THERAPEUTICS OF INDO-FIJIANS

1. Headaches (mur pero)

Massage the head with coconut oil.
Use "spirits", put on a cloth and tie tightly around the head keeping them out of the eyes, then lie down, rest.
Heat hing (asafoetida) and jawain in mustard oil and massage head and body with the mixture.
Mussala tea - make tea with milk and sugar and with spices such as cinnamon (dalchini), cloves (laona), cardamom (ilachi).
Mix coconut oil with Vicks and massage the head, then take tea and have a rest.
Bitter melon leaves (Karela pati) crushed, take out the juice and use it to massage the head. The head aches because it is "hot", juice will cool it.

2. Rheumatism (Tundi bimari)

Take the leaves of the neem tree, crush and make them into round balls or pills, dry in the sun and take one every morning with cold water, before breakfast.
Put coconut oil on both sides of the mudar(?) plant leaf, warm it and tie it on the sore knee with a cloth.
Massage with coconut oil which has a cube of camphor ground into it.
Crush basil (tulsi) leaves with butter and massage with it.
Boil a stone in water, wet a cloth in the hot water and wrap the heated stone in it, then place it where the cold and pain occur, for relief.
Pick the vine called akes bori which looks like a creeper (no roots or leaves), heat it and tie it around kneecap.

3. Flu (bokhar)

Boil water with Nandrala leaves, steam with it, maybe add Vicks too. Lemon leaves may be used instead.

4. Earache

Take one of the long leaves of the "snake plant", squeeze the juice out and drop into the ear.
Peel onions, take tender center out, warm in oven or fireplace and fry
lightly. Take a cloth, dip it into the juice and put the drops into the ear.

Take warm urine of opposite sex child (under 5 years of age), and put drops into the ear.

Fry garlic in mustard oil, strain it and drop into ear. Crush and squeeze marigold leaves and put the juice into the ear.

Warm coconut oil and put a few drops in ear.

Grind and fry jawain in coconut or mustard oil, then strain it put into ear and also massage head with it.

Fry garlic in coconut oil, strain and place a few drops into the ear.

Crush tulsi (basil) leaves with coconut oil, drop into ear.

Take the "fern type of leaf" (?), extract juice and put 5 or 6 drops in ear.

5. Eyes

Buy rose water from the chemist shop and put in eyes.

Crush gol mirch (peppercorns), put into breastmilk, strain and dip a small cloth into it, then squeeze drops into eyes.

Drop plain breastmilk into eyes.

Put castor oil into red eyes.

Put the juice of raw turmeric into eyes.

To treat sore eyes put a pot of black tea outside at night and let it sit, then use it as eye drops in the morning.

Mix breast milk and castor oil and use as eye drops.

Wild tobacco juice, goat milk or breast milk can be used as eye drops.

If eyes burn, use honey as eye drops.

For red eyes mash a wild herb (?), dip a cloth into it and put three drops into the eyes, then lie down and blink to make the tears come, then sleep.

6. Stomach ache (Pate pero)

Mix salt in cold water and drink.

Give castor oil to clean out the stomach.

Take kara neemac (black salt) and some hing (asafoetida), or go to the doctor.

Crush and squeeze basil leaves, take the juice.

Take the juice of kapoor leaves or theen pati (a herb with three leaves)

Boil water with jawain in it and then dip a cloth in it and apply it to the stomach.

7. Narde Okarde

This is primarily a female ailment, for which women use massage at home before going to the village midwife for her massage treatment. It is diagnosed by taking a string and measuring from nipple to navel on each breast. If the measurement is uneven, then the narde is believed to be misplaced and massage is used to put it back in place.

7. Sore throat

Take ginger juice mixed with honey.

Tie a cube of camphor in a cloth and tie around the neck.

Light a fire in the chula (cooking fireplace) and spit into it three times.
Take dry ginger in hot tea.
Take the juice of kapoor leaves crushed with salt.
Take black pepper mixed with honey.

8. Diarrhoea

Take salt and water.
Mash guava leaves with green tulsi (basil) leaves, add four ounces of water and some salt, and drink it. At the same time take lemon juice and sugar 3 times a day. Take no food until the next day.
Take theen pati, crush it with salt and eat it.

9. Urogenital

Take coconut water or take the spice drink called sont.

10. Periods

For pain, make a tea made with dry ginger, dhaniya (coriander) and jeera (cumin), cook it and add two bowls of water then strain and drink.
Crush black salt and take a pinch with water.

11. Cough

Crush kapoor leaves, place on head, tie in place and leave overnight.
Tulsi leaves and honey can be taken for cough.
Take ginger juice and honey.

12. Head cold

Put Eucalyptus oil into the parted hair and massage.
Massage with Vicks on forehead, nose and chest.

13. Measles, etc.

These children's ailments are thought to be brought by the goddess Kali when she is in a "heated" and angry state. Smallpox, chickenpox and measles are treated by calling the pandit and by having a special puja performed to placate the goddess.

14. Chest Pain

Take the Chinese medicine called "White Flower" which you can buy from the market.

15. Heart Murmur

This is diagnosed at home, I was told "we just know" when a patient is suffering from this ailment; it can be treated by inviting someone who can
cross the index finger over the little finger, to the home. Their presence for a short time will heal.

16. Sore Back

Any one who was born by breech birth can heal the sore back of another person simply by placing their feet on the person's sore back.

17. Cancer

To alleviate distress take *karela* (bitter melon) juice.

18. Cuts, bleeding

Apply red sandalwood paste.
Apply juice of *boharia* or *bakrela* plants which grow wild in the area for deep cuts.

19. Sores

If on hands, and if the tops of the fingers are spread out, then go to the woman *oriah*, she can heal them.
On hands, wash with warm water and salt, apply Tiger Balm and wrap with *karela* leaves.
Apply coconut oil mixed with kerosene.

20. Fever

Buy *cherata* (it looks like wood) at the market, and powder it, and boil it with water and then drink it.

21. Toothache

Break a leaf off the *mudor* plant(?), take out the juice and put it, on a piece of cotton then swab it around the tooth.

22. Morning Sickness

Take the leaves from the big or the small *tulsi* plant crush with *jeera* (cumin) and salt, roll them up and chew.
Take honey and add a bit of ash from benzene lamp, and eat a little of it.

23. Abortion

Put the juice of the *mudor* plant leaf on a cloth, tie around a stick and insert the cloth into the vagina. Within a week the periods will resume.
Cook a small green papaya, cool it and eat it.
24. Stiff neck

Massage with coconut oil

25. Diabetes

Crush and take karela juice. 7
Boil the leaves of salga bhangi (a leafy green) and drink the juice when the sugar is showing "high" on the test.
Crush the leaves of the neem tree, make them into balls and take everyday on an empty stomach.
Grind methi (fenugreek), fry it, make into small balls, take one a day.

These were the most common ailments and their remedies as told to me by people in the two settlements studied. The list contains mainly those ailments which have obvious causes such as diet, minor injuries, environmental factors, and accidents. Supernaturally caused illnesses such as spirit possession or possession by demons or gods and goddesses are treated in more depth in a later chapter.

Treatment for minor disorders is sought within the home first, with the hope that it will be of short duration. People recognize that some illnesses such as the common cold, are self limiting. A person can initially diagnose the illness without recourse to others in the family. The usual practice is to take a hot drink, lie down and rest. Someone in the family may come along and feel the patient's forehead to see if there is a fever. Most people treat colds with the commercial preparation, panadol. If the high temperature continues, another relative or neighbour may come over and decide with the family that the patient go to the outpatient clinic at the hospital for diagnosis and treatment. There, the patient may be examined and given antibiotics. At the same time, they may consult a pujari or orjah if the patient has been having some Interpersonal crises concurrently with the fever. Or a woman patient may have someone in the family give her massage treatment for headache or for abdominal discomfort, while taking one of the home remedies mentioned above. The treatments are often all undertaken concurrently, rather than sequentially. People in the settlements expect relief from Western
drugs to be immediate and they frequently discontinue the medication within a few days if they do not feel better.

Indo-Fijians generally are not reluctant to use the hospital facilities if their resources permit that option. The outpatient clinic (OPD) is frequently the only place outside the home where a young married woman, or single women or young mothers, are able to go to commiserate with other women friends. It is also a legitimate excuse to get out of the settlements for a few hours without criticism. Generally, several women will go together and unless one person is seriously ill, they will use the opportunity to do any household shopping during the same trip. It was not uncommon for me to have been working in the outpatients' clinic with the doctor, writing the diagnosis for her, and then hours later to see the patients still in town. (I discuss treatment in the Western Biomedical system more fully in the chapters in Part III.)

In summary, I have outlined the general assumptions about good health, as they are based in the traditional Indian notions of tundroosti, the hot and cold idiom of the humoral system, and in folk understandings of some of the Ayurvedic beliefs, Hindu religious and philosophical ideas; that is, the beliefs and practices that determine health status as an ideal state for Indo-Fijians.

I then outlined the illnesses which are treated by Indo-Fijians with home-based remedies. Folk remedies in Fiji as used by Indo-Fijians are based on a) the store of knowledge the indentured brought with them from various parts of India, b) new knowledge discovered in Fiji, from the Fijian herbal traditions called (jungli dawai [jungle medicine]) using endemic species of plants known for their efficacy in Fiji, as well as Fijian massage treatment, c) commercial preparations from the Chinese health care system, d) preparations from the Western pharmaceuticals (Panadol, spirits and Vicks, etc.), and lastly, e) additions to the repertoire of Indian practices as they are learned from the practices of new Indian immigrants such as the Gujeratis, who use and practice the Ayurvedic system with a little more knowledge.
than do the second and third generation Indo-Fijians. Gujerati merchants also import many of the medicinal ingredients and preparations.

As I discuss physiological processes of menarche, pregnancy and birthing in chapter 7 and 8, it will be seen that many of the ideal practices discussed in this chapter for the maintenance of good health and well being are relevant to it as well.

The scarcity of published data on early medical practices in Fiji makes it difficult to know which remedies were brought over from India and retained, which were added by later immigrants. What can be said however, is that it is quite possible that during the initial period of indenture many of the remedies people used as part of their healing repertoire in India were not continued. Since the ingredients were simply not available in Fiji, the practice was discontinued of necessity. It is also difficult to say what has been added to the repertoire, except that clearly some of the Fijian herbology has been 'borrowed'. In other cases, we do not know if the use of plants such as *karela* (bitter melon) are old practices from India, or a new addition to the Indo-Fijian practices. Were they available in the early days? A few remedies are also borrowed from the Chinese commercial preparations which are available as packets in the few Chinese stores.

Many of the indentured people, being young, probably had little or at least minimal knowledge of folk remedies. Another factor for the seemingly short list of both illnesses and remedies treated at home is that the Colonial Administration in Fiji had instituted a health care system based on the Western Biomedical model. This was in the form of "vaccinators" as early as 1876, and by 1888 had graduated three Fijians, the first of the Native Medical Practitioners, who were located in dispensaries. Very soon there were travelling medical officers and nurses, followed by the establishment of district nursing stations, health care centres and hospitals. After the decimation of many of the early indentured labourers due to smallpox and other diseases enroute to Fiji and to a later flu epidemic, the Colonial Administration was quick to
respond with the establishment of a system of Health Care. I discuss the Western Biomedical health care system in later chapters.

Indentured people saw the efficacy of Western medicine and were not hesitant to turn to it for care. This probably has meant that a more elaborate indigenous form of home remedy system has been slow to develop and is still emerging. Certainly, of the traditional healers, my informants told me that there were no pandits, pujaris or orjahs as healers in the early days; their entry into the traditional medical system in Fiji is quite recent. An elderly man, in his seventies, told me that the orjahs began to practice in the 1920's and '30's. One very elderly woman said, "Ahre! there was no one then, no pandits or pujaris, for marriages we just had a one day celebration amongst ourselves – then we were sent with the husband. They came later the pujaris, orjahs, those people".8

In this chapter, in terms of Moore's (1978) framework, I have shown examples of "processes of regularization". Socialization patterns which transport concepts such as tundroosti and shanti are regularizing processes. Similarly ideas such as those involving the hot and cold idiom relate to ancient philosophical systems. Because concepts and ideas encode traditional norms, values and beliefs, or an Indian worldview, they are "processes of regularization" which are passed on from parent to child. They are the traditions which are concretized or crystallized through the everyday reciprocities and transactions of people in roles who are mutually dependent on each other. Such processes, which are repetitive, produce continuity of cultural ways and result in the fixing of social reality.
Footnotes:

1. See Kakar (1978), *The Inner World*, a psycho-analytical study of childhood and society in India, for a thorough examination of the socialization practices of Indians and their relationship to identity.


3. Please see O'Flaherty, 1980:30-31, 44-48, and in the index under "retention" for further references. O'Flaherty, discusses this topic in Part II, pages 17-61 titled "Sexual Fluids".

4. Kakar (1978:2) discusses individual development as he states "...in terms of the individual's reciprocity with his social environment". His interest is in attempting to circumscribe the "Indianness" of Indians with reference to a sense of identity:

   "Identity, as used here, is meant to convey the process of synthesis between inner life and outer social reality as well as the feeling of personal continuity and consistency within oneself. It refers to the sense of having a stake in oneself, and at the same time in some kind of confirming community. Identity has other connotations, perspectives which extend beyond the individual and the social to include the historical and the cultural...It is...a subtle concept, the essential meaning of which is more accessible to intuitive grasp than amenable to systematic elaboration: it is forever on the tip of the mind, so to speak. The concept is ideally suited to integrate the kinds of data—cultural, historical and psychological—which must be included in a description of the 'Indianness' of Indians: the network of social roles, traditional values, caste customs, and kinship regulations with which the threads of individual psychological development are interwoven."

He is interested in explaining the Indian psyche, and in particular, "the interplay between universal processes of human development and the Indian cultural milieu".

5. O'Flaherty (1982:42-43) states breast milk is made from menstrual blood which is purified through the mother's breast—"...the most polluting of substances is transmuted into the purest of substances...". And later, "...the symbolism of interaction of body fluids expresses a deep emotional ambivalence, extending to the parent-child relationship as well as to the male-female relationship". Blood is also the origin of semen. (She quotes from Zimmer, 1948:185; Susruta 3.4.24.) She notes that this linkage between milk and blood has in rare cases been an impediment to a wife receiving blood from her husband if he has the same blood type. The implication is that if such a transfusion takes place their relationship is changed to that of parent/child and normal relations between them would be incestuous (O'Flaherty, 1982:43 quotes from Howard, 1977).

Although few Indo-Fijians know the ancient basis of their beliefs, this perhaps explains the reluctance of Indians to feed colostrum to babies, and why they refer to it as "dirty".
English education in the school is supplanting the old values now, and home economics classes teach modern women about vitamins, calories, proteins and carbohydrates. Most people think this is a useful addition to their cultural ways; the young women themselves place a great value on these new conceptions over the old ways.

Aslam and Healy (1983) state: "...the fruit karela (*Momordica charantia*) is used for making curries but is also used medicinally by the Hakim to lower blood sugar. It is apparently effective in diabetes mellitus, having similar properties to the allopathic drug chlorpropamide (*Diabinese*). In at least one case a diabetic patient became comatose after taking both karela and chlorpropamide."

Gillon (1977:47-65), Chapter III (The Sadhu and the CSR), discusses one of the types of social reformers, who are often also healers, who came to Fiji in the early 1900's as a response to the plight of the indentured Indians in Fiji. From Gillon's short account "the Sadhu" (hermit) appears to have been a charismatic figure who was able to influence Indians to strike against the Colonial Sugar Refining Company (CSR) of Sydney. It was at about this time (1915 - 1920's and thereafter) that pandits, pujaris, and orjabs emerge in their traditional roles. An interesting question for further research is: What were the circumstances which led to the resurgence of interest in traditional religious and healing roles in Fiji? I would expect that reformers such as Sadhu Muni, who urged a return to Indian self-respect, pride in Indian heritage, and self-sufficiency; as well as urging Indians to ask for equal pay for equal work in relation to European workers, did much to kindle an Indian renaissance in Fiji.
Chapter 6

PROCESS OF MANAGING POSSESSION AND
OTHER BEHAVIOURAL CRISES

Pluralism in medical practice has only recently been given analytic attention in the anthropological literature. In traditional medical systems it has long been in practice and utilized by people all over the world. Indo-Fijians seek medical treatment from many types of healers ranging from the secular practices of the midwife (or dai), to the folk practices of the orjeh (a magico-religious healer), to the religious practices of the maulvi (a Muslim religious healer), the pandit (the home priest) and the pujari (a temple based priest).

Each of the healers treats a small sub-set of illnesses based in an Indian world-view. In this chapter, I discuss possession and other behavioural disorders, for which people seek help or therapy from traditional healers. For such types of illnesses people feel that the causal nexus lies outside the healing capabilities of the Western type of doctors. People in the settlements are quite willing to talk about the fact that they rely on past experiences of healing to guide their decision-making about the choice of healer they consult for certain behavioural disorders. My informants make the distinction between doctor alla kum (the work of doctors) and that of the traditional healers (i.e. dai alla kum, or pandit alla kum, etc.).
In this chapter I am abstracting patterns from the field data, from actual examples of behaviour of real people. These abstractions or generalizations, sometimes no longer isomorphic with the total behavioral process of any one individual, allow me to show how a particular social form (illness) is generated (or patterned or conditioned) by the cultural context. People use various strategies to satisfy their needs and goals on the one hand; and they are constrained by social, technical, and ecological factors on the other.

The fundamental question asked in this chapter is: What are the elements (or factors) which the people believe determine both the illness and the outcome of the process of healing in cases of possession and other behavioural disorders? While this question will allow me to arrive at the broad etiologies of the illnesses, other questions arise to direct attention to the actual healing processes: Who initially diagnoses the illness, and what are the symptoms? Who are the actors in the process (the patients, the healers)? What is the setting for the healing? How is the decision as to the choice of healer made?

In any processual form, the time and duration of the process are important as well as whether it is a single event, cyclical or episodic and recurrent. The personal characteristics of the healer are also important, as is whether the practitioner is a full-time specialist or part-time. We can also ask whether there is a formal training period, or how the healer comes by his skills. Finally, in trying to discover the causal nexus of illnesses of this type, both the immediate cause as explained by the patient and healer, such as possession or sorcery; and the ultimate or social cause as revealed by the analysis are of interest.

There are many treatment options that Indo-Fijians in the settlements use. This multiplicity is a characteristic of the traditional medical system. As well as ghar dawai (home remedies), folk healers are another level of choice in the settlements. Each healer treats a
specific illness or complex of ailments which people believe cannot be treated in other systems. These ailments are mainly those thought to be of supernatural causation.

An Indo-Fijian doctor in private practice in a small town in Fiji first mentioned the healers referred to as orijahs to me. He was one of the few practitioners of biomedicine who did not berate their use, and who felt they gave a service not provided by other types of health care. Later, in the settlements, I visited a woman who had an interest in supernatural causes of illness; and over the next few months, she and others provided me with numerous stories of people who had been possessed. I learned the names of the spirits and demonic forces which possessed people, and the manifestations of the illnesses. My knowledge of the supernatural agents of causation, i.e., how they came to acquire their power for demonic possession, and of the healers who can counteract the evil, was acquired through everyday contact with informants in Nasavu and Solevu.

Oriah is a general term for a magical type of folk healer in Indian healing practices. There is a connotation of ambiguous use of power that is morally questionable in the person of the orijahs and in their healing practices. They are frequently men (or women) who live at the margins of society. They are known to be able to perform sorcery, to have the power to do so. They can also heal illnesses caused by angry, malevolent ancestral spirits, and by ghosts of people who have committed suicide, or have died by other violent means. Some of these spirits or ghosts are called bhut. Young women who die in childbirth are thought to become churael, a particularly vengeful and fearsome type of ghost. Some of these spirits are thought to possess the people they afflict. Another form of illness-causing spirit or force is referred to as hawa (or evil wind). Hawa may also possess people. Its presence is manifested in behavioural crises which take a variety of forms and which are of different durations. Hawa is also referred to as setan (evil spirit).
Healers who have the power to cure such afflictions must logically also be able to summon such spirits. As a consequence of these beliefs people think that orijahs are potentially dangerous, and that they have the ability, if they so desire, to use their powers to harm in some cases, as well as to heal in others. On this notion of ambiguity of power is based the paradox discovered here between the repeated and extensive use to which people actually consult orijahs; and to the refusal by many Indo-Fijians to admit that the use of this type of healing is entirely proper. Morally and ethically, it is suspect. Although people will not admit to consulting orijahs as sorcerers themselves, they are not loath to admit that orijahs are employed by others to do jaddu (sorcery). During the course of this research however, the orijahs with whom I talked did not admit to doing sorcery.

It is my impression that people think of the healing process used by maulvis as more acceptable than that of orijahs. The maulvi demonstrates his connection with the Koran in his healing by reading the text, by consulting it in healing, and by writing prose from it for the amulets (tabiz) he prepares and prescribes for his patients to wear. Maulvis do not do sorcery. I think healing presents maulvis with a dilemma since such practices are on the borderline of acceptable religious function. In Muslim thought magical healing is acceptable if it is based in Islamic religious doctrine. One maulvi whom I met, has been to Mecca in the last few years as well as to Medina and he now finds his healing presents a conflict for him with regard to his religiosity. He told me that he has stopped treating most adults and now heals only young children in his own settlement. In Fiji, maulvis, as religious healers, usually do not want to get labelled sorcerers; this may be another reason for his reluctance now to treat adults.

Pandits (domestic priests) and pujaris (temple based priests) are both involved in religious healing and have more prestige than do the deis (midwives) or the orijahs. I was told by people in Nasavu settlement that they consult pandits to cure peri (called "yellow fever").
This is actually a symptom (jaundice) of wider-ranging health problems, but Indo-Fijians treat it as a minor illness. Pundits also conduct astrological readings and perform pujas for healing purposes. They propitiate gods and goddesses to pray for divine intervention for their patients in cases of barrenness, repeated miscarriages, chronic illnesses and in other cases of bad luck and misfortunes.

Pujaris are temple based religious healers. They traditionally prepare people who undertake penances, austerities, vows, and fasts, at the temple. My research assistant told me that most pujaris have had a god or goddess "come onto them" (possess them). Such possession is demonstrated by going into trance states, and by undergoing various kinds of ordeals. Until a pujari has been possessed he cannot undertake healing others. Pujaris heal a number of patients at the temples during major ritual events such as the Tirnul held in August in Fiji to "cool" the goddess Kali (also referred to as Mari or Mariyamma). They also heal individual patients at other times during the year. I was told by a former patient that some pujaris have incorporated parts of the Fijian cultural complex (the yacoma rite) in their healing. As well as praying to the Hindu pantheon, they use tobacco and pray to the Fijian god Dakuwaqa (see footnote 1, Chapter 4) when they are healing. Although the healers summon the powers of the Fijian god, he has not been incorporated into the Hindu pantheon during religious worship by Indian supplicants.

Processes and Interactions in Curing and the Etiology of Illness

Although Indo-Fijians know of Ayurvedic systems of healing, they are not used in Fiji. Folk healers and religious specialists are the ones who conduct healing. Their notions are based on the ideal of wellness (tundroosti) being related to achieving and maintaining a balance in physical, emotional and spiritual states. These are maintained through diet and by following the hot/cold idiom related to nutrition, through rest and exercise, by being of even temper and
living in peace in all social relationships, and finally, by following religious practices and injunctions within all of these spheres.

Most of the people in the rural settlements of Fiji where I conducted research knew nothing of the humoral equilibrium theory (tridosas), the rajas, etc. of the esoteric beliefs of Indian Ayurveda (Kakar, 1982:231; Filliozat, 1964:171ff; Obeysekere, 1977). Although the hot/cold idiom is known and used by some people who are now in their twenties, younger people do not have an adequate knowledge of it to practice it unaided by their elders.

Table 6.1 is an explanatory model of the traditional medical system of the Indo-Fijians in the settlements of Nasavu and Solevu. It is presented next, in order to enable the reader to understand the discussion on the topic which follows.
Table 6.1
The Traditional Model of Healing: Healers, Etiology of illness and Treatment

<table>
<thead>
<tr>
<th>Healers</th>
<th>Illness/Etiology</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dal</td>
<td>Menstrual pains and problems, female ailments, pregnancy and birthing, “narde okarde”</td>
<td>Massage with coconut oil.</td>
</tr>
<tr>
<td>Oriahs</td>
<td>Hawa, setan, possession by hawa, setan, bhut, churel, nazar; argumentativeness and crankiness of children; dream analysis; some physical ailments such as hair loss, hearing and eyesight problems. Worry sickness, love sickness. tundi bimari (arthritis and rheumatism are referred to as “cold illnesses”). Behavioural disorders.</td>
<td>Sacred threads, treated oils and water, advice, sorcery and other magico-religious procedures. Sacred ash</td>
</tr>
<tr>
<td>Maulvi</td>
<td>Treat same illnesses as the orjahs</td>
<td>As Oriahs above as well as use of sacred tabiz</td>
</tr>
<tr>
<td>Pujaris</td>
<td>Hawa; setan; possession by gods or goddesses; invokes aid of gods and goddesses; skin conditions; tundi bimari, other behavioural and physical ailments.</td>
<td>Sacred thread, trance/ prayer, treated oils, sacred ash, Temple rituals, rituals to cool goddess Kali.</td>
</tr>
<tr>
<td>Pandits</td>
<td>Hawa; setan; astrological problems; pujas at births, deaths and for people who have physical ailments to invoke aid of gods and goddesses. &quot;Yellow fever&quot; (pari in Hindi).</td>
<td>Prayer rituals sacred texts sacred ash treated oils</td>
</tr>
</tbody>
</table>

This table presents my abstractions from the individual cases of illness noted during fieldwork. Following the general discussion below, I present examples of how Indo-Fijian values and conceptual systems generate this complex.
The illnesses shown in the Table 6.1 are divisible into those with supernatural causes and those for which human agents, in some cases the patient, are thought to be the cause. Those of the first type are illnesses whereby the person is possessed by malevolent powers of evil in the form of spirits and ghosts. These are the conditions Indo-Fijians refer to as hawa, or possession by churel or bhut. Churel are the ghosts of women who have died young, and usually in childbirth. The causes of death in such instances involved a great deal of emotion and were usually totally unexpected. Bhut are vengeful ghosts, often of a family ancestor, who wreak havoc on human lives in retribution for moral lapses or for social wrongs by someone. Flaunting social norms, disjunctions in relationships with kinsmen and emotional upsets are some of the conditions under which people become possessed and ill.

Human agents can be the cause of illnesses. Sorcery is the main type of power which is harnessed to harm someone; to cause illness, death or accidents. As well, a person can become ill because of self-neglect in terms of the values of well-being (tundroosti) mentioned above.

Another group of illnesses are those such as nazar or evil eye which are caused by jealousy, envy or rancour on the part of someone. In these instances too, people think that the person suffering from these illnesses is at least partially the agent of his or her misfortune for arousing these feelings in the community.

A third category of ailments are those emotional states known as “worry sickness” and “love-sickness” which affect a large cross-section of the community. And even the affluent and educated middle class seek treatment from priais for these afflictions.

A fourth type is that associated with astrological signs for which Indo-Fijians consult a pandit to avert misfortune, and to divert bad karmic influences which are causing illness.
The last group are the chronic physical ailments, such as rheumatism and arthritis of old age, and other problems such as eye ailments, hearing loss and skin conditions such as eczemas, and ailments referred to as peri ("yellow fever").

These are the primary categories abstracted from the fieldwork situation for which people in the settlements of Nasavu and Solevu turn to the traditional healing sector. As with all abstractions, however, this scheme is facile, a synthetic analytic typology which does not demonstrate the complexity of the actual social contexts of illness and healing. In many cases for instance, illness is a diffuse state and the patient diagnoses his or her own condition or it is diagnosed by the family, and then a type of healer is decided upon and consulted. The healer may in turn refer the patient to other healers or to the Western biomedical practitioners for treatment depending on the causal nexus he discovers. In some cases, patients and their families go to a variety of healers until they are satisfied with the cure. It was not unusual, in the two settlements of this study to find a patient presenting a number of different ailments in a brief period, and consulting many types of healers, as well as doctors. It is only by studying the processes and interactions involved that we can know how illnesses are socially constructed and to determine how they are related to the valuational and conceptual systems of the Indo-Fijian culture. In the following pages I outline some of these processes and interactions as they are operationalized in possession types of illnesses and in behavioural and physical disorders, for which people turn to the traditional healers.

One of the most common disorders in the rural areas is that caused by hawa (evil air), for which cures are sought from orijahs, maulvis and pujaris. Hawa is a diffuse type of illness which gives rise to a sense of unease and personal insecurity, to headaches, loss of appetite and general aches and pains which afflict the patient sometimes for several weeks or even longer. Hawa may also possess a person and in those instances there are behavioral disorders which are
manifested in unusual behaviours, out of character for the person and sometimes for the social situations in which they are presented. The following example shows the process of healing undertaken by one 23-year-old north Indian woman patient.

L. is a young woman who ran away from home with her husband in what is referred to as a “love marriage”. After some acute embarrassment and initial anger, their families have forgiven them. They now have a four year old boy and they live uxorilocally within L.’s grandmother’s compound, with L.’s parents. There are five homes in the compound, one belonging to the grandmother, another is that of L.’s father, and the remaining three house the families of her uncles (father’s brothers).

Although they live uxorilocally, they have not abandoned L.’s husband’s lineage; he visits his parents often, and they visit as a family on festive occasions. Her husband had worked until recently for a storekeeper in an adjoining settlement but was unemployed at the time I talked to her. She will not live with her husband’s family because she suffers in self-esteem by comparison with her husband’s brothers and their wives, all of whom have had arranged marriages and who are working as teachers. L. does not have any academic training; she left school to get married in the year when she would have written her New Zealand Entrance Examination. Her family are poor and had set their hopes on her achieving graduation, and then helping the others with their education.

When she goes to the home of her husband’s parents she is the most recently married woman, and since she is not employed, she is left to cook and clean for the whole family. At her parents’ settlement she is out of place too, since women once married are usually expected to go to their husband’s home to live. Nevertheless she prefers to live in her father’s home where she, her husband, and child live rent free but where they contribute to the food needs. The house is poor and too small to accommodate the ten people in the extended family; and some members of
the family sleep over at their grandmother's house in the family compound. The food is barely adequate, with no milk or eggs available unless purchased in the town (or occasionally given to them by a nearby farmer). The grandmother plants several acres in vegetables which she takes to sell in the market and out of which she allows them to take enough for their meals.

L. has recently had a miscarriage and lost a baby girl. Her health has been precarious ever since. She attributes her health status to several factors, first to the fact that she remained at her father's house last year when the major Hanuman puja was conducted. Since her marriage, she no longer belongs to this lineage so she should not have participated in the rite. As a consequence of breaking the religious injunctions, she feels she has become ill. This year she said she will go to her husband's home at that time.

In a space of two weeks she told me of several other reasons for her feelings of unwellness. She blames her in-laws for making her take goat meat at a puja when her son was born - she felt that she should not have taken meat at that time since meat is impure at religious rituals, and is not a good food for post-partum women. She told me she feels that her oversight in taking the meat meal angered the goddess who made her ill. Recently, she took her son for a walk in the evening, along a local road lined with trees, to the home of a neighbour. She and her son woke the next day in a feverish condition which she and her mother attribute to hawa (evil wind). She told me she knew the exact moment when she was attacked by the hawa for she had an awful gripping feeling. When she told her mother of the episode, they decided she should seek treatment from the Muslim woman orijah in the settlement. She gave L. and her son a sacred cord to wear which she prepared for them by blowing on it with her breathe and praying over it. (This orijah claims that she gets her power from the Koran.) L. felt satisfied with the treatment and mother and son both recovered.
She has also gone to an elderly Hindu male orjah for treatment because she is losing her hair, and to have a very bad dream interpreted. He gave her some coconut oil for her hair and analyzed her dream (she would not divulge it to me) at the same time. I was with her as she told him of her problem of falling hair and as he treated her for that by blowing his breathe on the bottle of oil, and turning it in the palm of his hand as he prayed over it. He also gave her some sacred ash to put on her forehead. For the dream analysis however they retired into an adjoining room where we could see but could not hear them. Generally, he was not secretive about his healing - he said his power comes from Bhagwan (god). He denies ever taking part in sorcery - his main aim is to strengthen the patient by invoking the aid of God, and by stopping some agent of illness who has brought certain other powers to bear against the patient. He attributes causation to human agents (sorcerers and people whose jealousy causes "evil eye") as well as to supernatural powers.

L. has also taken her son to the woman orjah for treatment of hasli okarde (misplaced collarbone) a common ailment with young children. The orjah felt the collarbone and advised L. to take him to another practitioner (a dai) for massage treatment, which she did with success. Soon after this treatment, L. asked me to take her son to the hospital for diagnosis and when I asked her why, she looked puzzled and could not tell me for what ailment, and soon forgot about it.

L. is tense, she is not manifesting any physical or debilitating illness, but seems to be under some stress which is somatized and for which she seeks treatment in the traditional sector. She has had grade eleven education and she knows that she could go to the Outpatients' Department at the local hospital, but she does not do so. She goes to the healers who know her and her family history, in her natal settlement. She refers to the orjah as grandfather, and her interaction with him is suited to someone in that role. He is kind and gentle with her, looks at
her affectionately and is sympathetic to her. He also understood her need for privacy when he undertook the analysis of her nightmare. He is a trusted friend to her who won't divulge her concerns. This is important because she is having marital problems.

Although I did not see the interaction with the female oriah on this occasion, I have observed her healing in another case. She is a warm motherly woman who exudes kindness and at the same time gives solid advice about personal problems in a non-judgemental way. Young women tell her 'secrets', about frustrations and love-sicknesses ("crushes" on boys), and she too does not make trouble for them by gossiping in the settlement. Secrecy appeared to me one of the key attributes of oriahs, thus providing the patient with an outlet for talking about personal frustrations and desires which have to be submerged within the family setting which emphasizes the sociocentric interests of the family group at the expense of the individual's needs and desires.

Young married women in the Indo-Fijian community appear to be especially prone to possession by hawa. A number of informants told me that people get hawa at weddings because the spirits of the dead who want retribution for social wrongs committed by the families of the bride or groom are about at that time and ready to afflict people who attend these rituals. Hawa is an evil entity and is also conceptualized as a power, energy and force, as embodied in the Indian cosmic notion of sakti. (Sakti is a power, it has heat as one of its attributes, and it may be used for good or for evil.) Hawa is also referred to as setan. When I asked people the difference they could not tell me except to say it is evil and it is air or wind. In the Indo-Fijian settlements in Fiji, people have difficulty articulating what form these supernaturals take, they refer to them by their characteristics which are in turn linked to the circumstances which give rise to them. In the case of hawa, setan, bhut, and churel, they are all linked to the notion of spirits or to ghosts of people who have died by violent deaths such as murder, suicide, accidents and other types of mischance. Indo-Fijians say that these spirits have such a strong attachment to the
living that they are not willing to leave this world. They possess people and sometimes manifest
the characteristics of the dead person, or they make people behave in very odd ways, or they
make people suddenly and unexplainably very physically ill. The following example exemplifies
the process.

D. is a Muslim woman with two infant children. Her mother-in-law and sister-in-law
related the story of her ailment to me before I ever met her. They said she has suffered from
possession ever since she was first married. The state is manifested in behaviour which they
described as follows:

"She was sometimes running around, pulling her hair, eating handfuls of fire from
the chula (hearth) – she was biting and hitting everyone..."

When I finally met and talked to D. she appeared shy and withdrawn but not reluctant to
discuss her ailment with me:

When I was getting married one of my neighbours committed suicide. At my wedding
they followed our customs and put the mehndi (henna) and the haldi (turmeric) on
me, but we are supposed to take the chaku (small pen-knife given to a bride to
prevent possession by evil spirits and to protect her from harm), but I was not
given it. I went to bathe at the well and there got hawa. One month later I knew I had
got hawa – when I went to do the cooking, I fainted.

It was at this time that D. began to exhibit the behaviours described above. She does not
recall any of the symptoms of her illness, nor do her in-laws relate those events in her
presence. They had told me that when she was ill, her clothing were disheveled and her hair was
awry. When a young married woman becomes ill in this way, her affinal family take her back to
her natal home for treatment. Her affines are reluctant to keep her for they fear that they may
be accused of sorcery, and keeping her with them will open up the way for recriminations and
reprisals from her parents.

In this example the patient's family first tried to get help for her and took her to a
pujari in another area of Fiji, and he sometimes came to see her as often as twice a week.
During this early and violent phase of her illness, the behavioural disorder manifested in her "wild" behaviour occurred anytime that a menstruating woman visited their household. They said, "she got the attack of *hawa* at those times", and they told me that she seemed to know in some psychic way that the woman visitor was menstruating. Her mother-in-law and sister-in-law told the story with what I thought was awe, curiosity mixed with concern and perhaps even criticism.

D. did not seem to mind her affinal women relatives telling me of her illness; in any case she could not complain since she is the junior member in the family. Of her violent behaviour, she told me she knew nothing, "I was *behos*" (unconscious). When she was returned to her parents, they took her to a doctor because of menstrual problems—she sometimes got her periods for as long as two to three weeks. He treated her with "injections"; she could not tell me of what medication, but said it was unsuccessful. Then they took her to the *maulvi* who treated her by reading the *dua* (holy prayer from the Koran) over a glass of water which he later gave to her to drink as a medicinal potion. He also gave her a sacred thread to wear. He did not talk to her about her illness but told her father and also gave him a *tabiz* (amulet) for her to wear. She told me that after this treatment she was no longer sick and she became pregnant.

D. now has two children, but she still wears the *tabiz* for protection because she feels she is not as strong as she was before her marriage. Sometimes she is still somewhat overcome at the time of her periods but she is not exhibiting the wild behaviour and is able to care for her family.

Sociologically the example demonstrates the anxiety suffered by young women when they are first married, and when they are suddenly faced with cooking and caring for a group of critical strangers in their affinal homes. In some instances in Fiji, young women (such as D.) from towns are married into families in cane growing areas. Many young women do not make the
transition without stress. When a young woman comes from an urban upbringing, it is physically exhausting to work in the cane fields. A newly married woman must live under the constant supervision and attention of her mother-in-law and sometimes of elder sisters-in-law. For some women this alone is a problem without the added burden of having to conceive shortly after marriage. In Indian culture a woman is most highly valued as a genetrix so that soon after marriage she should conceive to show that she is indeed able to bear children. The totality of these expectations placed an immense burden on D. which she exhibited as possession.

In Indian beliefs, causes of illness can be human agents and social events. D. chose to blame her own parents for their oversight and neglect during the wedding ritual when they sent her away without the little knife to protect her from spirits. The *chaku* codifies or is symbolic of the protection of a woman's lineal group as she goes to live among her affines who are strangers to her at first. Unprotected, she was susceptible to possession and she succumbed. She demonstrated her possession in her wild behaviour and was sent home to her parents for care and treatment. In this way she was able legitimately to go home to her own family for nurturance for a time when stress was most severe in her affinal home. The suicide of the neighbour also might be linked to disjunctions in social relationships in the settlement, and perhaps again she might have felt her own parents were negligent in not helping the victim. If the suicide had been prevented, she would not have been possessed by the ghost.

From her behaviour we can perhaps say that she perceived women from "outside" of the household and especially those who were menstruating as polluting and thus dangerous. Eating ashes from the fireplace may be related to the way mothers heal their children when they have "evil eye"; they give them a pinch of *babut* or sacred ash. She may have been attempting to heal herself or symbolically expressing a wish to be healed and nurtured. In any case I thought the
woman's worry about her neighbour's suicide, not having the protective knife, the fear of
dangerous, polluting 'outsiders', and her self-healing type of actions, indicated a) her concern
about a lack of care and attention from her families, and b) that complex and stressful
interpersonal relationships were involved in her becoming ill.

Hawa also may possess other people attending a wedding. One informant told me that she
"got in the way" of hawa that was intended for the bride at a particular wedding, and was herself
afflicted. On that day she said she suffered severe headaches and could not eat. Her mother told
me:

When we came back from the wedding at Nadi and opened the door, her father came in
first and after him the girl - she was standing near the door with big eyes and
swaying. Her other sister said: "look at her!" I took my daughter and sat her down -
her eyes were very large. When her father came in she started shouting - then she
sat for a while and started laughing! She was shouting and looking everywhere, this
way and that. We took her to the pujari and he gave her a dore (sacred thread) to
put around her wrist and babut (sacred ash) to put on her neck and forehead and he
gave a tabiz (amulet) for her to wear. Then he sent her home and she became well
again.

This example is of special interest for this is a Muslim family who took their daughter
to a Hindu temple priest in another settlement area for treatment. The treatment consisted of the
girl's father presenting the pujari with vagona and cigarettes. The healer lit the cigarette and
prepared the vagona. He sat the girl down before him, then he spoke in kabiti (Fijian), as if
praying. He gave a cup of the vagona to the patient, another to her father and then took some
himself. As he looked into the vagona bowl and prayed to the Fijian God, he could tell them the
events which had precipitated her illness: she had gone to a wedding in a family where someone
had died recently, and as she was going along the road in front of the bridal party, she got in the
way of the hawa meant for the bride.

This particular pujari is known for his great healing powers. He is able to use Fijian
Gods and Hindu Gods as well as Muslim healing. The example is of interest for the syncretic use
of all types of healing employed by one Hindu temple priest. The syncretism has not diminished the faith people have in him. In fact it appears to have broadened his scope and he heals people of all ethnic groups. This is the case with many orjahs and pujaris who have the power to use all types of religion in their healing. They are highly respected, and are widely known. I could find no indication of hostility on the part of the Fijians, Muslims or Hindus to this type of syncretism. And in fact I have been told that Fijians too, sometimes consult pujaris and orjahs. Indo-Fijians do not hesitate to go to Fijian healers in the settlements for herbal remedies or for massage treatment if they desire to do so.

I was told that maulvis however rarely incorporate other traditions. Nevertheless, J. a young 23-year-old Muslim woman married to a North Indian, (whose father is a Christian priest who speaks perfect Bauen), has gone to a maulvi for treatment. He asked her to take yagona and cigarettes for the treatment. She said: "They use yagona just as the Fijian healers do. They take it and pray to the Fijian God and they can see into it, they use it in the same way that Fijians do sevusevu (a gift presentation of yagona). I was told that Muslims in general do not go to orjahs often: "we cannot go because we read the namaz and go to mosque".

J. told me that possession by hawa, bhut, setan or churel can take place if someone is suddenly startled or frightened or suffers an emotional shock. Churel, the ghost of a young woman who has died in childbirth,

"usually come to the ladies. If the ladies get frightened in the dark then the churel will come to them - Dil me darne" (if they are fearful in their hearts, i.e. by temperament). (She told me she goes to the maulvi for treatment for severe headaches, for witches at a funeral...) the maulvi makes a sacred string for us to wear to take the witches away from you. If someone dies such as a grandfather or mother or father, they can come to you ...if you do wrong, or if your parent takes a new husband or wife...if your stepmother does not treat you very well, then your dead mother would come and make illness. So then she must go to the maulvi to get the sacred thread to wear. Witches are called setan, bhut, hawa in Hindi. They can be men or women."
Hawa also strikes or possesses children and they are especially vulnerable while they are asleep. One family told me that they came home one day after attending a funeral; their child was at home asleep at the time. The following day he became irritable and cross, crying a lot and he lost his appetite. They took him to the oriah in the settlement who gave him a sacred thread to wear. A Muslim family took another child who has a weak heart and is sickly all the time, to a maulvi for treatment. This healer treats illnesses by opening the Koran and saying the child's name. He seems to be able to diagnose possession. If the child has hawa, he writes the dua (Muslim holy verse) on a paper and puts it into the tabiz (amulet), which he gives to the parents to tie on the child.

Parents frequently take children who suddenly exhibit signs of argumentativeness, crossness and loss of appetite and who get stomach aches as physical symptoms, to orijahs or maulvis for treatment. Children are socialized to have respect for their elders, to share with others. And although tantrums are not uncommon, families normally cater to children and do not allow them to cry. Indian families lavish a great deal of attention on children. If a child cannot be quieted and shows signs of continuing ill temper, and physical problems such as stomach aches, the family will probably interpret this behaviour as hawa. Possession by hawa is one of the main types of illness caused by malevolent spirits.

Sorcery is another type of cause of illness and people frequently diagnose and seek treatment for it. Sorcerers have the ability to cause sudden illness, accidents and death. In the few instances I have knowledge of, people acquainted with sorcery were reluctant to talk about it, first, because people are afraid of sorcery and of sorcerers, and second, because the practice is illegal (Flower, 1985).

Sorcery is treated primarily by orijahs. Malevolent power is the force behind the practice of sorcery. Anyone who claims to find and cure sorcery must therefore have the power
not only to harness such power but also to invoke it. For this reason orjahs are an ambiguous category of healer. Highly respected for their knowledge and power, they are nevertheless the least trusted because they are at the margins of society. They often live apart from others, they frequently have personal characteristics which set them apart, and they have power which is ambiguous. Intractible and unexplainable misfortune, pain and bereavement are the healing province of orjahs. As folk healers their training is not formalized, often they have learned the art of healing on their own, from a variety of learned texts and as one orjah told me, by appealing to Bhagwan (God) for the ability to heal. It was my impression that most orjahs claim to be able to use legitimate religious power in healing. People in the settlements however, do not seem to have as much faith in their religious power as they have in their magical power. For recourse to religious power they turn to pandits, and pujaris.

During my fieldwork I met one couple whose married daughter had recently died. She left four very young children. Soon after that, a married son became very ill and suffered a prolonged and painful illness, during the course of which his father also became ill and suffered a heart attack; his mother too had a heart attack. The young man, like his sister, died leaving four children under ten years of age. Suddenly, the older couple had two of their children predecease them; and eight children had lost one of their parents. When I met them, they had an old man living with them. He was not placed in the geneology I took and when I inquired about him, they told me he was just an old man they took care of. Later, much to the anger of the older couple, my research assistant told me that they suspected sorcery was the cause of their misfortunes. She said the man was an orjah whom they had invited to come to stay to discover who the sorcerer was, and to determine the factors used to sorcererize them. One of my informants in the settlement also told me this 'story' about their misfortunes and how the family did not believe the cause of the deaths as told to them by their doctor. The doctor's diagnosis was
that the son who died had suffered from a liver ailment caused by alcohol abuse, as well as from other ailments. He was a good worker but had become an alcoholic and "ran about" so that the father had to sell the family car in order to constrain his son's drinking and carousing. When he became ill, they had tried all manner of cures and at the end he had been treated by doctors in the best hospital in the country, without success.

The family would not elaborate on the death, although I came to know them well. They continued to maintain that the old man was just someone who was homeless, without a family to care for him, so they took him in. In the course of conversation with him I later learned that he was an orijah. He allowed me to observe his healing practice, much to their chagrin. He treats many people in the settlement and is well liked and respected.

At the end of this research he was still in the settlement, a year had lapsed since the deaths, and as far as I know, no 'cause' was discovered for the deaths, although the orijah assured them it would be. My informant told me this family has been in the centre of tense land lease negotiations which have gone on for years. Several years previously, the native people from an adjoining Fijian village descended on the farms which they lease to Indians, and they started to stake the properties saying they were taking the lands back. The Indian farmers, fearful of the outcome, stayed indoors rather than get into a confrontation in the passion of the moment. Later, they sought legal aid and during the course of the examination they found that although the leases were not up yet, the payments on them were in serious arrears. A South Indian man in the settlement in the area had collected the lease payments every year but had not submitted them to the lessor, the Fiji Native land holding group called the Fiji Native Land Commission. The Indian farmers as a consequence took the lease collector to court. They had trusted him because most of the farmers do not know how to deal with bureaucracies. Also it was a convenience to them because he was one of the wealthy (thus upper class) people in the settlement and had time to go
to Suva about such matters. There are bitter recriminations between the South Indians and the North Indians, and the lessees have become two factions, one which supports the South Indians and the other which does not. The two communal groups usually each conduct their own affairs; the South Indians are a minority group among the Indo-Fijians with all the implications that minority status everywhere implies. To make things worse, there are always tensions, submerged but always just ready to erupt, between Indo-Fijians and Fijians on any land issue. The former are usually lessees, since they cannot own land in Fiji (except for freehold lands which are not farm lands). (I have described the land tenure system in Chapter 3.) Indo-Fijians feel they will never have the political clout to change the land tenure system to a more equitable one. "Fiji for the Fijians"! they say to me. There is a strong feeling among the Indo-Fijians that economic opportunities for them are restricted. Many of the stresses leading to disorders are related to these kinds of problems. Since this is not the topic of this thesis, I will not dwell on these issues but have provided just that background necessary for the understanding of the pressures and stresses in the lives of Indo-Fijians that makes clear the example under discussion.

The family who claim to be victims of sorcery are South Indian, but interestingly, they have supported the North Indians. They cannot do otherwise. Theirs is the largest market vegetable growing enterprise in the valley. They depend on the goodwill of the Fijians for the leases, and on both Fijians and North Indians for their labour requirements. Also, they are self-interested and want to put some distance between themselves and the kinsman who absconded with the funds. Nevertheless, the North Indians in the settlement dislike them and do not trust them. Most people in the settlement and the town say that their kinsman who fraudulently took the lease monies was morally deficient. The situation is difficult for all parties concerned and the person responsible has since died, leaving his son to bear the
consequences. The ensorcelled family are extremely well off, and continue their economic enterprise, a successful market vegetable farm, in spite of all their problems, but they do so now with a great deal of sadness and some paranoia. Other farmers in the settlement are jealous of their success. They also stand to suffer enormous losses if the leases which are now up for renewal are not renegotiated.

I believe the causal nexus for the sorcery is to be found in this political-economic situation, in which their social relationships in the settlement were less than optimal. The illnesses and deaths in the family have not only been a sad bereavement, but also a sign to others of their bad karma which others can and do interpret as just retribution for their previous arrogance (arising out of their wealth) and their formerly poor social relationships in the settlement. This hurts them, they have had to retreat socially, and, as others say, they are more humble. To the outside observer they are a very cohesive family, recovering admirably as well as undertaking the care of a widowed daughter-in-law, and the upbringing of their grandchildren. They also have assisted their dead daughter's husband to establish his life with another woman, to whom they have turned over all the gold jewelery which they had given to their daughter as dowry. They continue their farming in spite of everything, assisted by two unmarried daughters and a younger son and his wife.

The example shows the broad social process, the historical development of the situation and the interactions at several levels of societal function, within which illness and healing are embedded. Importantly, one can see the implications of the interactions created out of such situations, and how they create and structure society in general. Misfortune, incomprehensible sickness and deaths make the whole community reflect on their relationships and on their social values. Man's vulnerability in the face of cosmic forces shows up the pettinesses of men
attempting to diminish each other, they reflect on their social order and reassess their situation, often gaining back humility and their humanity.

I return now to the discussion of the traditional healers in the settlements.

Some orijahs have a vast clientele and they garner information from many sources. In this respect the information they use in diagnosis and treatment is based on their knowledge of the social histories of people in the settlements. They know the stresses and strains arising out of the interactions; of the social, political and economic situations of most families. Privy to gossip and confidences, and their own participation and observation, they are, in many respects an archive for the settlement. They also treat "love sickness" and "worry sickness" by giving advice on how to regain the love of someone, and how to overcome other problems. They will give magic potions which can be given to the loved one in a beverage or they give amulets which can be left in the home of the loved one. One young woman told me that the orijah told her to try to shake the hand of the young man she was trying to influence, this would enthrall him and he would then succumb to her charms. These treatments are meant to weaken another person and to make him or her vulnerable to influence. Even some of the leading business men are not averse to trying these methods when infatuated, as well as in getting advice for their commercial endeavours.

The group of illnesses referred to as nazar are the evil eye syndrome, which is caused by jealousy, envy, rancour or spite on the part of someone in the community. (The home remedies for such illnesses are treated in a later chapter.) There is a strong belief that the gaze of a person who longs to have the characteristics of another can not only diminish those attributes, but can cause illness. Most Indo-Fijians ascribe to the belief that the gaze of a widow, or of barren women is particularly harmful for new mothers and children; and a family avoids exposing new mothers and infants to such people. Mothers of young children put ash or
some other black smudge mark on the child to lessen its attraction to others. It is a customary practice for women to put a black tika (forehead spot) on all young infants to protect them from nazār. In children, nazār is diagnosed by crankiness, sudden unexplained illness, stomach ache or loss of appetite.

Women in the settlements treat nazār with home remedies or by consulting orjahs. I was told the home remedy is used when the symptoms are mild and before a family is sure the affliction is nazār. The remedy, preventative rather than cure, is to add chillies to a plate of burning coals and to circle the child’s head with the fumes. If the disorder is due to nazār, the smell of the chillies cannot be ascertained from the coals. In these cases the family will try to guess who the afflicting agent might be and they try to keep the child away from such influences. Orjahs are consulted when the symptoms are clearer and the family feels confident that nazār is the ailment. In such instances they feel that the cure should be effected by the traditional healer.

In one settlement a young mother C. whose son exhibited these symptoms consulted her mother who agreed the child had nazār. They decided to take him to the orjah who gave them a sacred thread to tie around his abdomen and some sacred ash to be put on his forehead. I observed the symptoms on a visit to their home one day. As we visited, the child became very cross and irritable, and the embarrassed mother, aunts and grandmother explained to me that they had taken him to the orjah a few days earlier because of this behaviour.

On this occasion his mother went into the kitchen and came back with an arthi (prayer plate) on which she had a number of items including a burning cube of camphor. The child was seated in his grandmother’s lap and was crying while she was massaging his stomach. His mother took the tray and circled his head with it a number of times then suddenly she took the sacred ash which the orjah had given to them from the tray and put a pinch of it into his mouth. He screamed and spat in fury, while the family all laughed at his anger. His grandmother
comforted him as he screamed and stiffened his body. Soon after, he relaxed and fell asleep to awaken an hour later calm and refreshed.

Earlier, his aunts had tried to coax him to be quiet, but he would not listen to anyone. In this culture they would be the persons suspected of jealousy which is causal in instances of nazār. One woman in particular, who has only female children, could be thought to be "gazing" at him with longing for a son of her own, and could make him ill. The "gaze" in such instances need not have hostile intentions but its consequences, nevertheless, would be illness and upset for the boy.

Many people attribute unease and mild illnesses (in people of all ages) to nazār. In these communities where everyone knows the intimate lives of others, jealousy and envy are always a part of life as people strive for personal success. As I have shown, the causal nexus of nazār can include not only unrelated people who are jealous or envious, but also the patient and his or her own extended family. A family that shows too much pride or admiration for one of its own members is thought to be creating misfortune by generating hostile feelings in others. For this reason people are not enthusiastic in their praise of their own children or other members of the family. Praise and admiration are usually contained amongst a few people in the immediate family. If people point out the positive attributes of someone in their own family they will preface the comment with "thanks to God...", thus taking the achievement away from the individual and placing it into divine hands.

Evil eye is widespread in extended family settings and in small face-to-face communities. In these families, in-marrying women must subjugate their personal interests in their children and husbands to the interests of the adoptive lineage group. Praising one's own child is frowned upon. Children can easily become a divisive force in families; they are socialized to be cooperative, even-tempered and to behave themselves. The grandparents are
careful to see that favouritism of one individual does not jeopardize the greater interests of the whole family. Outbursts of temper, crying and attention seeking are not easily condoned; and families do not like to take the blame for a child's misbehaviour. As I have shown in the example of C., by citing nazär they can remove the blame from the child, and its mother, and encourage others to engage in remedial activity. The problem is placed in the social context, and "others" rush to help quiet the child, to show their concern, and to remove the possibility that they are blamed for it manifesting the symptoms of nazär.

Not only do Indo-Fijians seek treatment for possession by evil spirits which can cause illness; they also sometimes seek possession by a god or goddess for healing. Many Indo-Fijians undertake vows at Hindu temples, and participate in temple healing where they fast, sleep on the floor, abstain from marital relations, eat only pure foods, sit in wet clothes and undergo other austerities in order to propitiate or be possessed by a deity to regain their health. A person may also make a vow in exchange for the intervention of the god or goddess on their behalf on some urgent personal problem. In two healing rituals which I attended, someone other than the patients became possessed. My informant told me that this is usually the case; it is infrequent for patients to be possessed. The god or goddess "comes onto" those people who are favoured because of their devotion.

The devotees who are known to become entranced travel from one temple to another to invoke the presence of the deities; and others benefit and are healed by this. These special devotees undergo trance states and other austerities, sometimes piercing their bodies with skewers, and beating themselves with whips. When this type of healing is undertaken it is at a temple with the pujañi officiating. He prepares a group of people for a week prior to the public ritual when the goddess Kali is "cooled". The goddess, when she is in her "heated" angry state, is the creator of pestilence (smallpox, and other illnesses such as measles, chicken pox, etc. are...
also attributed to her). The "cooling" ritual is conducted at a number of temples in Fiji, and usually at the Thirnal ceremonies held in August of every year in Savusavu. At this ritual a number of devotees are usually possessed and go into trance states. Prior to the ceremony, some of those undertaking vows may undergo skin piercing with skewers, through the arms, chest, cheeks and tongue.

Although many men undergo trance, I observed only one woman who undertakes religious possession and trance. On this occasion I talked to several of the seven people (all men) who were undergoing the healing rites. One man told me that he vowed two years ago to take part in the week long preparation for the ritual in order to cure a serious skin condition on his neck; and a state of debilitating weakness and dizziness which the doctors could not diagnose or treat to his satisfaction. His health was interfering with his ability to work and he was desperate to find a cure. He vowed to the goddess Kali that he would appear at these rites every year for three years if she would cure him of the affliction. This is the third or last year of his vow and he claims the bleeding neck condition is cured and that he has not lost time from work on account of the dizziness for two years.

A second man was reluctant to tell me why he was participating in the ritual; he believed the vow should be kept a secret. Another participant however told me about him. The patient wanted to improve his poor economic circumstances and thus prayed to Kali to intercede in his life situation. My informant thought the man had personality problems.

At a second such ritual late one night, I observed the procession taking the image of the goddess Kali to be "cooled" at the riverside. There were entranced devotees (one a woman), with skewers through cheeks, arms, chest and back; a number of patients and the pujari, all dressed in saffron coloured costumes, smeared with turmeric. They were followed along the path through the cane fields by people from nearby settlements. The pujari lit cubes of camphor along
route, another man sprinkled water on their path from fronds of bamboo. Several men swung lanterns providing arcs of light for the procession. The musicians kept up their drumming as the entranced woman and several men flayed their arms wildly as they danced along before the image of Kali. Several musicians played clappers or chimes. One of the men kept up a rhythmic chant "Govinda!, Govinda!", until suddenly he looked wild, his arms beating out. Other men in the group surrounded him, he uttered loud sounds, "Ho! Ho!", and fell to the ground on his stomach. His body stiffened, went into several strong spasms, then relaxed. Within a few minutes, his companions helped him up, he shook his head and moved back into the congregation as if nothing had transpired. I was amazed at his sudden "normality" after such a tortuous display, and watched him for the remainder of the night to see if there would be a recurrence. He remained calm.

On its return the congregation circled the temple several times led by the men undertaking the vows, by the musicians, the lantern-carriers, and by the pujari and the woman who were possessed by the goddess. In trance, they both danced as if swooning to the sound of the drum and the other instruments. The woman looked wild, with disheveled hair worn unplaited and flying loose, her arms, tongue and cheeks were pierced with skewers of which she appeared oblivious. Eyes glazed, she seemed to know nothing of her surroundings and of the crowd. A group of devotees, about 50 in number, followed them as they circled the temple. On the last circling a group of young mothers suddenly placed their very young infants on the ground in front of the entranced possessed men and women who stepped lightly right over them. To my amazement, not one child cried, but a few tried to crawl away from what was a rather eerie procession late in the very black night. My informant told me that these women were celebrating the birth of a child after being barren for years--they were giving thanks to Kali for her blessing--they had prayed to her for children at this temple. The problems of
barrenness constitute one of the disordering phenomena in social relationships; the topic is discussed in the next chapter.

In other parts of Fiji temple healing sometimes includes firewalking. In the area where I conducted fieldwork firewalking was not practiced. 4

Sometimes a person is possessed by a god or goddess and illness results. When the pujari treats such people he asks the patients which God has come unto him. The patients in such cases are able to know this and to tell the priest. Once the pujari knows he can give the patients sacred ash as well as treated coconut oil for massaging the head and body. The pujari can also effect a cure by his devotion, appeasing the angered god or goddess. Although I met several men who had been possessed by a deity, I was unable to interview them. They were extremely reluctant to discuss their experience. And they did not keep the appointments I made with them.

In another example of successful healing by traditional healers, a young man with a skin condition went to a private doctor and to the hospital for treatment without success. The hospital staff took blood and skin samples and sent them to Australia for diagnosis. The results showed no identifiable skin condition so the doctor at the hospital was unable to treat the condition effectively. This patient, a brother to one of my assistants, was advised by a friend to go to a Muslim orjah who prays to the Fijian God Dakuwaqa, to seven Hindu Gods as well as to Allah. The healer gave the patient special coconut oil for massage and the affliction was cured in a very short time. The patient told me he has faith in this healer and he has continued to consult him for other minor problems.

Chronic illnesses such as colds, allergies, aches and pains of arthritis, and rheumatism, are treated by orjahs, maulvis, pujaris and by dais. These are called tundi bimari or cold illness. It is usually treated by all the healers mentioned above, and in the same way. They blow their breathe on a jar of oil or water as they pray over it, all the while circling the jar in their
hands. Then the healer will give this "medicated water" to the patient for use in massage treatments.

One elderly farm woman with very swollen and sore knees, who I accompanied on a visit to an orjah, took her own bottle of oil. He met us as we arrived and he took her to one end of the veranda where they sat down on the floor. He listened to her describe her symptoms, then he lit the cube of camphor on the brass plate. As the camphor burnt, he placed his hands on her knee, eyes closed. I could not hear what he said, except that it was a rapid recitation of something in Hindi. I believe he says prayers as well as mantras (magical words). Then he took a piece of ruled scribbler paper, rubbed it in the soot, and placed it in the bottle of oil. She had been to him before for the ailment and knew what to do – she was to massage with this treated oil whenever her knees pained her. She told me that whenever she goes to the orjah for treatment her knees are cured until the next occurrence.

This orjah is not known to discuss the ailments or to talk very much. He heals with his hands, by prayer, and with the treated oils as well as with herbal remedies which he makes. He told me he can tell the illness by taking the pulse and by looking at a person’s eyes. Known throughout Fiji, at one time he had a large following because of his charismatic healing. Often more than three hundred people would be waiting to see him. Now his following is more steady with perhaps three or four people waiting to see him on weekdays and perhaps six to eight on weekends. People still come from long distances to be treated by him. He is the only healer in the area who knows anything of Ayurvedic practices, even though he does not use the specialty since he is not trained in it.

In these settlements, astrological healing or divination is done by pandits. They are the people most learned in the Hindu textual materials. Indo-Fijians consult astrologers in order to determine auspicious times for marriages, for family pujas, for the start of any endeavour.
and in cases of illness. The patient tells the pandit his problem or consults him about some event he or she is planning in the future. (The process is similar in all three cases.) The pandit consults the texts and determines what dangers (grahas) are present or were present at a particular time. (The pandit told me here are nine such dangers which can be malevolent forces in one’s life.) He then advises the family of the long list of foods and other goods which he will need to conduct the puja (religious rituals) to counteract the grahas. In addition to the usual foods, he asks the family to purchase nine packets of minerals and gem stones. (These are packaged and sold in the town.) The puja is conducted at the family than (outdoor shrine), and family and close neighbours are there to validate the ceremony, to provide material aid and support. Then he advises the patient about the religious rituals he or she must conduct everyday for the following nine days, one for each of the grahas.

Fiji’s rural Indians provide an interesting setting for the analysis of pluralistic types of healing, for the class of treatments referred to as magic, sorcery and possession (by spirits and deities), to alleviate illnesses of a particular type. The illnesses have socio-culturally relevant causes and they need treatment that is defined by the culture and that is socially mediated by it.

The people in my fieldwork area believe that the illnesses discussed here will not be relieved by hospital based treatment. They are diffuse illnesses and they give rise to a sense of unease and personal insecurity which often continues for a long time, accompanied by headaches and other such feelings of generalized unwellness. In the case of some illnesses people exhibit aberrant behaviours defined as odd by the Indo-Fijians. They seek treatment for them from orijahs and from specialists such as the maulvi, pandit and pujari.

The treatments are basically very similar, employing prayer, sacred threads, tabiz with holy scriptures in them, water and oil over which the healer has blown his breath while healing. The emergent phenomena in the healing is related to the syncretism in the healing
traditions, with the Hindu *pandit* and *pujari*, the Muslim *maulvi*, and the *orijah* each borrowing from the religious and cultural complexes of the other, and all of them borrowing from the massage, herbal and *yaqona* complexes of the Fijian culture.

I will show in this thesis that the illnesses and stresses are related in my view to the conditions of life of the Indo-Fijians, particularly to change generated in the following spheres of life:

a) stresses due to changes in traditional patterns of life such as kinship and marriage relations (i.e. as in the case of D. above), caste, class and ethnicity.

b) a system of land tenure which does not allow Indo-Fijians to own land and in which the system of land leases is not conducive to long term plans of usage by the Indo-Fijians, and which does not give them security of tenure. (I have shown this in the example of sorcery in this chapter.)

c) Changes in the degree of social conformity that is the norm in the society, as well as a questioning of the traditional rules in the light of rapid social and economic change. (This will be especially apparent in chapters 7 and 8, with reference to changes in rituals and marriage rules.)

d) An overarching belief that the political situation is geared to the needs of the major ethnic group (the Fijian), and that equality of opportunity will never exist. (The example of people saying "Fiji for the Fijians", in this chapter.)

In total there is a conflict of values and people question the traditional bases of these values in the light of the social and economic situation of the country. A growing sense of personal insecurity exists in the Indo-Fijian community, and a sense that to provide a good life for their families people have to find other means than they have and know of today.
In the light of such situations, I think the use of magic, witchcraft and sorcery are related to extreme emotional states such as fear, longing, envy, jealousy and stress. There is a feeling of frustration of felt needs and desires and a feeling of impotence—that every avenue is blocked by socio-cultural norms, or empirical constraints. It is for such unexplainable feelings of alienation and of existential crises that people consult the traditional medical sector—the healers are often of the culture, of the settlement and ethnic group. They have an archival type of knowledge of the families and of the individuals who consult them and they are not judgemental. Their healing practices allow for culturally recognizable behavioural disorders (often referred to as pagla [madness]) for which there is a wide margin of acceptability within the family and the settlement. (The option is that of going to the hospital for treatment of some of these behaviours, and of being labelled "mental"). The Hindi term and conception of acceptable aberrant behaviours is not as stigmatizing as the Western biomedical diagnosis of mentally ill.

Many of the possession types of illness, especially those which afflict women, arise out of what Moore (1978:49) has termed a "sea of indeterminacy" or the dynamic situation in which women face paradox, ambiguity, conflict and competition in their lives. They are at once valued for their reproductive capacity, but through it introduce envy, jealousy and other disjunctions in social relations. In the case of men the indeterminacy arises out of socio-economic relationships linked to rapid social change. The resulting stresses are given culturally sanctioned expression in possession types of illnesses which then engage the families (the therapy management group) in seeking the appropriate therapeutics to mend the disjunctions in social relationships, through "processes of situational adjustment". In the following chapters I will elaborate on this theme from my data using Moore's framework.

Some of the treatments in this chapter are for manifestations that cannot be understood as uniquely medical in terms of Western conceptualizations. Yet, in the settlements where I
conducted fieldwork, people fitted them into the Indo-Fijian medical categorizations. One such instance is astrology - and consulting the pandit for astrological readings--I consider them in this chapter because the people themselves felt that inasmuch as they were to prevent grahas (or dangers) which affect health and well-being, and in the sense that they are preventative procedures, they fit in well with modern health care systems.

In this chapter I have attempted to show the pluralistic and generative nature of the Indo-Fijian medical system in relation to illnesses arising out of possession by supernatural agents and illnesses for which human agents may have been responsible. I have shown that the healing system is hierarchically ordered along a continuum ranging from secular to sacred type of healing specialists.

I have tried to show how the patterns of illness and healing apparent in the macro processes and interactions link the Indo-Fijian culture and individual behaviour as one emergent system. This is, I think, obvious in the way the individual healers, although of one ethnic group, employ religions, cultural complexes and materials from another ethnic group. It is apparent at the cultural level in the way the changes in caste and class are taking place, in marriage patterns and in intermarriages, in changing economic and political patterns. Moore's notion of processes of situational adjustment is an appropriate analytical term for these processes of change.

Finally, the healing activities discussed here and in the following chapters make up a health care system defined by Kleinman, as...

a system of symbolic meaning anchored in particular arrangements of social institutions and patterns of personal interaction "including" patterns of belief about the causes of illness, norms governing the choice and evaluation of treatment, socially legitimated statuses, roles and power relations, interactional settings and institutions. (Kleinman, 1980).
Footnotes:

1. The argument is too esoteric to summarize here, it has been presented elsewhere by Woodward (1985:1007-1021).

2. I have explained above (p. 107) that Indo-Fijians refer to jaundice as peri in Hindi, and as “Yellow Fever” in English because of the yellowish colour of the patient’s skin.

3. Frequently, someone in the family will go to the healer on behalf of the patient. In this example the patient’s father consulted the healer on her behalf so that she would not suffer the embarrassment of personally consulting a male healer about her problems.

4. Firewalking in Fiji has been discussed by Carol H. Brown (1978) and M. Sahedeo et al (1974).
Chapter 7

THE PROCESSES OF MENARCHE, CONCEPTION, PREGNANCY AND BIRTHING

In this chapter I attempt to situate Indo-Fijian beliefs and practices about several natural processes—conception, menarche and pregnancy and birthing—in their traditional social context and to explore the ongoing processes and interactions which accompany them. In some cultural groups the onset of menarche is treated as a life crisis rite. My aim in what follows is to try to show the broad outlines of the processual form of behaviours and actions which accompany menarche and pregnancy, sometimes as rites de passage, amongst the Indians in Fiji.

The work of Van Gennep and Victor Turner inform my analysis of processes which make up aspects of menarche and pregnancy. Their work on the triadic structure of ritual and on formal processual analysis, is now fundamental to any analysis of ritual forms. A word of caution however. In what follows, where ritual forms occur, I was not so much interested in the detailed description of the ritual processes and their exegesis, etc. as in recording the changes from the extensive ritual structure marking the onset of menarche as the Indo-Fijian women told me it was treated at the beginning of the century, to its gradual elimination now. I also wanted to see what the implications of this were for social structure and social organization.
The question which now arises is, Why are menarche and pregnancy and birthing included in a section on traditional healing practices? I do this because menstruation is called "sickness" in the Indian culture. When women have their periods they say they are "bimar" (sick). On the other hand Indian women conceptualize pregnancy as a natural state rather than as an illness. Paradoxically, there are few remedies for the discomfort or pain of menstruation, whereas pregnant women are attended to by all manner of healing practitioners, and elaborate and well established prescriptions and proscriptions for treatments, food practices and pre- and post-natal care. Thus the topic of pregnancy too, is discussed here, as Chapter 8 but sub-titled section B so as to link these chapters together. I turn now to the questions which guided the work of this chapter.

During my informal talks with women in the settlements, I noted the woman’s cultural group, her age and the settlement where she lived. Afterwards, the following questions were usually raised about menstruation: At what age did you begin to menstruate? Did you know about it before it happened? (This question was asked to find out who prepared the girl if anyone did, or if she learned it by association with others, but on her own.) Who told you about it, and where were you at the time? (This question was meant to find out who actually explained it to the girl and what sorts of interaction were undertaken. The second part of the question was meant to make sure that undue importance was not placed on those who accidently happened to have to explain to the girl if she got her periods at school or at some other place.) Did they tell you about sex and pregnancy at that time? (In other words was there simply an attempt to handle a situation as it arose, or was this used as a time to communicate with, and to teach the girl about life processes.) Were there any special celebrations at that time? (This question was meant to elicit information about whether the event was shameful and hidden, whether it was a non-event, or whether it was open and celebrated.) And in each case, I asked: Why?
The simple questions asked to initiate our talks on the topic of pregnancy and birthing were: Can you tell me about your pregnancy? Can you tell me how your baby was born? Can you tell me about the work of the dai (dai alla kum)? And I draw on a number of "stories" as illustrative of how people make choices between competing alternatives and how they decide on certain actions in maintaining good health or in seeking health care during pregnancy. In this research, cases of sub-fertility and of barrenness were subsumed under the main topic of conception, pregnancy and birthing.

Several broad questions directed the work discussed in this chapter. First, who were the actors in each event described? Second, what actions or activities were involved and what were the implications of them for the choices or decisions involved in the process? Next, what implications can we draw for the social organization and social structure of the group under study? Last, how are these processes and interactions related to traditional medical practices. A further question, that of how these differences in historical traditions in Fiji bear on regional variation in India, is bracketed for now, in most instances, but is implicit, throughout the thesis.

During my fieldwork in Fiji, when relating a description to me or in answer to my questions about some process, the Indo-Fijians often used the "story" form to give an account of some event. I believe this usage was probably introduced into Fijian schools during colonial times and has been carried over into everyday life. Even the semi-literate used the English word "story" when telling me their view of a particular occurrence.

Thus, I have chosen to retain their word rather than the more common "example" or "case", etc. Methodologically, it places the "telling" into the proper perspective, that of the person relating the event.

Initially, I embarked on gathering information about pregnancy and birthing but soon found that the discussion seemed to start quite naturally with the earlier process of menarche.
As a consequence, this topic consists of two sections, one chapter on each. About menstruation, I wanted to know if women, especially mothers and daughters, could discuss it freely with each other. Or if they could not, why not; and if there were some categories of persons who did interact easily and in an instructive way, with the girl experiencing the onset of menarche. It seemed to me the interactions and the process involved could tell me about how women thought of their bodies, and selves. The topic had additional interest for me inasmuch as it offered opportunity to find out about how concepts of purity and pollution pertain to health processes as they exist in Fiji today.

In total I talked to forty-one women about menarche. Now, I present a summary of that data. The cultural groups were made up of North Indians (8), Muslims (10), Nepalese (4), and South Indians (19). I noted with interest that among the Muslims and South Indians more than one-half had been told about menstruation by their mothers (the actual figures being five and ten respectively for these two groups); while all of the Nepalese (4), had. Of the North Indians, only two women (of the eight) had been told by their mothers. The South Indians had the highest number who had been told by some relative other than a mother, mother’s sister, or brother’s wife. Of the total, only two had been told about menstruation by a non-relative, and in both cases it was a teacher who told the girl at school.  

The first question was more or less rhetorical, just to start the conversation about the topic. In reply to the second question, very few girls knew about menstruation beforehand. Those who did, knew from a sister or from a brother’s wife (bhabi), although several young women said they learned from the school biology class in Form 5. There was no real effort by an Indo-Fijian mother to tell a girl about life processes. Usually, menstruation was an event that was to be handled at the time that it happened. Sex and pregnancy were rarely discussed or linked to menstruation.
Amongst the North Indians, Muslims and Nepalese, there was no celebration or puja (ritual) to mark the onset of menarche, and in fact in these groups women felt some embarrassment and shame about it. Most mothers did not feel comfortable telling their daughters about these natural processes. When I asked them they said that between mothers and daughters there was a feeling of reserve and shame about their bodies and about menstruation and sex. As a consequence they avoided talking about such topics.

Some women felt that any discussion about sexuality was bound to be instructive and would provoke curiosity so the topic was avoided. It was as if the knowledge would corrupt the virginal mien which is so highly valued by Indo-Fijians. The gift of a virgin in marriage, pure meek and untarnished in thought as well as in deed is still the ideal. A woman learns about sex from her husband. In actual fact, many girls are told about sexuality by their brother's wife (their bhabi). This is usually just prior to a girl's marriage. More recently, with higher education available to young women, they learn about the physiological processes such as menarche, procreation and pregnancy in biology or home economics classes.

Several informants said that they were shy and would not even change clothes in front of a mother, aunt (father's sister), or grandmother without feeling shame, but felt comfortable with a sister, cousin or brother's wife.

Only the early South Indians in Fiji celebrated the menarche with a ritual. It is interesting to see that their recent celebrations have taken the form of a family dinner when close friends and relatives give the girl a few gifts. Of the six rituals which I have been told about, several (those recalled for me by two elderly women in the settlements which I studied) were marked with the ritual of separation of the menstruating woman, and her subsequent reincorporation. This short summary gives some idea of how the women in my fieldwork area thought about and responded to the onset of menarche. It answers some of the specific questions.
posed above. Next, I attempt to further outline the process of menarche and to answer the broad questions which I ask at the start of this chapter.

In the following pages, I abstract in some cases, or give excerpts, from the "stories" told to me which describe how some South Indian, North Indian, Nepalese and Muslim women regarded their first experience of menstruation. Recall that I have already discussed cultural group differences in Part I of this thesis. I discussed the historical antecedents, the processes by which the various cultural groups (South Indians, North Indians [including Nepalese], and Muslims) who interact, became as they are today. These historical events are related to urban/rural differences, proximity to urban spheres of influence, marginality and minority group differences, education, economics, politics and land policy. This discussion then, also furthers those ideas, prior to arriving at final conclusions.

Now, I go on to examine the empirical data from my fieldwork, presenting in turn South Indian, North Indian and Muslim experiences. Some commentary is embedded in the following account.

I have condensed the "story" told to me by S., an Indo-Fijian woman of South Indian parentage, born in Fiji in 1919, to show that there were a series of steps, a processual form referred to as a *puja*, which marked the transition of the pubertal girl to a state of womanhood among the South Indians of Fiji. I present that process next.

In telling me her story, S. was recalling the events from 1931, when as a twelve year old, she experienced first menstruation. She said that the first step occurred when a girl, experiencing the onset of the menses informed her mother. The family then told the girl's mother's brother who came and built a menstrual hut for her; and they arranged for an older woman from the settlement to stay with the segregated girl for ten to thirteen days to give her instruction and knowledge about her new physical and social identity. Special foods were prepared for her which took into account the hot/cold idiom (*garam and tunda*) related to the
humoral beliefs of India. Prasads (sacramental foods) used in religious rituals, as well as a special dish made of rice which was ritually important at this time, were part of the diet which was meant to keep her bodily and emotional state in balance. During this time too, they were following cultural proscriptions which showed that a menstruating woman was in a state of pollution and should be kept separate (alagi) from others. At the end of the separation phase, the mother’s brother burnt down the menstrual hut. He then built a second canopy-like structure (the mandapa) which is the same as that constructed for weddings. After a purificatory bath, the girl put on new clothing given to her by her mother’s brother. She was adorned with henna and sandalwood paste as befits a bride, complete with the wedding bracelet (the chewra); and the women then took her and seated her under the canopy. The dishes she had used and the clothes she wore in the hut, all of them considered polluted, were given to the old woman who had stayed with the her. The family meanwhile had prepared a feast to which they had invited kinsmen and neighbours, to validate by their presence and by celebration, the transition of the girl from the stage of pollution and separation, to that of becoming incorporated into their midst as a full blown woman, subject to the norms and values of that state.

This abstracted account of puberty rites forms a base line for my examination of more recent “stories” about menstruation. Before going on to examine them, there are a number of significant points which relate to social structure and social organization of South Indian groups which can be drawn from this first example.

First, the South Indians in Fiji did not think of menstruation as shameful. The girl easily told her mother about its onset and set the ritual process in motion. I think that this is in keeping with the behaviour pattern for women in the South Indian culture in India where there was greater freedom and less stress than in North Indian groups amongst whom a narrow circle of kinsmen interacted in reciprocal relations (Karve, 1965). In Fiji, as in India, there was apparently less need to hide personal processes such as menarche; they were openly celebrated
to show that the young woman had attained marriageable age, and could be claimed by either a cross-cousin or a maternal uncle (younger than her mother however). And, we see in the above example that it was the mother's brother who built the hut which secluded her from the others during the time that she was in a polluting state. At the end of the time of separation, he was the one to burn down the hut in which she was set apart from her community and kin. He also built the "wedding canopy-like" structure, and provided the clothing and adornments (including the all important wedding bracelet) which she wore later as she was reincorporated into the group to await her real wedding. The ritual was meant to prepare her not only for physical changes to her body but to give her new knowledge, less abstract and more personal, about roles, social norms and values.

The role of the mother's brother in South Indian culture in India was that of a potential affine, either as a marriage partner, or as a father-in-law. Karve (1965:250-51) states:

The Dravidian kinship organization is thus fundamentally different from that of the northern zone. The kin in the immediate family is arranged not according to generations but according to age categories of 'older than ego' and 'younger than ego'. Marriage is outside the exogamous kin-group called balli or bedagu or kilai, which has similarities to totemistic clans. Exchange of daughters is favoured and marriage among close kin is the preferred one. The rules for marriage as deduced from kinship behaviour are:

(1) One must not marry a member of one's own clan.
(2) A girl must marry a person who belongs to the group "older than self -- tam-mun" and also to the group "younger than the parents". Therefore she can marry any of her older cross-cousins, as also the younger brother of her mother.
(3) A boy must marry a girl belonging to a group "younger than self -- tam-pin" and who is a child of the group "older than self -- tam-mun". He can therefore marry any of his younger female cross-cousins and also a daughter of any of his elder sisters."

She states the marriage customs of the south in summary form:

The South represents the principle of immediate exchange, a policy of consolidation, a clustering of kin group in a narrow area, no sharp distinction between kin by blood and kin by marriage, greater freedom for women in a society which was mainly agricultural, with very few or almost no pastoral traditions (Ibid:252).
The customs of the South are in marked contrast to those of the North, which I present later in this chapter, after completing the discussion on South Indians.

Another sociologically relevant consideration in the processual pattern of South Indian menstrual ritual abstracted above is that of the notion of states of pollution (or with reference to women, of *mali* [dirty]) states.

The Indian conception of two fundamental principles which appear to divide entities into the dichotomy of *pure* or *polluted*, is recognizable in the patterns of thought and action in Fiji. Verbally, the people do not often say “polluted” (*mali*) when referring to menstruation unless they have to be specific, which is avoided if possible. They usually refer to menstruating as “being sick” (*bimar*) and sometimes refer in English to their periods as being “dirty”. They say a woman who has her periods is *alagsi rakhi* (kept separate). But when I asked under what conditions? The reply was “she is sick at that time”. I think there is an interesting problem here, that of sickness and pollution being conceptually analogous. Because I want to complete the discussion on menstruation and pregnancy, prior to delving into these sorts of issues, I will take up the point again in a later part of this thesis, bracketing it for now.

I believe that there is a power involved in the state of pollution. A woman has the potential to do harm, she must be shown how to harness that power, and in effect not to use it. In Indian culture women are thought to have an ambiguous nature, they oscillate between benefactresses of the family inasmuch as it is through the *pujas* (rituals) women conduct that a family benefits, their prayers are heeded by the gods on behalf of the past, present and future members of the family. Yet women are dangerous, their sexuality has to be controlled, they can shame a family through their procreative power and through pollution.4

Conversely, the prayers of men can only benefit the individual, and never the family or lineage. Men conduct the Hanumana *puja* in which women cannot participate. The god Hanuman codifies non-procreation and celibacy; thus during *pujas* in his honour no foods with seeds are
used as *prasads*. My informant, an elderly Gujerati widow, told me that post-menopausal women may take part in the Hanuman *puja*. Other informants concurred with her statement.

A woman must discontinue her prayers when she is in a polluting state, (i.e. while menstruating). The power of menstrual blood is harmful not only to humans but also to other species of life. In this "story" the left-over foods of the girl, while she was in the menstrual hut, had to be buried so that no animal could eat them. By contagion, if an animal had eaten the food, Indo-Fijians thought the menstruating woman would get stomach pains, and suffer menstrual discomfort.

A woman's reincorporation into the family after the ritual was a time of celebration, she had made the transition from girlhood to womanhood.

Another point illustrated by this first example is the hot/cold idiom related to foods. According to this theory, foods have certain thermal valences and must be consumed in such a way that they take into account physical and emotional states as well as environmental conditions. Since Indo-Fijians think of menstruation as a sickness, ideally, diet is prescribed to counteract the unbalanced physical state. Traditionally, cold foods were avoided because the loss of a heating substance such as blood, even though it was considered polluted, and Indo-Fijians thought it was necessary to cleanse the body of it, put the body in a cooler state and thus, at that time, more susceptible to negative health effects. This was especially the case if the flow of blood was copious.

A ritually important time, a *puja* marked the cessation of the state of pollution, the end of the menstrual period, and the foods served were those "pure foods" (*prasads*) which are usually used to propitiate gods and goddesses. Rice, symbolizing fertility, was one of the foods served to the menstruating woman; and it was appropriate, since it encoded her ability to conceive.
I believe this was the general process, with some variation, during the early days of the South Indians in Fiji. This pattern has since then been progressively modified in time, space and personnel.

In my second "story" J. is a woman born in 1938 (48 years of age). She told me the story of her eleventh year (1949), in the presence of her mother and daughters-in-law, my research assistant and myself as we sat on Fijian mats under the mango trees one very hot afternoon. There are some interesting variations in this ritual because of structural changes in this family. Here is what I was told (in excerpted form):

I lived with my mausi [MoSi] because my nana [MoFa] took me there...they had no children. My mausi (mother's sister)...told me, ...you are bimar...They built a hut of coconut leaves and took me into the hut for nine days and my nani [MoMo] stayed with me for nine days and I just sat quietly and after every other day they bathed me and she brought my food, aaloo [separately] with separate plates and glass and everything. My left-over food was buried and not even a pussy or dog was allowed to have it, if they let an animal have it, I would have a stomach ache. After nine days my mami [MoBrWi] burnt down the hut at three in the morning. They made special foods.... [and] my Kaka [FeYgrBr] brought seesa [mirror], kurta [shirt] and kanga [comb]....I was bathed and put on new clothes and my women relatives put haldi [henna] on my arms and feet, just like a dulaine [bride]. Then I was bathed and it was finished.

In this story from my field notes, several points are of interest. First, the woman is explicit that menstruation is called bimari [sickness]. This was the case for almost every person I talked to about the subject. Second, the girl lived at the home of her maternal aunt at the time. As is the case in many Indian families, if a woman is barren, she may take the child of her own sibling to raise. Consequently, J. lived with her Mausi.

It may appear strange that the man who brought the "wedding-type" clothing was the girl's father's younger brother. But as we have remarked already, amongst South Indians there were a number of close kinsmen who were in the category of marriageable partner or of potential affinal relatives. Even if the father's brother was married to the girl's mother's
sister, I think we can interpret his actions as those of a replacement acting on behalf of someone who for some reason was not available. Perhaps there were no relatives of the appropriate category in Fiji.

Other changes to be noticed are that no wedding-type of canopy was constructed and the wedding bracelet (the chewra) was not worn. She received no special clothing (such as a bride would wear) from her mother's brother, no feast was prepared and no guests were invited to witness the event. She received no gifts from her mother's brother (or his wife). She was reincorporated into the household, without the symbolism of the bride, which had previously marked the transition of a woman from one state to another among South Indians.

The changes in the actors in the event, as I have noted above, show that people made adaptations in the rituals to reflect the structural changes in the family type, as they went along. She could in effect not marry into the household in which she lived since it was not that of the cross-cousin, and the event signaled that in all its complication.

The rules about the number of days a woman was to remain separated or alaqi were not rigidly set. In all the examples I have noted the time was at least a week and perhaps longer. The example also shows that the ritual activity and the food preparation were also variable. The decisions about the process appear to have depended on the circumstances and wishes of the family. Before undertaking the ritual, they would have to consider whether they would be free from work, whether there were sufficient funds, whether and for how long the participants would be available. Not all families put the same emphasis on the significance of traditional events. Nevertheless, the process, in spite of variations, followed a general pattern.

I note that as Indo-Fijian society has increased its complexity (achieving higher education, urbanity, and complex economic and political activities) the society is changing its structural form; and the rituals are changing. In many instances they are so diminished that little ritual is left. The following extract from a "story" demonstrates the change:
I was kept home for seven days the first time. They gave me special foods, sweets made of ghi, no fish, no one could eat my left over food, it was juta (meaning polluted), and I had a separate plate and bowl and room in the house. They buried the left over foods. Afterwards I washed and used the clothes I wore at the time. There were no pujaas and we did not call anyone, but my sister gave me dress material. My mother's brother did not give me anything (This was in response to my question whether she had received any gifts from her MoBr).

The difference in this ritual from the preceding one is self evident and does not require any further comment except to point out that there are changes in time, space, personnel and ritual activity. More recently, the ritual process has been all but abandoned. In the case of N. (an 18-year-old South Indian woman), she was "bathed" (by this I mean the woman bathed herself while the other women, usually from the household and perhaps from neighbouring houses waited together) at the onset of menstruation. She was not ritually separated from others, she stayed in the house with her family. Only a small ritual was conducted:

...they took an arthi (the brass tray used for religious ritual), placed a [cube of] camphor on it and lit it and circled me [her body] with that. My mother made halwa (a sweet made for religious worship, a sacramental food) for us. I did not get any gifts or new clothes from anyone.

In this example we can see how attenuated the ritual has become. And finally, in the example of U, a South Indian woman of 18 to 20 years of age, I was told:

After three days it (menstruation) stopped and she (her mother) made kheer (a pudding like sweet made of milk, rice and sugar) for the family, but I did not get presents.

Still later, I talked to a young 19-year-old South Indian woman at the hospital where she had just delivered her first child. She said she did not know of any rituals at all that were performed at the onset of menstruation. And many of the young girls I talked to told me that it (the puja) is no longer done, in fact they asked me to describe it to them.

The discussion so far has centered on the processes related to menarche in the South Indian community. Now, I present some of the data on North Indian women.
North Indian women on the whole were more secretive about menarche. They did not have a ritual or puja to celebrate the onset of menarche. It was treated as a natural process, unmarked by rites of any sort. For this reason I cannot outline a processual form as was possible for the South Indian puberty rite. There are however many beliefs and conceptual systems which are pan-Indian and it is possible in this chapter to examine the similarities on this basis. First, I examine the purity and pollution concept which amongst the South Indians has many prohibitions connected with it, with reference to the North Indian women.

I asked one 23 year old North Indian woman if there were any rules to prohibit a woman from entering a kitchen or cooking during her periods. She replied: "No, not about cooking but we are not allowed to go to the temples and we cannot pray there because the Indian belief is that we are "dirty" then". A number of other women told me the same thing. This notion of women having the power to pollute, is examined further in the next chapter, with reference to pregnancy and birthing.

Another pan-Indian idea is that menstruation is sickness or "bimari". The North Indian women also referred to themselves as "bimar" when they had their periods.

Several North Indian women told me that they could determine, that is, almost set the number of days, of their menstrual cycle. One 26 year old woman told me:

In the Indian way they tell it like this: you will have the periods for three or three and one-half days only, if you go outside and mark it like this (indicating three short lines) in the mud somewhere outside the house.

This idea was repeated by another woman who stated: "It will only last three days if you get three sticks from the charde (broom) and put them outside, the first time that you get your periods".

In the first instance, I believe, although my informants said they did not know why they carried out the practice, that the woman was propitiating a North Indian goddess of the earth (tharthi), perhaps the same one who was invoked on the night before a wedding ritual. At that
time, the household women accompanied by the bride, took a sod of earth from the family compound and went out to the boundary of the compound or the land, to conduct a ritual. It was night so they took a lantern, a digging shovel or hoe, and they dug a hole and placed the sod in it. They placed a set number of items on the edges of the hole and they lit seven earthenware lights (dīs). Then the assembly of women sang a few songs and they danced together before going back to the household. When I asked about the ritual, they could only tell me that they conduct it in order to worship the goddess of the earth.

In the case of the broom, although my informants could not tell me this, I feel certain that they were propitiating Lakshmi, the goddess of the household, sometimes represented by a broom. She is the goddess of wealth and is the favourite of the North Indian people in Fiji.

These two examples are the only ones which I was able to obtain, apart from the sense of communitas invoked by women of the household waiting together at the ritual bath, about any semblance of North Indian puberty rites. Perhaps, in the past, there were folk rituals which have been lost to the people of Fiji. My feeling was that the first example above is from the folk traditions of the people of Bihar, while the second may be general to North India since Lakshmi is worshipped there, more than she is in South India.

In my analysis of the South Indian puberty rites, I was able to show that the rites were connected to the social structure and social organization. With the North Indian people, the link is not as clearly demonstrated. Still, it is there, in the behaviours surrounding the onset of menstruation. The North Indian women are generally much more secretive about bodily processes. Menstruation is not an event which signals celebration, it is not made public. In North India, a girl does not live in the midst of her potential affines, but with the consanguineal family, the males of which are in the category of prohibited marriage partner. There is no cross-cousin marriage. A woman's male cousin's are related to her as "brothers". A woman
marries and is incorporated into another lineage, a great distance from her own village. Karve has summed up the implications of this for behaviour:

The North represents the principle of extended exchange, a policy of expansion, incorporation of outsiders as wives into the family, leading to great stresses and strains, a double standard of women’s behaviour pattern, a wide circle of kin, a society having a pastoral economy or an agricultural economy supported by pastoral pursuits.

It is of interest then to note that although the women in North India have freedom of movement, and interaction with males within their natal village (since all males are related as consanguines), it is also here that the women are the more secretive about the process of menarche. In general there is more separation of males and females in the patriarchal north. As Karve states, there is a double standard for North Indian women; they are much more restricted as to behaviour and interaction once they marry and are under the control of their affines. In general, the male and female spheres of life are much more separated than in the South Indian society. The full implications of these standards have been explored by others; they are not my main topic so will not be dealt with any further here.

As well as North and South Indian women, I also talked to Muslim women about menarche. There are no menarchial rites for Muslim girls. Muslim women generally think of menstruation as “dirty” and a few women showed their repugnance as they told me this. One woman, a twenty-nine year old nurse said: “It is dirty, as Muslims we call it dirty”.

Menstruation is also polluting, a thirty-five-year-old Muslim woman told me: “Period time – stop! We cannot go to the mosque, can’t pray during period time. We can cook and handle foods though”.

The behaviours of the Muslim women are similar to those of North Indian women. Menarche is a private concern of women. The Muslim marriage rules are similar to those of the North Indians and there is no cross-cousin marriage amongst the Muslim people I talked to in Fiji; in fact they showed an active dislike of the principle. The virtue of the women is protected
by the patriarchal males, and separation of the sexes is more pronounced than it is amongst North Indians. A woman is reserved in demeanour in the affinal setting.

In summary, I have noted how, in Fiji, the South Indians celebrated the menarche with ritual and openness, whereas the North Indians, (including the Nepalese) and Muslims did not. Karve stated the differences concisely. When discussing Indians (in India) she noted that the kinship organizations of the North and South were fundamentally different and that this represented the behaviour of the people in the two areas. These behaviour patterns have of course been carried over to Fiji. Amongst the South Indians in Fiji too, the potential marriage partners of ego, in the early days, were closely related kinsmen. In the early days in Fiji, the onset of menarche was a time for celebration since after that, a woman could be claimed as a bride by someone within a very small group of kinsmen.

More recently, the marriage patterns have changed, and South Indians in Fiji no longer marry their cross-cousin or their mother’s younger brother. I feel that they are still however, more relaxed about menstruation as a process in comparison with the other Indian groups in Fiji.

Amongst the North Indians (in India) marriages were arranged with people who lived a great distance away. Behaviour patterns were more strongly controlled and the women were more secluded. These patterns are evident in the North Indians of Fiji, as well as among the Muslims there today.

As we have seen in the examples above, in the South Indian groups, a woman was told about menstruation by the generation above her, her mother, her mother’s sister or by the older woman who stayed with her in the menstrual hut. Amongst the North Indians and Muslims, it was more usual for someone in ego’s own age group to tell her, usually a female sibling, or the wife of a male sibling.
In all of the Indian groups in Fiji with whom I discussed it, menstruation was treated as an event in itself and there was rarely communication of the connection between menstruation, sex or pregnancy, at the time of the first occurrence of the menses. Within a family, pre-marital discussion of sex and procreation was quite restricted inter-generationally, and occurred mainly between women who were age mates, whether friends, sisters, sisters-in-law or cousins. More recently, in the last ten years at most, education in the schools is supplanting the need for the family to be the first to tell the young woman about these natural processes in their lives.

In terms of the concepts of purity and pollution, both the North and the South Indians in Fiji, whom I met and knew in the two settlements of study, and the hospital, told me that they did not go to the mandirs (temples or household shrines), when they were menstruating because of the pollution aspect. They did not refrain from cooking or entering the kitchen at that time, but they bathed first to purify themselves, very early every morning, before they started any household duties. In most families women who were menstruating did not hesitate to serve food to members of their own families, but several women told me that they would never serve food to a pujari (the temple priest), or to the pandit (the Brahmin religious specialist), if they came to visit the house at that time.

With regard to religious activities, however, the South Indian women were not ashamed to watch religious ceremonies from a short distance away from the place where the ceremonies were being conducted. It was my impression that the North Indian women observed the same rules regarding their states of purity or pollution, but they were much more modest about being noticed in public as a group 'set apart' for this reason. They usually stayed out of sight, if they could not attend.

Although by custom the Muslim women in Fiji do not go to the mosque to pray, it being prohibited to them to do so, they do recite the Namaz at home with their daughters and other
household women, while the men and boys go to the mosque. (My informant was talking about the Shi'ite Muslim tradition, but I believe the rule applies throughout the Muslim faith.). During menstrual periods Muslim women do not recite the prayers. Among the North and South Indians, I had the impression that the women accepted the idea of their bodies being in a polluted state, in some abstract sense, almost as if it were happening to someone else. They usually said they were not 'clean'. Or they just signalled the condition with a funny look on their face and other women did not enquire further; they understood. I think the Muslim women, by contrast, were more concerned about the notion of their "selves" being polluted.

In all Fiji-Indian groups, including Muslims, menstruation was considered *bimari* (illness). A woman was said to be *bimar*, and there was allowance made for her in terms of household and farm labour if she was in discomfort. Interestingly, I found few household remedies that were used to relieve menstrual pain or discomfort.

I have already mentioned the importance of the hot/cold idiom, above. The older women followed some of the beliefs concerning the effect of hot and cold foods, at the time of their periods. Younger women today, those in high schools and college, and those who are newly married, are less concerned with this system of hot and cold foods and their effects on their health. They do however observe the religious proscriptions related to menstrual pollution, and they restrict their religious activity accordingly.

I have shown, in this section on menstruation, that although there is some variation in individual experience, in response to situations, and although rituals have become modified, there is also a general uniformity of attitudes within each of the Indian cultural groups studied in Fiji. I have also shown that the major changes in processes within each Indo-Fijian group are related to the social structural changes resulting from their mutual adaptations in Fiji and to interactions with each other over the last fifty years or more. These adaptations are what Moore (1978) refers to as "processes of situational adjustment". They are most clearly shown in the
diminuation of rituals which marked the onset of menstruation among the South Indians. I have shown that the changes in ritual are directly related to changes in kinship rules and marriage practices. By contrast, the North Indian practices with regard to menstruation have changed very little since indenture, or because of it.

Other "processes of situational adjustment" are those related to socialization patterns. For example young women learn about bodily processes (as well as housekeeping practices, nutrition, etc.) from institutions such as schools rather than in their homes from their kinswomen. This new knowledge is more congruent with other institutions such as the biomedical health care systems (birthing, knowledge about anatomy) and is thus one of the "processes of regularization", since it is being concretized by the major institutions in the country. By contrast, in many ways, some of the traditional practices are being diminished (i.e. the hot/cold idiom).

Between Indo-Fijian cultural groups however, differences in attitudes to these natural processes remain, and I will continue to examine them in the study of pregnancy and birthing in the next section. And, finally, in the summary of these two sections, relate them to the traditional medical systems in place in Fiji today.
Footnotes:

1 I am using Mayer's (1973:144) term "cultural group" to distinguish between North Indians, South Indians, Nepalese, and Muslims in Fiji. "Ethnic group" distinguishes between Indians and Fijians and other non-Indian groups.

2 Now, an excellent program of biology in Form five, and instruction about families in home economics courses in the high schools prepare young women so that they are ready for these natural physiological processes. Several mothers with whom I talked about the high school training expressed relief, saying that the schools prepared the educated girls better than they had been prepared, and better than they could explain it to their daughters.

3 I do not know if the woman was of the washerman caste, nor did my informants tell me. It is quite possible that in the early days the dal, who in India was traditionally responsible for the removal of the pollution of menstration, served in the same role in Fiji.

4 The nature/culture argument is now common in the literature. Sherry B. Ortner's (1972) article "Is female to male as nature is to culture?", reprinted in Woman, Culture and Society, ed. M. Z. Rosaldo and L. Lamphere, pp. 67-88. Stanford: Stanford University Press, 1974, was discussing a basic structural relationship between the sexes, which various other writers have discussed in slightly different ways. For example, M. Strathern (1981) in "Self-interest and the social good: some implications of Hagen gender imagery" in Sexual Meanings. The cultural construction of gender and sexuality, by S. B. Ortner and H. Whitehead, expresses the idea in terms of women's involvement with particularistic aspects of life, while those of men encompass those of women and the society as a whole, and for that reason are thought to be of higher value.

5 The puberty rituals were no longer being practiced, or where they were, it was in very attenuated forms. None of the South Indian people with whom I talked reported recent instances of traditional puberty rituals.
In the last chapter I discussed the topic of menarche as one part of natural processes in the lives of Indo-Fijian women. Now, retaining the interview questions set out in the first part of that chapter, I discuss various aspects of barrenness, conception, pregnancy, birthing and post-partum care of women in Fiji, with reference to social processes and interactions within the traditional cultural context.

The successful cure of barrenness is demonstrated in these first two examples.

**Barrenness, a cultural response:**

Traditionally, the most crucial expectation the afflines of a newly married woman have is that soon after marriage she should conceive. In Indian culture, a woman is most highly valued as a genetrix. Barrenness in women disrupts normal social processes in the group, and families react to it and intervene in order to assist the woman who is afflicted.
We come now to the process employed by one North Indian Brahmin woman in her attempt to overcome the stigma of barrenness, and to conceive. Here, I present her "story" in a synoptic form, to show the outline of the process.

N. is a woman of about 38 years of age, who is married into one of the Pandit families in the Nasavu settlement. She and her husband live in their own compound, in the area referred to as Brahmin jola, by the other residents in the settlement. They work in the town for a large government sponsored farmer's cooperative where he as the manager and she, his assistant. They now have a daughter, about 12 years of age. Both appear to be contented with their life situation, one in which they work with both Indians and Fijians in the Sigatoka valley area.

When after two years of marriage N. had not become pregnant, she became anxious and she and her husband approached his mother about the problem. N. had already talked about it to her own mother. They decided together that N. should go to see the woman doctor in the town for an examination. This doctor could find nothing physically wrong, but referred her for further examination to the specialist at the Divisional Hospital in Lautoka. Here she was examined and advised to undergo a "private operation" (a D. and C.) which she explained as necessary to "clean out the stomach" (pate saf karna). The fees paid were those normally paid to the public institutions. After waiting for one year without result, she talked about it again with her mother-in-law and the two women decided to go to the highly revered oriah, who is also often referred to as a vaitya (ayurvedic physician). He prescribed medicine made of ash and holy water. (The two women went to the healer in spite of the fact that N's husband was sceptical about the results). This healer was given one dollar, although he does not charge any fees whatsoever and lives on the donations his patients give to him.

Again, they had no success and the two women decided to visit still another oriah, this time a Muslim woman with extraordinary powers. This woman treats by prayer to Allah and with readings from the Koran. As well she interprets string configurations known as dare to discover the ailment, and she gives the afflicted person a holy thread to tie around the abdomen. She told N. that her "baby bag" (potnar) was not in the right place and advised her to go to the dai (local midwife) for massage treatment. This oriah is known by one and all to charge a fee of three dollars, although she no longer asks for the money, she is paid it. As advised, N. went to the dai and was treated to massage lasting 20 to 25 minutes each time for three visits. She paid a sum of nine dollars, which is the standard fee the dai charges. Still N. did not conceive.

In the interval she also went to two Fijian women healers and she was examined internally (sili - bimanual examination) by them, as is their medical tradition. After five years had passed, her husband told her to forget about children and to devote herself to God through her prayers "and to live on Him". Soon after she had a dream during which a woman in a red wedding sari came to her. When she woke she told her mother-in-law about the dream, and together they went to the pandit (priest) to have him interpret the meaning. He said N. had had a visitation from a
goddess and that it was a sign that she should do a major puja (religious ritual) to the goddess, and that after that she would conceive. The puja was performed as prescribed by the priest. And they gave the priest gifts of saris and other clothing and food "for the goddess" to propitiate her. (These items are used by the family of the priest as the intermediaries of the goddess). He told her to repeat the puja if she conceived.

She did finally become pregnant. The last several months of her pregnancy were spent at her parents' home as is the Indian custom. Conveniently, it was also close to the Lautoka hospital. When she gave birth it was by caesarean section, the child weighed nine pounds, fourteen ounces.

After some few months, they performed the second puja as the pandit had told them to do and they presented the pandit again with the same gifts they had at the first ritual.

Soon thereafter, N. made payments of money or goods to each of the healers she had consulted, for she said she knew that each healer would have some "claim" on the outcome. She was not at all reluctant to pay each of them.

The diagnostic process used by N. in her search for a cure for her barrenness shows the following preference order of consultation with family members and to healer: a) her husband, b) her own mother, c) her mother-in-law and other women in her husband's family, d) a woman doctor (general practitioner), e) a male doctor (specialist), f) an Indian healer referred to as an orjah and sometimes as a vaidya, g) a Muslim woman orjah, h) a dai (Indian midwife), i) two Fijian healers (both women), j) a pandit, k) the Lautoka hospital.

The order of consultation, according to what she related to me, was decided upon by N., her own mother, her husband and her mother-in-law at the time (the therapy management group, in this case) and did not indicate a cultural preference so much as their on-going strategy to find a means towards the desired end or goal, that of finding the right healer.

Some aspects of the search for therapy however do reflect their position as pandits, the highest position in the caste hierarchy. As in most Indian families, the first place for consultation about the problem was within the kinship group itself. Then as many of the educated higher castes do in Fiji today, they sought treatment in the Western biomedical system. (Most Indo-Fijian families today have a doctor whom they consult.) The family was united in its
search for therapy and they decided to consult a woman doctor in town. On the advice of this
doctor N. underwent both examination and operation in Lautoka.

We can see that in the search for a cure, the women were more flexible in their
approach to curing and were not reluctant to try the traditional healers, while N.'s husband was
sceptical about their use. M. was disappointed in her husband's lack of enthusiasm for the visit
to the orjaha. Nevertheless this did not restrain N. and her mother-in-law from seeking therapy
using all of the avenues open to them. N.'s husband's position is understandable if we recall that
they are of the pandit or priestly caste. Their social position as Brahmins militates against her
husband condoning her use of the orjaha because of their ambiguous nature as healers on the one
hand but as having the potential to be sorcerers on the other. Morally, as a member of the
religious specialist caste, he could not approve. She told me however, that she felt the treatment
could not be effective or successful unless he participated and had faith in the process. He acted
as if it was doomed for failure; consequently she felt it would not succeed. She told me she
believed that when she did finally conceive, it was as a result of divine intervention when the
goddess came to her in a dream to aid her, and the pandit mediated the process by propitiating the
goddess through ritual and prayer. Normatively, the cure was within the correct belief system
for Brahmins, attribution was within their religious system.

Most of the Brahmins or pandits as they are called in Fiji, are still quite particular
about caste obligations in many aspects of their own social interaction, although generally
throughout Fiji the Indo-Fijians will disclaim caste as an organizing principle of the society.
When I examine the transactions as pandits undertake them, it is clear that the principles of
hierarchy, purity and pollution are undergoing rapid change, but they are by no means
abandoned. Rather, as Moore (1979:2-5) states: "'Processes of regularization' include all the
ways in which conscious efforts are made to build and/or reproduce durable social and symbolic
orders," that is to live within the social order as it exists in the context. But rules are only a
part of a complex of action, people are constantly faced with "processes which operate outside the rules, or which cause people to use rules, abandon them, bend them, reinterpret them, side-step them or replace them". Their behaviour is located in time and context and is adjusted accordingly. Thus caste in Fiji has, and is, undergoing a transformation. This research explores the connections between Indo-Fijian values and social behaviour within the context of healing. After this brief digression we return to the discussion of traditional healers.

Although I discuss the traditional healers throughout Part II of this thesis (and especially in Chapter 6), I now briefly consider them along a continuum of sacred to secular according to whether or not they charge fees for their services. In most religious healing, the practitioner views his own ability and it is viewed by the community, as a power given by a supernatural agent. As the recipient of this power, the healer has been favoured, and normally should not charge fees. At the other end of the continuum, is the healer whose power is secular, based on his or her own abilities, and in some cases a caste specific occupation such as midwifery (i.e. dai). Secular healers do not usually hesitate to charge for services rendered.

In the example of N., the dai has charged for her services and the fee is stated and collected as a wage for services performed. This is not the case with the orijahs. The Muslim woman who is an orijah claims she received her power from Allah and from reading the Koran. She does not charge a fee, but the expectation, passed along by word of mouth by her clients, is that each person she treats pay the set fee of three dollars per visit. It is not demanded, but everyone knows that she would not treat them again if the fee was not paid.

The male orijah falls into a slightly different category than either of those discussed already. A person who practices ayurveda, the professionalized medical system from India, is referred to as a vaidya. The male healer discussed as a vaidya here, is highly respected for his mastery of Hindu texts, even though he has not taken the formal training necessary in India to be an ayurvedic physician. His knowledge, some of it acquired from his father who was a learned
Hindu scholar, combined with his knowledge of herbal medicine, and yogic traditions, give him an esteemed position in the Indo-Fijian culture. He is known all over Fiji for the power of his healing. He does not charge a fee for his therapy, but people give him what they can, sometimes in coinage and other times as substantial, generous donations. Local people look after his food needs and many of his female patients take prepared foods to him for his meals since he is now an elderly widower. People leave the money for him without discussing fees.

Interestingly, when I asked him about his religious beliefs, he said his “dharam is Hindu”, but he went on to explain that he also believes in the ancient yogic traditions of India (which is in keeping with ancient ayurvedic origins and practices). Although some people refer to him as an orijah, I believe it is his attitude towards fees, and his knowledge of Indian texts which makes his followers hold him in such high esteem and to call him a vaidya.

The pandits and pujaris on the other hand are not directly paid for their services. Nevertheless, in healing transactions involving them, more material goods change hands than is the case for any other healer. Foods are among the goods presented to them in their roles as mediators of the deities being propitiated. People who give the goods say they are gifts for the gods or goddesses in question. The value of these gifts is transacted by the pandit and the supplicant beforehand and they are presented to him during the puja. The pandit and his wife retain most of these items for their own use, but they redistribute some to the poor in the settlement. The foods used in the puja are shared among the devotees participating in the ritual in the form of sacramental offerings.

From these cases we can see the relationship between fee structure and religiosity of the healer. The closer the healing practice is to religious practice, the less likelihood that a formal fee is levied since the power to heal is a gift from God; an exchange for devotion.

Finally, the Fijian healers too were given gifts of clothing. This is a slightly different and complicated issue. N. and her husband are sensitive to the cultural nuances involved in
treated the Fijian healers on a par with the Indian, both in going to them for treatment and in gifts to them for services rendered. They both work with the Fijian people in a close interactive way through their work in the cooperative movement, and their problems and concerns are known to one and all. Consequently, when they were advised by their Fijian friends to use the Fijian healers, they did. They respect the Fijian traditions and do not doubt the potential efficacy of their therapeutics. They gifted the two Fijian women healers just as they did the oriah and the vaidya. In the final analysis however, it was the pandit who was credited with the "cure".

Another woman, A., in the same settlement as N. also had difficulty conceiving. She was married for five years before she finally became pregnant. She told me that she began to be concerned after she had not conceived by the third year of her marriage. At the time she lived in the interior of Viti Levu at a place called Vatumele. She said she was ill with headaches and stomach aches the whole time she lived there. She also suffered from a copious menstrual flow which often lasted for two weeks at a time. She and her husband decided that she should be examined by a woman doctor in the town. After examining her, the doctor could not find any physical disorder but gave her some medicine to control the symptoms. A. told me the doctor remarked, "I have not a patient like you!" A.'s mother said that she was not cured by the doctor's medicine because the sickness was temple alla kam dhara (work [healing] to be done through the temple). Subsequently, they went to the pujari (the temple priest) as some friends and relatives had told them to do. They took vagona and tobacco as required by him, to conduct the ritual. He prepared the vagona as a beverage and drank some of it, then he lit a fire and burnt the tobacco over it as he prayed. I was told that this pujari, a Hindu priest, also uses prayer to a Fijian fish god, Dakuwaqa (see footnote 1, Chapter 4), in his healing, and that is the reason for the vagona and tobacco). A. continued to consult him once a month or every several weeks for about a year and a half to no avail. She had also gone to a dai in an area called Ba for treatment on
the advice of her mother-in-law who lives there. This dai as well as being a midwife, and giving
massage treatment, works like the orjahs do, and interprets the dora or thread configurations.
In addition she gave A. a sacred thread to wear around her abdomen to dispel any evil. Finally,
they moved back to Nasavu, to her parents' home and she conceived "on the fourth day". They
were specific about the day of conception.

When I asked her if she knew which therapy helped her of all the types of healing she
had tried, she and her mother told me that their house in Vatumele was built over an old Fijian
burial ground and "had bad hawa" (evil air or wind). Her mother explained that in those days a
dead body was just put into the ground without being taken care of "as they do today". Thus the
spirits of the dead were causing troubles for her and she could not get well or conceive until she
left the place. The child was born in Lautoka where she and her husband stayed in order to be
close to the major Divisional Hospital in case there was a problem with the delivery. The child
was safely delivered by an obstetrician. At the time I talked to her, the baby was four months
old. A. still looks wretched when she tells of the five years of waiting and of her unwellness "at
that place".

In order to cure her affliction, A. went to a) a Western woman doctor, b) a pujari, c) a
dai/orjah and d) to the specialist, an obstetrician at the hospital. Like N., in the first example
above, A. too is a pandit, but she did not turn to the traditional healing complex of the pandits.
Instead, she turned to temple healing, and to a pujari who combines Hindu religious worship
with invocation of Fijian gods to assist in those cases where Fijian spirits might be involved.

This example is interesting from a number of perspectives. First, it reveals the extent
to which syncretism is a factor in healing. The dai in this example functions within the
traditional role, and as a magical healer. This pujari, too, prays to a Fijian god. During my
fieldwork, I have noted two other pujaris who practice combining faiths to this extent, one who
lives in a cane growing area, and the other in a suburban area.
A. and her mother have constructed an explanatory model of the sickness and of the cure, through a process of reflection over a five year timespan, and in the light of each step of the process, until A. finally became pregnant. I think that their sense-making was along the lines that if the doctor couldn't help, then it wasn't an illness based in the type of healing doctors perform (that of Europeans), and if the puari could not assist it wasn't based in the temple sphere either. They also eliminated an Indian physiological causation and a supernatural one by going to the dai/oriah. That left the evil spirits from the Fijian dead which created bad hawa (evil spirits, air or wind) for her. These they had no system to deal with, although the puari tried to appeal to his Fijian god for help. They decided it was best to leave the place for a safe haven, her parental home, where they still live.¹ In situations of uncertainty and anxiety, when a number of healing systems are consulted, it is not unusual for Indo-Fijians to postulate that a particular cure or healer was most effective; and consequently rationalize that the cause of the illness must have been within the healing province of that particular healer (i.e. healer specific).

In the foregoing pages I have related the processes of menarche and the therapeutic choices made by two women who had problems conceiving. I have revealed Indo-Fijian attitudes towards both menarche and barrenness, although only menarche is considered bimari (illness). Barrenness, on the other hand is not simply thought of as illness, but rather misfortune which can be "cured" using the religious healers and their therapies. For both menarche and barrenness I have provided sketchy descriptive accounts from longer "stories" told to me by my informants. Now, I turn to the processes and interactions made apparent during pregnancy, birthing and post-partum care as practiced by Indo-Fijians.

As mentioned above, the data on these processes were obtained by unstructured, open-ended talks, usually in a group of at least two, and more often three or more women sitting together. I found no hesitancy on the part of my informants to discuss any topic about pregnancy
that I introduced. Usually, the women wanted to tell me in order that my "book" on their medical practices should be as complete as possible. Several women who were reluctant to tell me something in a crowded setting would say that they would tell me later, meaning when I was alone with them. The data presented next were from the two settlements, Nasavu and Solevu.

The Cultural Patterning of Birthing in the Traditional System

As I have mentioned above, while discussing fees charged by traditional healers, the settlement midwife or *dai* is not involved in religious type of ritual activity when she is delivering a child. Her role is in keeping with the Indian ideas of childbirth and pregnancy as being natural processes and not sickness. One *dai* said to me while telling me why she delivered her daughter-in-law's babies at home: "Sub chej hacha ha, bimari nai hai!" (everything is fine [during pregnancy], it is not sickness!). Because of this belief, pregnant women are not relieved of their normal work routines which include farm labour. In Fiji, in the settlements where I conducted my research, one area is a cane growing settlement (Solevu) and has heavy seasonal requirements of cultivation labour. The other is a market vegetable growing area (Nasavu), and has on-going cultivation needs which women provide. At the same time most women in both settlements have their household chores. These consist of preparing meals with rather primitive methods combining cooking over a wood-burning *chula* (open hearth), with portable kerosene stoves. The open-hearth is made of clay. The kitchen is usually a fairly open lean-to attached to the house, and has earth floors. In both settlements many women still carry all of the water for washing dishes, and for household baths. They wash clothes at the river, carrying the wet wash home to dry. Such activities, as well as cooking for the field labourers, mean that they begin their days early, usually at about five o'clock in the morning and go to bed last, after everyone else has been fed and retired. For the young newly married woman the routine is exhausting, and for the pregnant women, especially so. The activities are usually carried on until the woman is finally given respite if it is her first pregnancy, and she goes to
her parental home for the last six weeks or one month before the child is due. Women having a second and third child may not be so lucky, especially if their work is urgently needed or if they have other children to care for.

Although Indians normally supplement the diet of a pregnant woman, this is sometimes not possible in poorer families. In Fiji, where many areas which were once primarily vegetable growing and provided subsistence, are now changing to a mixed economy, we see many adjustments being made to the new economic circumstances.

In Nasavu especially, the dietary intake of a woman is not changed from the normal one during pregnancy. Many families no longer own cattle for dairy products and must purchase milk, butter and yogurt. More and more, a mixed economy has reduced the size of the farmed areas and cropping patterns and labour requirements are different than they were ten years ago. The variety of agricultural produce no longer exists; people contract to grow one or two crops for the commercial vegetable buyers. Many men go to the towns to work, or they work in the tourist industry, and do not have time for subsistence gardening. Some lands, although on lease, lie fallow. As a consequence the family diet is more and more reliant on purchased foods and since wages are very low, nutrition standards within the homes are adversely affected. Lentils, dried beans and dals which provide protein when combined with milk products, are not consumed in sufficient quantity or variety to give the pregnant woman an adequate diet. Fruits are seasonal; consequently most rural families cannot afford fruits imported during the off seasons. Meat proteins are expensive to purchase and few families raise sufficient meat to give them the daily requirements. Some families are vegetarian, especially in Nasavu, where there are several extended families of Brahmins. In order to be nutritionally adequate, a vegetarian diet must be well balanced with a wide variety of animal and vegetable protein. I am uncertain to what extent the vegetarian diets in the settlements would meet the nutritional criteria.
In the broader context of course we see that food is unequally distributed, the more prosperous people have an adequate diet, but many of those with small farms and those who work in wage employment do not. One does not have to be conducting a class analysis to see that social class differences are reflected in nutritional status. The implications of diet for morbidity and mortality are often painfully obvious at the empirical level, in the settlements, villages and at the health care facilities (Doyal and Pennell: 1979:83-92).

Such then are some of the conditions which result in the poor health status of pregnant women: protein deficiency anaemias, premature labour and miscarriages. These problems are discussed in later chapters. Now, I discuss the traditional midwives, the dais, and the process of birthing in the settlement areas of my research.

Although there are still dais in most settlements today, the Fijian National health care system discourages pregnant women from using them. The emphasis in Fiji is on the use of government clinics for pre-natal and post-natal care. District nurses and doctors expect the paturient women to deliver their babies in a hospital. All pregnant women are given a health chart at the time of their first visit and their attendance schedule is set up for the duration of the pregnancy. Women who do not report to the clinics regularly for their checkups are reprimanded.

Most dais today are elderly and do not have anyone who can continue their practice. Young women in Fiji today do not value the work of the dai which was learned in earlier times by someone accompanying and assisting the midwife. Still, a few young women in rural areas do practice midwifery on an occasional basis in the settlements. Their ideas are heavily influenced by what they believe to be "modern" hospital practices.

Traditionally, the dai came from the lower castes in India, those which handled the polluted and polluting aspects of life noted above, such as menstruation and childbirth. The pollution of childbirth covers a longer time span and is discharged through a series of ritual
events spread out over at least two months. Because of the pollution aspect, higher caste women rarely became midwives, although in rural Fiji they assisted in births if it was a necessity when a dai was not available.

One elderly pandit woman told me that she has delivered four of the six children of her neighbour (also a pandit) who lives across the road; and one premature infant (who died), in her own extended family within their compound. She and her daughter-in-law explained very carefully to me that she DID NOT WASH the babies although she did cut the cord. Afterwards, she just wrapped the babies up and waited for the dai to clean them. She said, "Pandits cannot wash the baby, that is the work of the dai".

Until quite recently, most Indo-Fijian women delivered their children at home assisted by a midwife. When a woman in the settlement was due to deliver, the midwife was usually not too far away and could be readily summoned.

In Indo-Fijian culture, childbirth is a private process. Children, and the men in the family, are sent away so they cannot observe the birth or hear the moans or cries of the parturient woman. The dai attended to the woman, during the birthing process, from the time the bed was prepared for the woman to lie on until the family dispensed with the services of the dai during the post-partum period. Dais traditionally offer a range of services, although each has her own style which is influenced by the cultural expectations and attitudes regarding intervention.

I found that I could distinguish between several types of midwifery intervention in the two settlements:

a) Verbal moral support which respects the autonomy of the parturient woman and her modesty, with a minimum amount of internal examination or attention to the perineum. The midwife reduces tension by keeping with her preparations, stopping to wipe a brow or to pat an
arm or abdomen or to hold a hand. The dai talks to the woman in labour and there is some eye contact. Then the baby is delivered, and cared for and the birth process is completed.

b) Physical intervention is used in a normal birthing situation. This includes applying oil to the birth canal, internal examination and massage of the arms, legs, abdomen and stroking a hand or arm and perhaps rubbing the abdomen with oil. Verbal instruction is given (birthing talk) and eye contact is made frequently. Then the baby is delivered, and cared for and the birth process is completed.

c) Passive non-intervention is used, the mother receiving no physical attention except occasional eye contact and verbal reassurance. During the last stage the baby is actually delivered by the dai taking hold of the head and then the body of the baby and the birthing is completed.

d) Interventions of types (a) and (b) are combined and perhaps a second woman is helping with care and with verbal moral support, and with eye contact, or by offering her hand for support, or she has the parturient woman’s head in her lap, or the parturient woman leans against the back of the helping person, or the dai or her assistant has her feet against the vaginal orifice as the child is about to be delivered. Or, alternatively, the woman pulls against the legs of a bed, or a rope from the rafters.

It is my impression that in Nasavu and in North Indian communities generally, intervention took the form of (a) or of (c). Several dais said they stayed with the mother, but since they were usually summoned only once the labour was well under-way, they had work to do to prepare for the birth so they could not always just sit with the mother and wait. The mother of the pregnant woman or some other relatives would assess how long it would be before she would deliver, and then they would send for the dai.

It is my impression also that in Nasavu, among the North Indians the dai did not intervene to the same extent that the South Indians in Solevu did. Childbirth was treated as
something which could occur unassisted unless it was prolonged and difficult, except for moral
support such as touching and patting or stroking, by the dai in Nasavu. I was told that many
times two dais travelled together and one attended to the birth, getting the cloths, and everything
ready, while the other provided moral support such as words of encouragement and massaging
legs and arms. Most often, a senior woman from the family and a dai would stay with the
pregnant woman throughout the labour and delivery. North Indians appear to be more reluctant
to turn over the care and custody of the pregnant woman to a dai, but they rarely had more than
one woman relative stay during the delivery. The immediate support group during the birthing
was made up of the dai and perhaps one other woman. Other women in the house would prepare
the beverages or would go about the household work as they waited.

During pregnancy, as with menarche, there are some cultural differences in responses
to these physiological events and in attitudes towards them. They are apparent in the
descriptions I have of the actual sequence of events which comprise the process of birthing in
several Indo-Fijian cultural groups.

While I did not have the opportunity to observe dai-assisted home births (since they are
now infrequent), I have numerous accounts which were given to me describing the process or
certain aspects of a process about which I inquired.

In Nasavu only one dai, a North Indian, was available for comment during my fieldwork.
She delivers the children of her own daughters-in-law at home since they are afraid of hospital
deliveries. When I inquired why, she told me how her daughter-in-law had problems with
bleeding when she was carrying the child during her first pregnancy; later, during the hospital
delivery, the doctor had used forceps on the child and the baby had died. While she did not say
that the cause of death was the forcep delivery, she implied it. (Her comments about hospital
deliveries will be discussed later in this thesis.)
I asked her if she had ever had a problem while delivering a baby. This is what she told me. She had once had difficulty delivering a baby, a breech presentation, the legs came out slowly; as she pressed the woman's body the legs came out and then the arms, and she indicated how, by having both of her own arms bent at the elbows to the chest, with fists closed. Then the head was stuck but then the tharde (beard - meaning chin) appeared and she helped it to come out deri, deri (slowly, slowly). The mother was safely delivered of a healthy baby.

In this case, since it was a dire necessity, the dai served an interventionist role and assisted with the birth itself. I was told by another North Indian dai that she did not intervene, it happened by itself when the time came, and she assisted by giving words of advice to encourage (himat) with the actual birth. This seems to have been the general trend with North Indian dais.

Now, having presented a preliminary analysis of some of the features of pregnancy and birthing with regard to North Indians, I present examples describing these processes and interactions amongst the Muslims and South Indians.

J., aged forty-four years from Solevu, a cane growing area, told me that all of her children were born at home, with the aid of the traditional midwife or dai. Recall that Indian women usually go to their parental home to deliver their babies. During this time they are relieved of household and heavy cultivating chores. They can interact more freely, with the people of their own area, and they have the chance to visit childhood friends and relatives.

She told me that she went home one month before her baby was due; her mother who was a dai, examined her. When the labour began, her mother made hot coriander (dhaniva) tea (without milk or sugar) for her. Her mother then prepared a place for her on the floor near the foot of the bed. Then she placed a mat and three pillows on the floor and covered them with a plastic sheet, and covered that with a cloth. When the pains began J. laid down on the place prepared for her and could hold onto the legs of the bed behind her. When the strong contractions began, J.'s mother sat at her feet with her back against the wall and put her bare feet on either
side of the birth canal and helped to push and soon the baby's head appeared and the child was born.

Her mother then first washed the baby's face and then she shook it to make it cry. Then she told J. to push the end of her braid of hair down her throat to make herself gag so the placenta would be delivered. Once it was delivered, the dai lightly rolled it with her foot, until the baby started to cry (breath). The dai put the razor into warm water and then into a mixture of hot water and spirits. After that she felt it was sufficiently clean and she cut the cord about one hand's width and two finger lengths away from the baby. She tied the cord with a white cotton thread. Then the baby was wrapped and taken to the bath and the cord was treated with spirits.

Once the child and the mother had been attended to, the dai took the soiled cloth with the placenta in it and placed a two-cent piece in it, then she buried the bundle outside. She could not tell me why the coin was put in, but just said that is the way they do it.

When I asked J. to compare home births with hospital births, she was thoughtful and then replied, “it is better at home, you get a warm bath and get to drink sront.” She said at the hospital she could rest and sleep and had the use of an indoor toilet, but she could not have a bath after the delivery. At home on the other hand, she had to return to work soon after the birth. Still she preferred the home birth.

Most Indian women look forward to the post-partum phase of the birth when they are given achā khānna (good foods) and the sront drink (described in footnote 3) which most Indian women are given for a few weeks post-partum. J. also told me:

At home you get to wash your hair after three days and you get to seka (warm yourself)--you take some hot charcoals and put a handful of jawain over them, then you stand over the coals, covered with a cloth. If you do this you won't get the cold sickness (tundi bimari - rheumatism). You first tie a cloth around your head and then you warm yourself over the coals and then go to bed. For twelve days you take the heat treatment - if you do this you will sweat a lot.
The process of warming oneself over the coals is referred to as *sake* which means "to warm". Spices are added to make an aromatic and cleansing heat to counteract the pollution of pregnancy and the coldness of the body due to loss of blood during the birth. In some cases the mother and the infant were treated to the *sake*.

Then she went on to tell me about the foods which were prescribed and proscribed during the post-partum phase:

...do not eat *matar ki dal* (a soup made from split peas), but you can eat *dal* made from *harar* (pigeon peas). Also, tinned sardines are good to eat - you put two tablespoons of *ghee* (home-made) in your rice and *dal*, and add sardines. You must finish eating all of it even if you have had enough. Then at one o'clock take a bowl of cocoa and a boiled egg.

She then told me that the *dal* massaged the mother and child every afternoon at about four o'clock. She put oil on the vaginal orifice and pushed hard with her fist three times to make it return to the former size and shape. This treatment was carried out everyday for more than a week. J. was treated and cared for by her mother. She said the *dais* usually charge a total of about one hundred dollars to attend the mother during the post-partum phase; twenty dollars for the delivery and then two dollars a day for the massage. The charge for washing the sheets and clothes after the delivery was five dollars.

In this example and in the following one, the *dal* was in no hurry to cut the cord after the birth, and in fact waited to do so. Before she did she rolled the placenta with her foot. The practice of waiting to cut the cord and of rolling it seems to be unusual; however its value is noted by McLean (1951:136):

Delay in cutting the cord, however, has been demonstrated to add an appreciable amount of iron to the baby’s store by favouring maximal drainage of blood from the placenta into the baby’s body.

In this next example, the birthing process is identical to that described by J. above so I will not repeat the whole process but will bring out only those parts which differ. It is the "story" of R., born in 1948 and mother of four children, all born at the home of her mother who
was a dai. R. recalled that after the birth, the baby was bathed, then the dai bottle fed the child with glucose and water. After the third day the baby was allowed to nurse. In this case, the child did not receive the colostrum which is present in the breast fluids during the first two or three days.

After the birth, her mother sponged her body with a cloth, gave her coffee to drink and told her to rest, while she did the wash. On the first day there was no massage, but after that, for 15 days the dai massaged her arms, legs, back and head with mustard oil. When I asked her if she had any heat treatment, she described the after care process as follows:

First have a bath with water boiled with guava, anado(?) and lemon leaves. Then take leaves out and bath with the water, also wash the hair with soap. Then heat the charcoals and ashes and take them from the chula (fireplace) and put them onto a plate. Put the plate on the ground on the floor of the house on a piece of wood and put the spices: jawain, and loban (a white powder of some type) onto the charcoals. Then put a blanket over your head and stand over the plate with one foot on either side. Warm yourself and then go to bed and rest. Every second day for fifteen days wash your hair.

With regard to her food regimen, she said: eat acha khanna (good foods) like chicken soup (unlike some of the other examples I have, she does not add brandy to her soup). Cold foods such as cucumber, or drinks taken cold from the refrigerator are not good. Eggplant is prohibited because Indo-Fijian women believe that it is transmitted through breast-milk and affects the healing of the baby’s cord, by introducing infection. Mutton and lamb chops are also not good for the pregnant woman but “warm foods” (garam chal), such as fish, harar dal, potatoes, eggs, bheji (a spinach-like green) and cabbage are all good foods for the woman who has just delivered a child. Massala (sometimes called sont) is also a good food.

In many instances in the settlements, where the houses are dispersed, a woman has found herself without aid or transport to get to a hospital in time for the birth, consequently the child is born at home. The case of D., a 38 year old woman of South Indian origin from Solevu, who is a dia herself, is an example. She told me that she was preparing to go to the hospital for
the delivery, when the pains started and they came every half-hour. No transport was available so she asked her brother's daughter to help her to prepare a bed on the floor. Then she sent her niece home. She had the child at home alone but did not cut the cord until her mother-in-law came and summoned the District Nurse to the settlement. After the nurse cut the cord, she gave D. an injection of an antibiotic. Immediately afterwards, D. got up and did her own work, bathing the baby and making the *sont* for herself. She said she felt quite fit to do so after the birth.

She too, talked of the "*echo* foods" which a new mother should take. She said,

...do not take fish, it is not good, the baby is *kacha* (raw) yet and so is the mother. Don't take eggplant either, the baby will get diarrhoea. Drink lots of water, the milk will then come down. Eat the *hacha* foods...don't eat goat meat or mutton either.

In most families the diet of the mother during the post-partum phase is supplemented with foods which are thought to be *garam* such as nuts, poultry, ghee, greens, eggs, dairy products, and some types of fish. Here again, my research reaches different conclusions than that of Morse (1983:291), who states: "The mother's diet does not contain any other nutritional supplements". It is a pan-Indian belief that the diet of a woman should be supplemented during pregnancy and especially during the post-partum phase. This is the case except in poor families who cannot afford the added expense, although even they attempt to provide the new mother with *sont*.

To return to D., she is a *dai*, and two of her children were born at home while two were born in the hospital. When she assists at a birth, she ties a cloth to the rafters for the mother to hold onto and to pull on. She told me that if there is *taklif* (discomfort) she gives the woman courage (*himat*) to help her to draw upon her own resources, but beyond that she does not help the mother physically during the birth. According to her, "if I do that I cannot do anything else - no I don't help".

Two older women who were present as I talked to D. remarked that the "first" people (early immigrants) actually assisted the mother. In those days the *dai* would set the bed in such
a position that she could sit with her back against the wall and place her feet on either side of the birth canal to assist in the delivery.

D. breast feeds her own children well into the second year. As a dai, she said that she gives the new born raw (unpasteurized) cow’s milk:

"I do not give the first watery milk from the mother to the baby, but I wash the woman’s breasts with warm water and the breast milk will come".

The older women described the process as follows:

The first three days don't give it (breast milk), after the third day wash the nipples because they are very dirty, wash well and squeeze out the watery fluid, then give the mother a complete bath, and wash her hair, and then sit her over the hot pan with jawain and garlic cloves chopped, then let her steam herself, then warm her hands and put the baby to her breast. A new mother should never try to feed her baby when she is cold herself. If she has just washed clothes, then she should first have a warm drink herself and warm herself otherwise the baby will get cold.

In most cases of South Indian birthing, the process was as I have described it above. Now, I present those South Indian examples which introduced slightly different steps in the process.

In the example of D, an older South Indian woman who has borne eight children, I was told that the dai not only tied a rope to the rafters for the pregnant woman to pull upon, but she also assisted in the actual birth with her hands. After the birth, the dai bound the stomach tightly with a cloth. She was the first woman to tell me of the terrible pain; most women never mentioned it. After the birth, for the first three days, the infant was not given the watery fluid (colostrum), but was fed with warm water or with one feeding of cow’s milk a day and two of warm water. The new mother had a diet of garam (warm foods) and satt to induce lactation.

Many South Indian dais tied a rope to the rafters as a support for the parturient woman. The custom of binding the abdomen also occurs among the South Indians whereas my North Indian informants said they did not use the practice. M. Nichter and M. Nichter (1983:238) in their work on South India state:
The custom of stomach binding after delivery practised by some women reflects the association of baby space and stomach space. If the stomach is not bound it is thought that after the delivery a lot of room will remain in the stomach requiring much rice to fill it. Many women noted that the "more space" occupied by other substances, the "less space" the baby would have in which to grow.

Thus far in these pages I have not discussed the Indian conception of female anatomy, nor do I have sufficient data to do the subject justice. Nevertheless, Nichter and Nichter point out that the South Indian conception of anatomy has a direct link with notions about the diet of the pregnant woman and with consequent baby size at birth. The belief that food and baby compete for the same space may determine the amount of food ingested by the mother at any one sitting. Such ideas about anatomy could be related to the high incidence of low birth weight babies which occur in Fiji as well. (For instance, in 1985 in Annual Report for the Western Division hospital of Lautoka, 2356 births were recorded to Indians, of which 368 were registered as low birthweight (i.e. from 1 Kg. to 2-1/2 Kg.) as compared to 1131 births recorded for Fijians of which 51 were low birthweight. The figures are representative for Sigatoka, which is in the Western Division.)

In my research, I note that the general term for abdomen is pate and for the womb seems to be potnar. Many women however have taken on the terminology from the Western biomedical system and refer to the womb as the "baby bag", the vagina as the "baby passage". The link between procreation and conception was described to me by one orjah as she interpreted the dore (string configuration) in the case of a woman who could not conceive: she showed me how certain strands came together into twisted braids in a "C" shape which she called the potnar (womb). Another single twisted braid-type of single loop was at an odd angle from the "C" shape. This she said was the "baby pump" which was unable to reach the potnar. With this simple explanatory model she was able to show the woman why she had to go to the dai to have massage treatments to have the potnar placed at a different angle so that conception could take place.
Now, in this final example an old dai (C.) in Solevu settlement told how a part of her intervention in the birth process was that she would put castor oil on her hands and also on the birth canal of the parturient woman when the baby was ready to come. She also massaged the mother's abdomen with oil. When the baby came she cut the cord with a razor blade that had been boiled. She put spirits on the blade before she used it, cutting the cord a good index finger length. Afterwards, she cleaned the baby; and then wrapped the placenta in a cloth and buried it outside the house. Then she bound the abdomen of the mother with a band. About breastfeeding practices, G. said that the breasts are washed and massaged with castor oil, the first day and then she squeezed the watery milk out and gave it to the baby. She did not wait until the third day to allow breastfeeding as many other daís did. (By doing this she allowed the infant to ingest the colostrum which confers immunological protection on the child.) The massage treatments did not begin until the third day, and then continued for nine days in all, when the family had the ritual (chetti) for the baby. In this case, then, we see that the patterns and processes of birthing and aftercare within an ethnic group could be quite varied and were often idiosyncratic to daís. In the main however, there was a fair degree of standardization about the processes in any one group.

At the beginning of this section on pregnancy, I began by outlining the simple questions which directed this work and which would help to make clear the processes and interactions that surround conception, pregnancy, birthing and post-partum care in the context of the Indo-Fijians. Now, I attempt to summarize first the general or broad similarities in the birthing process, between the various cultural groups which make up the general category, Indo-Fijians. One of the fundamental principles which underlie the culture of Indians in Fiji is that of caste and of the concepts of purity and pollution.

My observations above note that caste observances have been retained in Fiji and they are made apparent as we rediscover them by focusing on the interactions of people in such roles
as that of the dai, traditionally a lower caste occupational group; and the pandits or brahmins, the priestly group. As I note above, there are certain aspects of the dai's work which a pandit woman will not perform because they are polluting. By examining the roles, processes and interactions, we can make apparent how caste has changed, the spheres of life in which it has been retained, or if it has been dispensed with altogether. By focusing on interactions and processes in this way I have been able to discover the extent to which fundamental changes have occurred to some of the basic principles in Indian life in Fiji. Simply, I have found that caste observances exist today in Fiji, with regard to ideas about pollution during menstruation and pregnancy, in attenuated forms.

The North Indians, South Indians and Muslims, all utilize the dai as the midwife, in the traditional form of home birthing. Dais usually, learned their calling from their mothers through observation and by assisting. I have made the argument that all dais intervene in the birthing process, and have provided a framework above to enable the distinction between five levels of intervention. This is on the firm belief through my interviews that the dais are usually sympathetic and empathetic individuals who see their own role as one of providing care and moral support through verbal, physical and symbolic means. A dai prepares the birthing space, the items for use in the process; and she guides the birthing process, physically and through instruction and guidance. During the post-partum phase, she prepares the mother for breastfeeding and looks after the mother and child. She is often responsible for the feeding and the physical needs of the mother and child. She intervenes and mediates the whole process of birthing. Having said this, now I show that each of the cultural groups can be shown to have a different type and degree of intervention. This is a basic difference and it relates to the differences which I located in the process of menarche.

I noted above that most dais do at the very least some minimal internal examination, even if often it is just by sight. I think that the dai in the North Indian group intervenes more
through verbal/symbolic means; whereas the South Indian dai appears to intervene through both verbal and physical means such as more preparation of the perineum, more active assistance during the birth, by providing her own body as a leverage, or by providing ropes from the rafter, for the birthing mother, as well as through massage. I have noted here that there are differences in the birthing process as it is conducted by different cultural groups which make up the Indo-Fijians in the settlements which I studied in Fiji. These comments are offered as hypotheses for future research and not as definitive statements arising out of this research.

I noted that in the Indo-Fijian culture, the ideal is that a woman conceive within two to three years of her marriage. If she does not conceive, it is considered a misfortune. Women go to great lengths to seek treatment from many types of traditional practitioners from orijahs, to vaidyas, to pujaris and pandits, as well as dais. The order of seeking treatment is not as important as the fact that the family group muster their forces to seek treatment and they make certain choices and decisions depending on the structural position of the couple in the family, their caste and other considerations such as cost, time involved, as well as region and proximity to healers. Fear of examination and medical facilities, differences in world view and lack of faith, are all factors which influence choice of therapy, and distances Indo-Fijians from some therapeutic choices, while orienting them to others.

Once a woman conceives, since pregnancy is not thought of as an illness, a woman’s usual work routines persist. Because people in the area under study are both market vegetable growers and cane farmers, the labour of women in the household makes up a large portion of the yearly farm labour requirement. And since most farms cannot afford to dispense with the labour of one person, women continue to work on the farm and with their household tasks until late into the pregnancy. The exception is in the case of first pregnancy. This work pattern along with a diet low in the necessary constituents for a healthy pregnancy can result in
complications of pregnancy such as maternal anaemias (10 gms. and under), in low birth weight babies and in some cases of pre-eclamptic toxemia.

An Indo-Fijian woman's diet is supplemented during the post-partum period when special attention is paid to maintaining a balanced diet in terms of the hot/cold idiom based on the Indian humoral system. Women are given sorg, to induce lactation.

As a general rule, Indo-Fijians did not feed colostrum to babies; to prevent its ingestion, babies were withheld from the breast until the third day. During the first few days, they were given water and sometimes diluted cow's milk, or more recently, glucose and water.

Current breastfeeding practices reflect major changes in attitudes in the process, with many of the new ideas coming from the Western biomedical practices and influences related to industrialization and new economic structures. Early severage of breastfeeding is one outcome of these changes in Fiji. As van Esterik (1984) states, there are two models for breastfeeding styles, that of breastfeeding as a process or of breastmilk as a product. Mothers in Fiji appear to be making the transition to the later model which has serious implications for the nutritional status of the infant.

In this chapter, my emphasis has been on showing the processes and interactions relating to menarche, conception and pregnancy, birthing and post-partum care. These processes and interactions have been related to the specific questions posed at the outset of each section and to the three general questions for the chapter as a whole.

I have shown the actors involved in each process, and the activities involved in it, as well as the implications of them for the choices and decisions surrounding the processes. I have also remarked on the relationship of the processes to the social structure and social organization, in the general discussion in the relevant sections of the chapter. Throughout, I have focused on examining the traditional medical system regarding these processes in the lives of the Indo-Fijians.
Now, one final task remains, that of linking the empirical data to Moore's (1978) framework. In the chapter I have shown that the birthing complex is a "process of regularization". Births are primarily "regulated" situations, with women serving as dais in traditional roles or occupations (once caste-linked); and in the role of parturient woman and a therapy management unit, usually consisting of her lineal kinswomen. These were "...durable social and symbolic orders" (Moore: 1978:6), which Indo-Fijians consciously reproduced or maintained, and which were linked with other belief systems such as religion, caste, purity and pollution, as well as concepts of wellness and the hot/cold food complex. She states that "...existing orders are endlessly vulnerable to being unmade, remade, and transformed, and that even maintaining and reproducing themselves, staying as they are, should be seen as a process" (Ibid:6).

The situation of barrenness however, is a factor of indeterminacy in so far as it creates structural conflicts and problems which must be resolved through processes of transaction during therapy management. I have shown how Indo-Fijians exploit or use every possible strategy in the process of securing a 'cure'. They even adopt therapeutics from the medical systems of other ethnic groups in their midst. Their exchanges and transactions depict "processes of situational adjustment".
Footnotes:

1 Professor Belshaw states this is also a common Fijian response (personal communication, 1987).

2 My observations in the settlements were confirmed by the Sister-in-Charge at the Sub-divisional hospital where I was a research associate.

3 Sont is a drink which Indo-Fijians use to induce lactation. I was told it consists of hot milk with the following spices: jeera, peepul harar, mauri, ginger, methi and mangarel. The spices are first fried in ghi (clarified butter). There is considerable variety in the ingredients a family will use for sont. Poor families use fewer spices.

My list is similar to that of Janice M. Morse (1984:291), who states sont "Contains milk, dry ginger (zingiber officinale Rosc.), ghee (clarified butter), mangarel (nigella L. Sp.), harræ (glycyrrhiza L. Sp.), peeper (piper nigrum L.), Jeene (Cuminum Cyminum L.), and methi (Trigonella Foenum-graecum Linn.)." I do not know the Latin term for mauri in my list.

4 See O'Flaherty (1980) for an interesting discussion on Vedic and Post-Vedic notions about bodily fluids. She discusses the transformation of menstrual blood into breast milk. Interestingly, she also states that the pollution of menstruation is removed after the third day with the ritual bath. This, even though the menstrual cycle itself may last four or five days.

Here, the fluids from the breast for the first three days are considered polluting or unclean and Indians do not usually want to feed colostrum to the newborn, but wait until after the third day to put the infant to the breast.

5 Personal communication, Dr. B. to me at the Annual General Meeting of Obstetrics and Gynaecology, 1986, in Lautoka.

6 These data contradict Morse's (1981:90-92) work. She states "the dai's role is mostly one of passive non-intervention, watching and waiting." Indo-Fijian dais distinguished many forms of intervention and they were warm and caring, prior to and during birthing and were especially solicitous of the mother and child for the week to ten days post-partum.
Chapter 9

CONCEPTUAL OVERVIEW OF THE TRADITIONAL PROCESSES OF HEALING

In the prologue to Part II I stated that I will examine the processes and interactions in the traditional health care system of the Indo-Fijians. I wrote that my research into the available literature in Fiji showed that in the early days of this century there were few religious or medical practitioners or in fact literate people among the indentured people from India. Now, having examined the medical beliefs and practices in two Indo-Fijian settlements, I present a conceptual overview of the traditional medical system that is utilized by the Indo-Fijians, based on my discovery of their concepts of health, prophylaxis and curing.

Together with the meanings and explanations Indo-Fijians have about their experience of the most anxiety producing aspects of life, sickness and sudden or unexplainable deaths, the interactions and processes involved in diagnosis and seeking therapy reveal the traditional or folk aspects of the overall socio-medical framework of beliefs and practices utilized by Indo-Fijians.

I stated above that the traditional medical system of the Indo-Fijians has only a tenuous relationship to ayurvedic principles and is not analogous to the professionalized medical systems (Ayurveda, Siddi or Unani) of India. My examination of, and search for, “the traditional”
medical system of the Indo-Fijians in many ways parallels the findings of Belshaw (1964) as he analyzed and sought to describe the traditional religious system of the Fijians in the same region of Fiji:

To describe the traditional religious system on the basis of contemporary practice and belief would be highly inaccurate and misleading, since various elements in it are followed by different individuals and groups without formal system or consistency, largely because of the confused state following the injection of Christianity. What follows, then, is not an account of a traditional system, but a statement of more or less consistent elements derived from a traditional background. (Belshaw, 1964:182).

The Indo-Fijian healing system which I will continue to call the traditional one, is similarly made up of elements borrowed from the folk traditions from many regions of India. Their socio-medical framework of beliefs and practices is made up of ancient Indian philosophic, yogic and religious beliefs; and other more recent syncretic beliefs, derived from contact with Fijians and Europeans during and since the time of indenture.

The average Indo-Fijian lay person has little knowledge of the background assumptions which inform the principles involved in the humoral theory of bodily processes. In spite of that, they do have a rudimentary understanding of the hot/cold idiom; and the elders and middle-aged people today use it in their daily practices.

In India, Ayurveda, the Sanskritc theory of Indian medicine, and Brahmanic ideals are closely related. Wherever Brahminism is a strong force, the lay person's knowledge of Ayurveda is more comprehensive and is used in healing along with folk remedies. As Obeyesekere (1977:155) observes, the philosophical assumptions of Ayurveda "are derived from Samkaya, one of the six orthodox systems of Indian Philosophy". Thus Brahmins as a caste are philosophically supportive of ancient Ayurvedic principles, and they give support to both the theory and its practitioners.

As well as Ayurvedic and biomedical physicians who are registered full-time practitioners, throughout India there are a vast number of folk therapy systems. In most of
these the roles are performed by part-time practitioners who combine religious and other indigenous forms of healing, forming a continuum from registered physicians of professional medical systems to religious healers, maulvis, to mystical and astrological healers to itinerant sadhus (holy men) and secular healers (midwives and lay people).

The traditional medical system in Fiji has its counterparts to these roles. The link to Ayurveda, provided in India by the Brahmins who are specialists with knowledge of the Sanskrit base of Indian philosophy (which includes medical practices), is almost non-existent in Fiji. There are no professional schools of Indian ayurvedic medicine, and there were no practicing ayurvedic physicians in the area of this fieldwork. In Fiji Brahmanic textual knowledge is limited to a very few specialists, and that concerned with the vedic medicinal sources is said by my informants to be quite absent. Brahmanic healing (i.e. by pandits) is primarily reserved for astrological consultation about illness, divination about the future, and for healing by propitiating particular deities during home-based rituals. Pandits are also the only healers who cure peri or “yellow fever”.

Amongst the healers, only one was referred to as a vaidya (ayurvedic practitioner) by a few of his patients; others said he was actually an orijah. Although he knew Hindi and could read the texts, his understanding and application of ayurvedic principles was very minimal even in his own estimation (personal communication). He had acquired a good knowledge of herbology from his father who was from India, and from Fijian healers. In his healing he used Hindu prayer, and yogic principles of meditation, and magical words (mantra). He was a charismatic type of healer and at times had a following of hundreds of people who lined up to be touched and healed by him. Since his death in May 1986, no one has replaced him in the area where he practiced.
The orijahs cure demonic possession, illnesses with other types of supernatural causation, and behavioural disorders some of which arise out of problems in social relationships. They are known to resort to sorcery as well. There is no special training for orijahs in Fiji. Most of these healers are self-trained, motivated by their own inner drives and perceptions of psychic awareness and control. Usually, they profess to have religious rather than magical power.

The pujari in Fiji heals at the temples through religious possession and ecstatic types of healing processes. He focuses on the illnesses caused by gods or goddesses, which are cured by devotion to specific deities in the religious pantheon. Measles and chickenpox are in this category. Pujaris do not have the same degree of formal training as the pandits have. Their roles are involved with functions (including healing) primarily at the Hindu temples. An important discovery of this fieldwork is the fact of the syncretic use of the Fijian vagona complex (which turn the purity and pollution beliefs upside down), as well as the use of the Fijian God. If therapeutically effective, can worship be far behind? Perhaps, Hinduism continues to be a syncretic religion, one reason for its continued existence over the millennia.

The maulvi, too is a magico-religious healer, but unlike the orijah, he is supported by the Muslim religious tradition. He heals a wide range of illnesses, possession types, as well as those of physiological or psychological causation. His training is based in Islamic religion and is derived through texts and religious instruction. His prestige derives from his interpretation of these texts, from going on pilgrimage to Mecca and Medina, and from his healing power.

Within the traditional sector in Fiji there are behaviour patterns based on self-treatment, and home remedies which use elements of folk medical traditions from various parts of India. Indo-Fijians also rely on commercial preparations from the biomedical sector (Vicks, Asproclear, Panadol, etc.). There is also widespread use of other folk practitioners
whose knowledge is often illness-specific. For example, the dai in the settlements attends to pregnancy, birthing, and post-partum care of women. She also attends to other physiological concerns of women, massage types of treatments, and a few children’s ailments. Traditionally, the role of the dai was the caste occupation of lower caste women who removed the pollution of menstruation and childbirth.

In Fiji, the health care system used by Indo-Fijians is an emergent one inasmuch as new elements from India are added as new migrants come from India. This is especially the case with Gujerati people who as merchants, import therapeutic supplies. They are also the traditionalists among the Indians, since they arrive from India today already socialized in the Indian belief systems. The Indo-Fijians try to emulate their ways.

The system is emergent in other ways too, it is syncretic and "borrows" ideas from other ethnic groups as well as from within its own cultural group. Recently, a Fijian charismatic healer attracted hundreds of people to a beach near Nadi. He claimed he received power from a golden cowrie shell which he found on the sands nearby. The cowrie spoke to him, and told the Fijian man that he had the power to heal, it could not be transferred and he would have the gift for a only a very short time. People flocked from all over Fiji, at great expense and inconvenience, to find this healer. Among the patients were Indo-Fijians seeking cures for chronic conditions, for paralysis, for terminal illness, and for many other types of ailments.

I, along with several hundred other people, observed the Fijian man’s healing, and we waited hoping to see the miraculous cures we had been told to expect. One patient was an Indian lad of about seventeen years of age, a cripple. The healer asked him to lie down on a cot; then he struck him over and over with a steel rod. As the spastic boy cringed and whined, the people watching laughed nervously. There was no instant improvement but the Fijian man said the boy would be completely healed in time. The week before our visit to the healing site on the beach,
the people accompanying us had brought a relative crippled with arthritis to be healed; they claimed their relative's condition was vastly improved and seemed to be steadily improving afterwards. This healer had a large tent where he consulted with women patients unobserved by the men in the crowd.

At the same time that Indo-Fijians are incorporating healing from other systems and their medical system seems to be transitional or syncretic (and emergent), there is an explanatory system (or a paradigm or model), of traditional medical practices which the Indo-Fijians employ. (As Moore (1978) states, the "process of reglementation" provides continuity [in the form of following established medical processes] at the same time that change or "situational adjustment" [in the form of incorporation of new elements or medical practices] is occurring.)

The traditional process of healing is composed of a) the experience of ill health or disease by the patient, b) recourse first to consultation within the household (the therapy management group) to evaluate options and choices in diagnosis and to therapeutics. Indo-Fijians also evaluate the condition of the patient and the circumstances surrounding the illness. Thus, one of the early tasks of the therapy management group is to legitimate the illness, the patient role, and to provide some form of home remedy or at least comforting care.

If the illness continues, c) a subsequent or concurrent decision is taken to consult the appropriate medical practitioner. In such cases, d) if the illness is not cured, further therapy is undertaken by the patient in consultation with the family, neighbours and other relatives.

From the lay perspective, Indo-Fijians distinguish between several forms of disease. First, those which have natural causes (they happen quiderti [naturally]), colds, fevers of short duration, rheumatism, some chronic aches and pains, minor accidents, rashes and other illnesses (listed in Table 5.1 in Chapter 5) are among those treated with home remedies. If
these worsen, then as a first choice the family doctor is often consulted. Chronic pain suffered by the elderly is frequently ignored except for simple attention such as applying heat. Many people in the settlements believe that the elderly do have pains, but they regard them as the natural outcome of old age, and to be suffered. The elderly are not treated to therapy in the same way as younger people are, and they rely to a great extent on the local healers, who are less costly than doctors, and live nearby where they are readily available.

Amongst Indo-Fijians, pregnancy is thought of as a natural stage in the life of a woman. Consequently women do not receive special medical attention even though the procreative function is one of the major values of women in a patrilineal society. Most families express happiness and caring when a woman conceives and many prescriptions and proscriptions exist regarding diet and rest. But they are not “therapy”, as much as a holistic response to a life cycle circumstance, a natural event.

An Indo-Fijian woman who missed several periods, consulted a midwife. But secondary amenorrhea was not unusual among Indo-Fijian women. The stress of going to live among a set of strangers, diet low in protein, iron deficiency and work on farms combined with strenuous household chores, often resulted in missed periods. A dai was sometimes consulted if the woman suffered some discomfort, and in many cases, the massage treatment revealed that the woman was pregnant. In other instances, the daís treatments were continued, and often a woman was given a healing thread (a doré) to wear, to heal and to protect her from negative influences in her environment.

During pregnancy, birthing and post-partum, a woman experiences affection and caring from her families (patrilineal and affinal). During the birth, I have shown that there appears to be a difference between cultural groups as to the degree of intervention by a dai in the birth process. The interactions and processes reveal not a lack of caring and support, but different
cultural styles of interaction and expectation. It is my impression that North Indian and Muslim styles of interaction are more similar, and that South Indian styles differ from them. The South Indian interactions were more demonstrative in their interventions and aftercare more ritualized. But this is a preliminary statement which requires further research.

A second type of disease Indo-Fijians distinguished was the acute sudden illness, usually this too was a "natural-type" of disease. Most of the families with whom I talked, had a 'family doctor' (a private doctor) in the town, or at least knew that a doctor could be consulted in the Outpatient's Department at Sigatoka District Hospital for acute illnesses, serious accident or injury, or self-inflicted injury.

Indo-Fijians located the cause of natural illnesses in stresses or imbalances of the body resulting from poor observance of dietary rules (the hot/cold idiom), lack of rest or sleep, intoxicants, natural diseases of childhood or old age, poverty and poor living conditions. In other words, to remain tundroost, a person observed the necessary daily practices I have outlined in the chapters above.

Interestingly, my data show that the afflicted parts of the body, or the disease, treated in the Western Biomedical system were labelled with English names, i.e. "heart trouble", "sugar-ha" (diabetes). In a few instances, Indo-Fijian anatomical words (potnar) are explained by the doctor with simple English labels i.e. "baby bag", to stand for biomedical anatomical features i.e. uterus. I have shown, on the other hand, that the simple English labels, are becoming the medical terminology for traditional healers, thus expanding not only their language but also repertoire of illnesses treated and therapeutic techniques and medications used.

A third type of diseases distinguished by Indo-Fijians are in the magico-religious realm. Illnesses with supernatural causation such as evil spirits (hawa), ghosts (bhut, churel) are in this category. And others have a divine causation such as punishment for infringing the
moral and social order, for neglecting devotion to the gods; or illnesses due to bad karmic or astrological forces.

In order to treat these illnesses the patient and the therapy management group first attempt to locate the cause of the illness (i.e. evil eye, envy, spite, etc.) by reflecting on the recent circumstances which could have had a bearing on the health of the patient. Then they consult the appropriate healer. In this sense the management of these types of illnesses is healer-specific.

Consulting the appropriate healer is conditioned first, by identifying the type of illness. Second, people select the appropriate healer in whom they have faith. Appropriateness depends on the perceived etiology and faith depends on having communication with other people who can confirm (or deny, as the case may be) that the healer does have the knowledge to proficiently heal other similar cases.

Third, there are also a number of types of problem factors which must not be difficult to cross for a person to consult a healer. Physical or geographic distance to a healer can be a distancing feature in two ways. In the case of traditional healers, most Indo-Fijians consult healers in their own communities or nearby, who know the situation and the people involved in it, intimately. Often traditional healers have an archival sort of knowledge, combined with their ability to garner information and to use gossip and confidential materials without divulging the source. The origin of most illnesses which confront traditional healers is in problems arising out of discordant relationships. Therefore, such information is of great value in the analysis of the circumstances leading to the malady, as the healer attempts to work out a therapy satisfactory to the patient, and to the therapy management group.
But geographic proximity to a healer is a negative factor too, if one is attempting to harm someone else through sorcery. For that purpose, Indo-Fijians seek healers a great distance away in order to preserve the secrecy of their vengefulness.

Cultural differences are a fourth factor in how people define illness and where they seek therapy. I have shown that Indo-Fijian people seek therapy from both within and outside of their own communal (religious group). For instance the Indo-Fijians (North and South Hindus, Muslims, and Nepalese) in Solevu settlement consulted a Muslim Maulvi for the simple reason that he lived close by, so they did not have to travel out of the settlement for healing, a costly undertaking. But in other cases they have travelled far to find a healer of the “correct” group (i.e. a pujari instead of a maulvi).

Many of the religious healers themselves incorporate aspects of each other’s healing into their own healing repertoire. I showed that a Hindu pujari used Fijian ceremonial (the yaqona complex) and appealed to a Fijian god in his healing. A Hindu orijah (vaidya) used Fijian herbs, yogic traditions, as well as magical words (mantram). Some Hindu healers give the tabiz (amulets) thought to be from Muslim traditions by some Hindus, to their patients. All in all, there is a good deal of mixing of traditions. In their strictly religious observances however, Hindus and Muslim keep sharply within their own religious tradition. There seems to be less borrowing of cultural practices than there was during the early Indenture period.

As well as cultural differences, economic costs are a factor in the healing sought. Indo-Fijians think about the economic costs of transportation, of time lost from work, inconvenience to members of the family and friends, when they make decisions and choices about healing. Economic considerations determine who therapy is sought for, and the source it is sought from. Fees, the length of treatment, and the cost of ritual preparations are given careful consideration when people undertake certain types of therapy.
Other important elements in the decisions taken in the curing process are those such as the social role and gender of the person who is ill, ethnicity, the strength of his or her attachment to the traditional world-view, the education level of the group, and their knowledge of Brahmanic, Ayurvedic and other healing systems.

All of these processes and the interactions constitute the Indo-Fijian conceptual framework of traditional medical beliefs and practices. In the forgoing chapters, I have attempted to describe these in some detail.

The task still remains of deriving the model or overview of the traditional processes of healing. These are made up of a number of basic elements (or variables) such as the illness to be explained; and the various levels of causation such as social relationships, religious prescriptions and proscriptions, supernatural beliefs, environmental factors, hygienic practices, ancient beliefs, and social norms and their contravention. Each of these in turn has various valuations.

The explanatory model of the processes and interactions analogous to the Indo-Fijian conception of what constitutes their system of medical beliefs and practices is unique. Thus far, I have discussed only the traditional medical beliefs and practices. Nevertheless, I will make a beginning by presenting my abstractions from the data in Part II (later adding the findings from Part III), as basic postulates about good health, diagnosis causation, and decisions about the choice of healer and curing.

1. Indo-Fijians have an indigenous concept, tundroosti (or good health and well-being) which encodes the fundamental premises of the achievement and attainment of good health and of the prevention of illness. Thus we can say the system is fundamentally one that emphasizes prevention of ill health and is a holistic type of health ideology. The codification is elaborate and can be rigorous. The emphasis is on bodily cleanliness (inner and outer), on a homeostatic state
of the physical body achieved both through diet, and attention to mental or psychic states (at its most basic, the hot/cold idiom of the humoral system). Also, the fundamental premises for maintaining good health include a way of life that outlines the various stages of life, the role and gender of the person, contentment with one's station in life, and concordance in social relationships. All of this is related to ideas about purity and pollution which refract religious and social precepts into far reaching dimensions of the overall worldview of Indo-Fijians. Tundroosti then can be seen to be basic to social structure and social organization of Indo-Fijians.

2. Disjunctions in any of these areas can cause illness. Once a person experiences unwellness, then it is usual for him or her to manifest it in some way that signals the condition to others in the family who act as the therapy management group. This can be achieved by giving up the normal functions of his or her roles and taking on the role of the patient. (The patient role as manifested for the main types of ailments has been described in the forgoing chapters.) At this point the family responds. The decisions people make in the settlement of Nasavu or Solevu involve first treating the patient within the home with ghar dawai (home remedies - See Table 5.1, p. 93), especially for minor ailments such as headaches, common colds, etc. If the illness does not respond in the usual time frame for these self-limiting illnesses, then other members of the extended family within the compound are consulted. I found that people did not concern themselves much with causation for common ailments such as colds, coughs, etc. But once the illness became more serious and the patient was clearly not malingering, then people look for causation.

There is a wide range of ideas about causes of an illness. I have discussed them at length in preceding pages so it is unnecessary to mention them here except in a very summary form. (They will be discussed also in Chapter 17, the conclusion.) Causes may have to do with
disruptions in social relationships, in religious and supernatural spheres, in purely physical aspects as in the case of menarche and pregnancy, in environmental causes, or in accidents.

Causation can be a result of neglect of bodily processes, discordance in social processes, or misuse of power in supernatural processes. Environment is also a factor in illness.

3. Once the therapy management group decide upon the probable cause, its members select the most appropriate recourse to therapy; that is whether to consult with one type of healer alone, or with a number of healers concurrently. Most families usually decide to take the patient to a doctor at the hospital or to a private doctor in the town before they seek other therapies. Concurrently, or just afterwards, if they suspect that the illness could have been caused by sorcery, or possession by hawa or other evil spirits, one of the healers such as the orijah is consulted to treat the illness. Alternatively, if the family decides the illness was caused by gods or demons, then the pujari is consulted at one of the Hindu temples. In the case of the latter two healers, a family can diagnose the illness by certain behaviours or from the patient's self-diagnosis. Or, if a family is unsure about diagnosis, they will consult an orijah and pujari in order to "hedge their bets". In the case of an illness such as peri or "yellow fever", illnesses which have obvious symptoms such as jaundice, they will consult a pandit. When Indo-Fijians believe astrological forces (graha) are responsible for illness or bad luck, they consult a pandit, who reads the astrological charts in special texts and advises the family about the actions they need to take in the situation.

The important point is that the decision as to which healer to consult is based on many factors. At times the choice of healer is limited because some conditions and illnesses can only be attended to by certain types of healer. For example only a dai is consulted by pregnant women and women with other problems of female physiology. Other illnesses which are healer specific are peri, and grahes (healed by pandits), hawa and similar ailments with supernatural
causation (healed by pujar is and orjahs). Indo-Fijians always treat acute illnesses by consulting a family physician, or by going to the Outpatients' Department at the hospital. They may later also seek additional surety by going to one of the traditional healers.

Gender also influences the type of healing that will be attempted. A woman cannot easily assume the patient role because her duties as wife, mother, daughter-in-law, and farm labourer prevent her from being away for more than a few days at a time. That is why many of the pregnant women I interviewed did not easily give up the month they could spend at their natal home prior to delivery of a child. It was the only time a woman could legitimately take more than a day or two off, unless she was critically ill, or suffered from an illness in the psychological domain, such that she was possessed by a supernatural force.

A curious fact of gender in India is that women more often rely on home remedies, and consult local traditional healers who are cheaper and in the immediate locale; while men or young boys are taken to doctors and to hospitals for treatment which is more expensive (Kirkpatrick, 1979). This is not the case in Fiji, where women make up a large percentage of the patient population at both the local healers and the hospital.

I have discussed the process of menarche in these chapters on traditional health care because Indo-Fijians say it is bimari. The ways in which various cultural groups within the Indo-Fijian culture treat the onset of menarche has been treated in enough detail that little further comment is needed here.

In summary, most people in the area where this research was done relied first on their family physician, especially for treatment of any acute illness. Concurrently many people would consult a traditional healer just to be sure they were not overlooking that aspect of therapy. For other illnesses they were extremely flexible in their choice of healer, and often consulted more than one healer at a time.
Although in some chapters I have been able to show how some cultural groups have responded differently to some circumstances (i.e. onset of menarche, and pregnancy) based on differences in social structure and social organization, this does not hold entirely true when we consider how people choose healers. **First** and foremost, in all cultural groups the choice of healer is usually based on the family’s diagnosis of the illness and if the illness is healer-specific. Acute illness is always treated by consulting a doctor. I have discussed the illnesses treated by specific traditional healers above. **Second**, therapy is also based on proximity, cost and other practical considerations such as empathetic, behavioural and personal or interactive characteristics of the healer. Was he or she trustworthy, and would the healer keep the illness and treatment confidential? Basically, did the familial group seeking healing have faith in the healer? People rely on common knowledge of past experiences of the healer’s knowledge and ability to handle different kinds of natural and supernatural powers. If Indo-Fijians do not trust a local healer, they go to great distances to consult another healer in whom they do have faith. In cases of sorcery, people went to distant healers (or sorcerers) in order to preserve secrecy.

Many people went to the doctor for injections, or tablets and at the same time to the maulvi or the orjah for tabiz or dore. For many chronic illnesses, especially of the aged, or in the case of terminal illnesses, there was no one hierarchical way in which people resorted to healing and cure. If one type was not efficacious within a certain time, then the patient went to another healer. Time was an important factor in healing. Nor were people hesitant to utilize multiple therapy systems or to consult healers from different religious traditions or ethnic groups than their own. This was common practice.

In this thesis I am not analyzing caste in Fiji although it is an element which in some ways affects Indo-Fijian healing practices, I mention just a few of these factors next, because in
some ways caste affects decisions and choices made by Indo-Fijians and cannot be dismissed.

In Fiji, I found that people thought that the cure of some ailments was the work of a specialized role incumbent, often of a specific caste group. The daei for instance was usually from a lower caste whose duty until quite recently was to a) assist a girl at the onset of menstruation, in the case of South Indians; and b) generally assist in the birthing process, dispose of the impurities of birthing, and to attend to the complete post-natal care of the mother and child.

At the same time, Indo-Fijians said that when the need arose in the settlements and there was no daei, or one was not available, women helped women during the entire birthing process irrespective of most aspects of caste except for cleaning the mother and child after the birth. These aspects relate to Indic ideas about purity and pollution. Brahmin women especially, would assist in a birth if necessary, but observed the purity and pollution aspects. Other people were not as particular, they did what had to be done in such cases. Today, most births are at the hospital, but if a woman's labour begins and transportation is not available, many women are still competent helpers, although they are not trained as daeis.

In the same way, the pandits and pujaris too have caste related duties. As incumbents of their roles, they perform specific duties related to health care. Purity and pollution observances are central to their functions as religious priests and cannot be separated out in the case of the therapy they provide.

Maulvis, and ajrabs do not belong to specific caste groups. The processes and interactions they engage in however show that they too, heal only a small group of specific types of illnesses. I have discussed these healers along a continuum of sacred to secular which my analysis shows is related to purity and pollution concepts. Diagramatically, these ideas can be shown along the gradient as in Table 9.1 below.
Table 9.1
CASTE, PURITY AND POLLUTION: HEALERS AND HEALING

<table>
<thead>
<tr>
<th>Pure</th>
<th>Impure</th>
<th>Magic/Religious</th>
<th>Secular</th>
<th>Magico/Sorcery</th>
<th>Magic/Sorcery</th>
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<tbody>
<tr>
<td>Religious</td>
<td></td>
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<td></td>
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<td>Secular</td>
<td>Religio</td>
<td>Secular</td>
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<tr>
<th>High Caste</th>
<th>?</th>
<th>Low Caste</th>
<th>Casteless</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pandits</td>
<td></td>
<td>Pujiars</td>
<td>Oriahs</td>
</tr>
<tr>
<td>Divination</td>
<td></td>
<td>Temple</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>re:dangers</td>
<td></td>
<td>healing</td>
<td></td>
</tr>
<tr>
<td>(Astrological)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow fever</td>
<td></td>
<td>Possession</td>
<td>Possession</td>
</tr>
<tr>
<td>Massage:</td>
<td></td>
<td>Minor and</td>
<td>Minor and</td>
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<tr>
<td>Chronic</td>
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<td>Chronic</td>
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<td>Ailments</td>
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</table>

Today, Indo-Fijians say caste is not a strong organizing principle of their society. They usually give their laxity in food practices, related to purity and pollution concepts as evidence of the disappearance of caste. For instance they cite their involvement in the *vagona* drinking complex of the Fijians as evidence of their more egalitarian views. That such data show that they are different from their caste brothers in India, there is no doubt. The hierarchical structure of caste has changed its form. But caste principles are being infused by the growing numbers of Gujaratis from India amongst others, who are much more orthodox in their practices. As Indo-Fijians gain access to more wealth, some of them also take on the attributes of higher castes. Individuals in Fiji are able to change their caste, since there are no caste communities to impose sanctions. I have noted some of the ways in which caste is an important factor in the
social organization of Indo-Fijians as it relates to medical care. A complete analysis of caste in Fiji is long overdue and is a problem beyond the scope of this research, one which needs separate further careful research and documentation.

Finally, a word about the healers. As I have shown, the healers are very flexible in their own choice of gods and spirits who they propitiate, in the use of therapeutic devices, and techniques, and in the choice of herbs which they use. Most healers are eclectic, they combine many types of knowledge in order to enlarge their medical repertoire. Flexibility may be a key concept in how Indo-Fijians conceptualize traditional processes of healing. Throughout the chapters in Part II I have tried to show, although not always explicitly, that illnesses and their treatment in the Traditional Medical sector are related to Indo-Fijian social structure (ethnicity, kinship, roles, etc.) and social organization (behaviours and interactions). Some of the illnesses are broad categories which I have termed "possession", are referred to as syndromes such as hawa, setan, bhut, etc. These are specific to the Indo-Fijian context and the people diagnose them by symptoms which range from various types of manifestations of behavioural disorders to non-specific somatic illnesses.

Throughout the chapters in Part II, I have found Moore's (1978) framework a useful link to explaining some of the empirical data. The perspective is useful in depicting change which she says "...can be a matter of actually changing the rules, that is, of explicitly replacing one regularity with another. Or change may be a much more subtle thing, a shift from regularity to indeterminacy, or from indeterminacy to regularity, or through the whole series of possibilities occurring in the way Barth (1966) has emphasized, through the cumulative effect of changing individual choice" (Moore, 1978:47-48). The interactions and processes in Part II show how people transact therapy, their exchanges and negotiations as they go through the whole gamut of strategies in seeking cures in the Traditional sector. I have attempted to show
some of the pressures as well as the inducements, the coercive force of tradition, and collaboration in the situational context which affect seeking therapy and compliance.

Some illnesses are known to be best healed by resorting to the biomedical model and its practitioners. In Part III, we now turn to examining the processes and interactions involved when Indo-Fijians seek treatment in the biomedical health care system.
Footnotes:

1 J. Filliozat, in *The Classical Doctrine of Indian Medicine*, Delhi: Munshi Ram Manohar Lal, 1964:1-16, gives the names of three ancient ayurvedic medical texts, the *Caraka-samhita* compiled in the first century A.D., the *Susruta-samhita* compiled in the fourth century A.D., and the *Astangahrdaya* from the seventh century A.D.

These systems of thought were radically changed over the years, as contact was made with Galenic medicine (Leslie, 1976:356)

2 This is one of the few elements from Fijian culture that Indo-Fijians have thoroughly accepted, and which powerfully dissipates the strength of caste, since the basic values systems are polar opposites. Yaqona drinkers share the cup and bowl with their fellow drinkers. Caste observances hold as anathema sharing of water between people of different caste groups. In Fiji, Fijians, North and South Indians, and any other ethnic group, is accepted around the *yaqona* bowl, all drinking together, often from one cup which is dipped into the bowl for the next drinker without washing. As Belshaw, has pointed out (personal communication), some people do take their own drinking bowl, but that is an exception to the Fijian rule of sharing and sets one apart from others. Indo-Fijians have participated rather than be set apart.

3 Mayer (1961:150) states:

"The conditions of indenture and early settlement supported and often strengthened the closeness of these communal ties. People of both religions were housed in the same barracks, and worked in the same fields. Many of them, illiterate and without spiritual leaders, performed impartially any rites of either religion which they imagined would be beneficial. And, a most lasting effect, the small numbers of women caused inter-marriage between Hindu and Muslim."

He goes on to say that Muslim and Hindu, in those days, were closer because of place of origin, than were North Indians and South Indians. The latter came to Fiji as indentured labour just as the former were freed.

4 Mayer (1973, 2nd edition) and Brown (1978) provide two ways of analyzing caste in Fiji.
In Part III the problem addressed is that of studying the second part of the research question posed at the beginning of the thesis. The chapters which follow examine the interactions and processes when Indo-Fijians go to the biomedical practitioner or hospital to seek treatment for illness, taking into consideration their cultural values and beliefs. In these chapters I attempt to clarify and reveal the factors which induce Indo-Fijians to select treatment; and to show their responses to diagnosis and treatment in the biomedical sector.

Recall that the population under study, the Indo-Fijian, is in fact made up of very different "cultural groups", each with its own religion, origin in India, diet, and a very short time ago, language. Many other differences in social structure and social organization exist as well; they have been presented in Part I and II. The Indo-Fijian cultures are embedded in the total culture of Fiji, including that of the Fijians (with its own cultural gradations, languages, etc.), and a very influential expatriate community which at one time was primarily European. Today the culture of Fiji, as represented by the physicians, technicians and nurses in the biomedical sector, is made up of a culturally heterogeneous group of people.
This part of the thesis then presents an alternative medical orientation and set of practitioners, to that presented in Part II, in order to arrive at what I believe Indo-Fijians cognize as one medical system, based on their complementary use.

Throughout Part III the interactions and processes include those of both Indo-Fijians and Fijians. That was the way health care evolved in the actual setting, with patients and health care staff of all of the ethnic groups learning from their interactions and processes, new applications and principles in treatment and in seeking health care.

Methodologically, the perspective in these chapters in Part III, shifts from that used in Section II above. There, I interviewed Indo-Fijians in their settlements and reported their view of their interactions and processes, as well as my own observations of what they do when they are sick. In this section, the perspective is more biomedical inasmuch as the data are from my observations of the processes and interactions within the biomedical hospital institution, of patients who came for treatment, as well as of the physicians and nurses as they provided diagnosis and treatment. My role was more that of a clinical anthropologist, I worked alongside the medical staff. Thus, the language is couched necessarily in biomedical as well as Indo-Fijian terminology, etiologies, classifications and taxonomies. When I interview and present the perspective of the patient, or of the biomedical practitioners, I state that is so.

A major difference was that of the role I took in the hospital organization. As well as participant-observation, the traditional role of the anthropologist, I became more and more involved in practising interventionist anthropology, learning by adopting in part, an action oriented role. A kernel of a thought mushroomed into an applied anthropological project within the confines of doctoral research. I describe it in the following chapters.

The arrangement of Part III is as follows:

Chapter 11 gives the details of the structure and organization of the National Health System in Fiji. It describes how the present biomedical system evolved and shows the linkages to
international health organizations in the South Pacific, the World Health Organization, as well as Fiji's dependency on external aid. Then it proceeds to describe the situation at the Sub-divisional hospital in the small town of Sigatoka, again showing the structure and organization.

Chapter 12 describes the Indo-Fijian utilization of the hospital facilities. The interactions and processes as revealed when patients seek care in the Outpatients' Department, in Women's, Men's and Children's wards are described and discussed, as well as interactions between medical staff.

Women and the Biomedical model is the topic of Chapter 13. The ante-natal, post-natal and gynaecological clinics; the labour, delivery and gynaecological wards are discussed. The interactions between pregnant women and hospital staff, parturient women and nurses and doctors, care of the mother and child after birth are the focus of the chapter.

Then in Chapter 14 the focus shifts to Public Health Care delivery in the rural areas at the District Nursing Stations, where Primary Health Care or PHC (Fiji is a member of W.H.O.) is looked after by District nurses and Community Health Workers. The chapter evaluates the suitability of health care delivery at the grass roots level to two ethnic groups, each of which has a different social structure and organization.

Chapter 15 proceeds to describe an intervention project which I initiated, a hospital-based auxiliary with an outreach educational component. The chapter reflects how the sets of ideas we carry to the field do two things. They suggest alternative ways of doing things, but they also sometimes prevent us from seeing our own background assumptions. I also point to the difficulty of initiating a development project, without independent funding, and under the umbrella of an existing bureaucratic organization. The transactions reveal conflicting roles, and the "real world of politics, power and persuasion".

A conceptual overview of Part III concludes the section, as a summary.
Chapter 11

THE ORGANIZATION OF THE WESTERN BIOMEDICAL MODEL

In this chapter I present the general use of the biomedical system as it exists in a small town in Fiji, in the Nadroga/Navosa area. The processes and interactions of usage of the system by the Indo-Fijians, are a complex of ethnic differences, statuses and roles, and class divisions, within the hospital institution.

The specific features of many interactions and processes are meant to highlight the general. The approach used here is a useful one because these issues have not been dealt with in the health care literature on Fiji to the present date. During my discussion with a member of the WHO staff in Suva, we noted that Indo-Fijian health concerns appear to have been given only secondary interest or to have been left out of the document "Evaluation of Primary Health Care in Fiji", research conducted by the Working Group of the Ministry of Health and Social Welfare, Suva, and Office of the World Health Organization Representative and Programme Coordinator, Suva, Fiji, November, 1984.

The reason for this is immediately apparent in the document which states that the initial push to participate in PHC (Primary Health Care) began in 1977 with the recognition that the concept is similar to the then existing village health committees in Fijian villages which had existed from about 1924 but had declined shortly before and after independence in 1970. The
focus of the PHC then was to concentrate on revitalization of the existing structure through seminars on health care in Fijian villages. The document states:

Among the problems considered was the higher incidence of malnutrition and the lower family planning acceptance among the rural Fijian ethnic group. These considerations contributed to the initial concentration of the primary health care activities on this segment of the population (1984:1).

The evaluation thus reflects the progress made by the PHC program, and shows that most PHC activity until 1984 has remained concentrated on extending service to the rural Fijian villages with very little if any focus on the Indian settlements. The words "village" and "settlement" in Fiji, and in documents written there, reflect the ethnic community discussed, the former referring to Fijian and the latter to Indian.

That the extension of health care to Indian settlements is recent is stated in the evaluation:

A WHO-funded Primary Health Care Project was initiated (sic) in 1980, the main thrust being in support of seminars at grass-roots level-individual villages or several villages in an area....Enthusiasm for this approach grew, and the number of seminars has been expanding to the present, covering many Fijian villages, and more recently, some periurban areas and Indian settlements (Ibid:2).

My contact at WHO, apologetic about the lack of information about, and their inability to add the material on Indo-Fijians, felt my work could offset their shortcomings and detail the Indo-Fijian lives and health care strategies, as well as their health care needs. The neglect of the Indo-Fijian data in the evaluation report was attributed by him to a lack of sufficiently trained Indo-Fijian researchers with the cultural knowledge to assist in the project.

I have not posed a number of questions at the outset in this chapter as I did in Part II. In the data collection for Part II, I noticed a great range of variability in the processes and interactions involved in diagnosis, seeking therapy, selecting the appropriate healer or healers and in the therapy prescribed. Here, I take a slightly different tack, one which offers more
leeway for description of the empirical dimension. The core question posed for the chapters in Part III is the following. Why does the range of data involved in the interactions and processes in diagnosis, seeking therapy, selecting the appropriate healer, and the therapy prescribed, vary in the way that it does?

The question which was uppermost in my mind as I worked at the hospital and one which could direct my everyday work was "What is happening here"? In fact, almost daily, as I arrived at the hospital, I found that by asking this question, I could quickly get someone to respond with an overview of the situation at the hospital on that day. The question elicited any major illness, accident, or if anyone from "my two settlements" (Nasavu or Solevu) had been admitted to the hospital. In the individual case the same question asked of a patient or a member of his or her family, a nurse or doctor provided the 'history' of the case and the diagnosis. The question although seemingly simple, is sufficient to generate a conception of the processes and interactions which are of interest in the chapter. I did ask myself what are they doing? Or, How do they do that? And How and why do people constrain each other in their roles? Many other questions occurred to me, but I believe they are all encompassed in the overall problem of untangling What is going on here? and in keeping the core question in mind.

The general purpose of this chapter is to present the structure and organization of the national health care system at the sub-divisional level in the Western Division of Fiji. This will be followed in the next chapter by the presentation of empirical material for the analytic approach utilized here, the research into the processes and interactions in the Western Biomedical system.

The Biomedical System in Fiji is administered under the auspices of the central government by the Ministry of Health in Suva. I have briefly discussed the National Health Care System in Chapter 2. Now, I provide some depth to what was written before by first, presenting
the organizational structure of the delivery of health care at the Divisional and Sub-Divisional levels in Tables 11-1 and 11-2. Table 11-3 shows the number of medical personnel in Fiji. Then, a historical perspective of the development of health care in Fiji is provided in Table 11-4, followed by a discussion of links with International Health Care, and Health policy. Then, I go on to discuss the Local Area Level, the site of this fieldwork, the Sigatoka District Hospital and nearby settlements and villages.

### Table 11-1

**ORGANIZATION AT DIVISIONAL LEVEL**

<table>
<thead>
<tr>
<th></th>
<th>Medical Superintendent</th>
<th>Lautoka Hospital</th>
<th>Labasa Hospital</th>
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<tr>
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<td><strong>Dental</strong></td>
<td><strong>Technical</strong></td>
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<td><strong>Staff</strong></td>
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</tr>
<tr>
<td><strong>Administrative &amp; Account Section</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Medical Officer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td><strong>Nursing</strong></td>
<td><strong>Accounts &amp; Administration</strong></td>
<td><strong>Health Inspectorate</strong></td>
</tr>
<tr>
<td><strong>Medical Staff</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From: Ministry of Health Annual Report for the year 1982, p.9. NOTE: The sub-divisonal Medical Officer in the following chart is part of the Medical Staff shown in this chart as under the jurisdiction of the Divisional Medical Officer.
Table 11-2

ORGANIZATION AT SUBDIVISIONAL LEVEL

<table>
<thead>
<tr>
<th>Subdivisional Area</th>
<th>Hospital</th>
<th>Health Administrative Staff</th>
<th>Public Health Staff</th>
<th>Nursing Staff</th>
</tr>
</thead>
</table>

| Medical Staff | Dental Staff | Technical Staff |

From: Ministry of Health Annual Report for the year 1982, p.9. NOTE: The Sub-Divisional Medical Officer in this Table is under the jurisdiction of the Divisional Medical Officer as part of "Medical Staff" in Table 11-1.

The number of medical personnel in Fiji at the end of 1984, the year prior to this research, are shown in Table 11-3.

Table 11-3

MEDICAL PERSONNEL IN FIJI, 1984

<table>
<thead>
<tr>
<th>1984</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
</tr>
<tr>
<td>Nurses</td>
</tr>
<tr>
<td>Nurse/population ratio</td>
</tr>
<tr>
<td>Doctors &amp; Medical Assistants</td>
</tr>
<tr>
<td>Doctor/population ratio</td>
</tr>
<tr>
<td>Dentists</td>
</tr>
<tr>
<td>Dentist/population ratio</td>
</tr>
</tbody>
</table>

Brief Historical Overview of the Development of Health Care in Fiji

The Health Care system in Fiji developed in several steps. First, that introduced and developed by the administrators of the colony, the British, between the years 1874 when Fiji became a colony and 1928 when the Rockefeller Foundation gave a grant to start the Central Medical School in Suva. Later, the health system was affected by the co-operative efforts of countries in the South Pacific, such as New Zealand and Australia. And third, since independence, it has been influenced by the efforts of international groups such as the South Pacific Commission and WHO.

Table 11-4

SOME HISTORICAL HIGHLIGHTS IN MEDICINE IN FIJI

1874 Fiji administered as a British Colony
1875 Measles epidemic kills 40,000 Fijians (1/5 of population)
1879 First Indians arrive in Fiji, suffered from outbreak of cholera and smallpox. Government of Fiji trained first native "vaccinators". Indians quarantined for 2 months.
1886 First Medical School founded (Suva Medical School)
1888 First three Native Practitioners graduated
1923 Colonial War Memorial Hospital opened
1926 First Indian graduated, as Indian Medical Practitioner (IMP)
1928 Central Medical School opened with grant from Rockefeller foundation from 1928 – 1932.
1930 First issue of The Native Medical Practitioner published.
1931 Medical syllabus increased to four years, graduates called Native Medical Practitioners (NMP)
1945 Dental training started
1946 The South Pacific Health Service formed and the Central Medical School was linked to this organization. Member countries: Fiji, Gilbert and Ellice Islands, Colony and the British Solomon Islands Protectorate, New Zealand and its island territories.
1948 The South Pacific Commission formed with Australia, France, Netherlands, New Zealand, United Kingdom, and U.S.A.
1951 Medical syllabus increased to five years of undergraduate training. Graduates renamed Assistant Medical Practitioners.
1961 Medical School renamed Fiji School of Medicine (FSM)
1962 Training of Health Inspectors started.
1970 The Royal Australasian College of Physicians and Surgeons admitted select Medical graduates from FSM to fellowship examinations and membership.

Chronology compiled from Guthrie, 1979 and Miles, 1984.

Links with International Health Care:

The biomedical health care system first instituted by the colonizers from Britain and further developed and co-ordinated by input from regional countries in the South Pacific, was later augmented by International Health care groups and through international aid from other countries.

The regional South Pacific Health Service (SPHS) was formed in 1946. According to Gurd (1984:111-14), it was funded primarily by the Government of Fiji. He states its role:

The main purpose of the SPHS was the co-ordination of health policies and activities, particularly at the level of medical, paramedical and nursing education, and recruitment, as well as with regard to quarantine, preventive campaigns and the publication of health education and other material. All this was effected with the utmost administrative economy with an annual budget of a few thousand pounds ($22,388 in 1970), largely due to the the fact that the South Pacific Health Board was made up of honorary representatives from each of the participating Territories - while the only full-time administrative staff was the Inspector-General's secretary and clerk.

Out of the interaction with Fiji, the SPHS helped to "...put Fiji's considerable educational facilities in the field of health at the disposal of the other participating territories and this in turn had the same effect of fashioning the health services of the Island Territories according to the same master mould" (Ibid:113). The process was developmental and through interaction it was also to some degree self-correcting. Medical officers from Fiji once trained there and in New Zealand were placed in posts in many of the other Island groups in the South Pacific. Thus Fiji has provided service and training as well as receiving it from abroad.

The SPHS with the help of the Government of Fiji and the Nuffield Foundation, had its greatest effect in preventive medicine, by sponsoring the Department of Preventive Medicine in
Fiji which trained medical officers for the Certificate of Public Health, and trained Assistant Health Inspectors.

The SPHS was later incorporated into the small international South Pacific Commission (SPC). Later, W.H.O. entered the health picture in the South Pacific. As Miles (1984:122-23) states:

When SPC was formed all the territories concerned were dependencies of outside countries and WHO regarded them as essentially the responsibility of those more developed countries. Since by now most are independent countries or have internal self-government, WHO is putting a greatly increased effort into the region which is much better staffed and financed than the SPC. Clearly it would be foolish for SPC to duplicate functions better carried out by WHO, but there are areas where SPC can in its own region, despite limited means, do better than the world organization.

In the writer's opinion it has special functions in providing a regional epidemiological information service, in providing a forum for the regional health authorities and in the specialized fields of environmental health and health education in a region its officers know so intimately. Probably most other medical functions should now be left to better financed organizations.

Gurd's (1984:114) statement indicates that some tensions may have existed between the three levels of international organization:

It will be seen that the Service [SPHS] depended to a very large degree on Fiji Government resources and the existence of the SPHS side by side with the South Pacific Commission and more latterly WHO called into question the need for three international health agencies working in the same area. Ideally two agencies, one of a local co-ordinating nature and the other an international agency, would have been enough. For the latter, WHO was by far the best equipped and financed, and strategically placed in its Suva headquarters to reach out into the South Pacific and to liaise with the SPHS. But it was not to be and the gaining of independence by Fiji, followed by the retirement of the Inspector-General, gave an ideal opportunity quietly and sedately to lay to rest the body corporate of the SPHS ...and then there were two.

Since 1977, World Health Organization's programmes (PHC and HFA/2000) have provided a guide to health care policy and services in Fiji. At the international level, the Ministry of Health is involved in on-going interaction with a regional office of WHO based in Suva, which is guided by the Western Pacific Regional Office in Manila, Philippines. Through
WHO, Fiji has been able to get UNICEF funding in the past for some of its health education seminars (WHO, 1984). Ministry of Health documents show that funding is often provided by WHO, but rarely are the amounts shown. I have been told that in fact they are token amounts.

I have shown above the links with New Zealand, Australia and other countries through SPC and SPHS. Fiji also receives aid from many other countries: Canada, India, United Kingdom, U.S.A., Japan and the Philippines. A major donation of five million dollars (F), was received from the Government of Japan in 1984, for the construction of a new School of Nursing. I do not know whether, or the manner in which, funding of this magnitude is politically motivated aid.

Fiji has many other international sources of aid. Aid from the United States is mentioned most frequently in the newspapers. I notice that it is in the form of numerous small projects (i.e. $2-3,000). I do not know of the larger U.S. aid projects in Fiji.

Fiji received four ambulances from Japan and one from France. WHO donated three vehicles (MHSW, 1984:14). As I show in following chapters, the problem of transport in Fiji is crucial. There are not enough vehicles to provide the services needed, and for one reason or another, many vehicles once received by the Ministry of Health, are not maintained. In spite of receiving 26 new vehicles in 1984, and the eight vehicles mentioned above, "...75 vehicles either remained in very bad condition, were completely unserviceable awaiting Board of Survey or awaiting write-off actions following completion of Board of Survey or were already written-off and not replaced" (MHSW, 1984:14).

As well as monetary and material aid from overseas, Fiji receives international personnel. During 1984, "..25 Peace Corp volunteers and three Volunteer Service Overseas were...engaged in various areas of health sector" (Ibid:14). The Ministry also had 24 professional people from other countries on contracts of various terms serving in Fiji. For instance, a mobile physiotherapy unit and the services of a physiotherapist to implement a
program were provided by an agency in Holland and linked to the Crippled Children's Organization in Fiji. There are many of these types of contracted short term aid projects which provide material assistance, as well as service, and professional personnel.

The Minister of Health and the Permanent Secretary for Health and Social Welfare travel internationally to seminars, workshops, conferences and meetings. Major health care conferences held in Fiji also provide interaction with international professionals and agencies.

At most Health Care seminars and conferences, international pharmaceuticals are well represented by salesmen who set up displays of their products. Doctors obtain samples of antibiotics, fungicides, decongestants and gestational charts, free. Many seminars are partially sponsored by overseas pharmaceutical companies.

Overseas training is provided for some health care professionals:

...two [students] went to further their knowledge in Orthopaedic Surgery, three to study for the Diploma in Public Health, one for the Diploma in Paediatrics, one for the Diploma in Obstetrics, one for the Diploma in Radiology, one to pursue M.R.C.O.G. and one to complete Ph.D. in Virology. There were others who took up courses in Biomedical Engineering, Medical Technology, Herbal Medicine, Master in Public Health (Nutrition), Master in Oral Surgery, Artificial Eyes and Dental Mechanic (MHSW, Annual Report for the Year 1984, Parliament of Fiji, Parliamentary Paper No. 1 of 1966:16).

Another way in which Health Care in Fiji is linked internationally is through the curricula of the Fiji School of Medicine for training physicians, and the instruction received by nurses is heavily influenced by input from overseas, mainly New Zealand and Australia.

Professionals from these countries come to Fiji as consultants to evaluate educational programs and to suggest new ones. Recently, the curriculum at the Fiji School of Medicine was increased from a five year program to six years after advice from consultants from Australia. (The medical programs are now closely affiliated with the University of the South Pacific.) This sudden increase placed a financial burden on many students who were close to finishing.
Nevertheless, the new program was necessary to raise the standard of medical care in Fiji. At the same time, the century old program of medical assistants was discontinued.

*Health Policy, Voluntary Groups and Non-Governmental Organizations*

I stated above that the clearest statements of health policy are to be found in the development plans.

DP8 (Fiji's Eighth Development Plan, 1981-1985) presents a brief overview of the goals of DP6 as: "Having ensured a fairly extensive network of medical stations throughout the rural and urban areas in the DP6 period, emphasis during DP7 was diverted slightly toward preventive medical services, family planning, maternal and child health care". In addition, major capital works were completed adding hundreds of hospital beds and increasing and updating health centers and nursing stations (DP8, Dec. 1980, p. 265-73, provides a review of the Health Service in Fiji at the completion of DP7).

The overall change in medical staff/patient ratios between 1980 and 1984 was as follows:

<table>
<thead>
<tr>
<th>Medical Personnel Ratios</th>
<th>1980</th>
<th>1984</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor/population ratio per 1000*</td>
<td>1:2062</td>
<td>1:1553</td>
</tr>
<tr>
<td>Nurse/population</td>
<td>1:581</td>
<td>1:562</td>
</tr>
<tr>
<td>Dentist/</td>
<td>1:7519</td>
<td>1:4179</td>
</tr>
</tbody>
</table>

According to the Ministry of Health, the major setback during DP7 was the failure to reduce the birth rate from 29/1000 to the targeted 22/1000.

The policy for the Health Sector in DP8:267 was stated as follows:

12.3.11 Health sector objectives in DP8 are to:
(a) direct health services and monitor basic needs in regions where deficiencies exist, with special attentions given to low income areas;
(b) generally promote the physical, mental and social well-being of the nation; and
(c) promote and maintain the quality of health standards throughout the country.

About Primary Health Care, the following section from the same part of DP8, continues the policy statement:

12.3.12 Programmes aimed at ameliorating the health standards in any community should directly include the participation of the community and not merely depend upon the initiatives of the authorities concerned. The concept of primary health care was adopted towards the latter part of the DP7 period as the strategy for implementing the many aims of the health sector. This, as noted in DP7 is done not at the the expense of curative services but as a measure towards easing the pressure on clinical facilities.

In DP9 (1986-1990), the main concerns, as I have summarized them, are (a) "the stagnant national family planning protection rates", (b) "the rising incidence of diabetes which is one of the major causes of heart disease, kidney trouble, infections/gangrene and blindness. A large number of hospital beds are occupied by diabetics at any one time. The problem is made worse by the fact that many people do not know that they have the disease, and those who have it lack adequate selfcare"; and lastly, problems of maternal and child health (DP9:143-44).

During DP9 the government plans to increasingly involve the private sector in the provision of health services and there will be an increased reliance on "community and the voluntary organisations in the delivery of preventive and primary health services. The Ministry of Health will explore the feasibility of setting up a National Health Insurance Scheme, and the establishment of Area Hospital Boards in Fiji" (Ibid:144).
10.4.14 The major objectives for the Health Sector during DP9 will be to:
(a) improve and provide appropriate, efficient and effective health services, particularly to those in depressed and rural areas;
(b) provide preventive and primary health care, clinical and rehabilitative facilities, together with adequate health manpower to satisfy national need;
(c) ensure attainment of a population growth rate at a level which is conducive to better standard of living; and
(d) promote and maintain the quality of health standards throughout the country (Ibid: 145).

The main emphasis during DP9 will be on Family Planning to reduce the rate to 25/1000 by 1990. As policy, DP9, in section (b) and (c) above states it intends to implement Primary Health Care and family planning through community participation using both voluntary and governmental agencies by providing "...adequate assistance and encouragement to non-governmental organisations to effectively participate in further improving the health delivery services throughout the country" (DP9:145). A public education campaign is also going to be implemented.

The organization of the National Health Care System is divided into the Divisional level, sub-divisional level and area level. According to health care policy one system of health care is adopted throughout the four divisions of the country, with emphasis on both curative and preventive health care.

My research is concerned with the Area Level.

THE AREA LEVEL OF HEALTH CARE

In the Sigatoka Medical area, at the beginning of this research there were four Health Centres of which the primary one is the Sub-Divisional hospital. The others were the Kelasi Health Centre, Lomawai Health Centre, and Semo Health Centre. Since 1985, two Nursing
Stations have been upgraded to Health Centres, Korolevu and Raiwaga. Administratively, they fall within the Western Division of Fiji.

In addition there are a number of District Nursing stations supervised by the Sub-Divisional Medical Officer (SDMO) and the Public Health Sister. Figure 2.1 (page 32) shows the Existing Health Facilities in the Western Division. Those in the Nadroga and Navosa Province are discussed in this research, with special attention to Sigatoka District Hospital and District Nursing Stations along the Sigatoka River.

By comparison to the account by Belshaw (1964:248-249), the health care delivery system has been considerably augmented. Nevertheless it has yet to reach past Kelasi, thus many of his earlier observations still apply. Communication remains poor, and the roads still unpaved, are sometimes impassible in the rains. There is no telephone service. Patients still must ford the rivers to reach medical facilities.

The Sub-Divisional Hospital

I have written briefly about the sub-divisional hospital and its placement within the structure of Medical Care in Fiji, in Chapter 3 (p.67). I described the hospital itself and provided the structure of the hospital organization in Table 3-1 (p.67) showing the organization of the National Western Biomedical Medical system at the area or local level.
The Organization chart for the Nursing Staff at Sigatoka District Hospital is as follows:

**Table 11-6**

**ORGANIZATIONAL CHART OF NURSING STAFF**

<table>
<thead>
<tr>
<th></th>
<th>Sister</th>
<th>Nurse Tech</th>
<th>Sister</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBS. LW-OT</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>C.L. WW</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>OPD</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MW</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>CHW</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OBS. = Obstetrics  CL = Clinic  MW = Men's Ward
LW = Labour ward  WW = Women's Ward  CHW = Children's Ward
OT = Operating theatre  OPD = OutPatient's Dept.

Individual advancement in these hierarchical organizations is usually marked by transfers from one locale to another. Thus the medical staff, technicians, nurses and doctors are shifted around the country every few years, moving them from their home areas and involving transfers of spouses who work in other institutions and jobs. Transfers of this type serve to move the more highly educated Eastern elite Fijians into the Western Division.

The small township of Sigatoka and its surrounding rural area, the location of this fieldwork, is in the Western Division of Fiji and is served by the Sigatoka sub-divisional hospital (hereafter referred to as SDH). The hospital is a 56 bed facility with an Outpatients' Department, Dental Department, Surgical Theatre, Labour Ward, Paediatrics Ward, Men's Ward, Women's Ward and the Obstetrical/Gynaecological Ward. Every week a number of clinics are held at the hospital: the antenatal, post-natal and gynaecological clinics, as well as a diabetes and surgery clinic. The Outpatients' and Emergency areas are open around the clock, everyday. The hospital is equipped with basic technical procedures such as X-ray, a laboratory for basic blood work and other simple analytical procedures.
Utilization of Health Services – Outpatients' Department

Sigatoka District Hospital (SDH) is the referral point for Indo-Fijians and Fijians from the whole of the Nadroga/Navosa area, including the District Nursing Stations, the Health Centers, Community Health Workers, and the private doctors. Patients also decide on their own to seek treatment from the hospital staff. The Outpatients' Department (OPD) is open 24 hours a day, everyday of the week, but the main hours of attendance are during the day. Each of the doctors serves in "Outpatients" sometime during the week, for the clinics. There is always a nurse on duty during the evenings and at that time the doctor who is on call that evening is summoned to OPD or emergency, as needed.

Each doctor has a large book which is his or her outpatient record, no on-going patient records are kept for Outpatients' department by the hospital. The doctor's book records the name, age, sex, settlement or village of residence, diagnosis and treatment, and the doctor records the payment of the fee, in order to balance the account to submit to the cashier at the end of the clinic. The fee is 20 cents for adults; no fee is charged for children under 15. If a patient is admitted to the hospital, the charge is 50 cents per day. The hospital pharmacy is located to the side of the OPD clinic room. Some patients are treated immediately with injections and they are given enough tablets for one day from the dispensary. The doctor writes a prescription for the patient to purchase the balance of the medication needed for treatment from the chemist in the town. Oral rehydration packets are given free for the treatment of diarrhoea which is endemic.

Emergency cases are also treated in the OPD, in the adjoining treatment room which is equipped with two examination cubicles and the necessary equipment and supplies. Here, the nurse under the direction of a doctor, lances boils, treats minor wounds, cuts and lacerations, gives injections, treats asthma cases, etc. When a doctor in OPD is examining a patient, he or
she sends the patient into the treatment room for complete examinations, or for other medical procedures for the nurse to carry out. Some cases are examined and sent for x-ray before diagnosis; others may be admitted to a hospital ward for observation and treatment.

The general process of treatment of patients in OPD is that each patient is given a number when he or she comes to the hospital. As the doctor calls the number the patient enters the office, sits down at the right of the doctor, pays the fee, and tells the doctor his or her problem. The doctor then takes the patient's history, examines the patient, asking questions at the same time, and then diagnoses the illness and prescribes a treatment regimen. This interaction takes from 2 to 3 minutes at most, unless the patient is sent to the nurse for some treatment, in which case the doctor goes on to the next patient. There are often between 20 - 50 patients in a day. When the doctor calls the next number he or she has no idea who the next patient will be: man, woman or child, Indian, Fijian or "other". This is the general procedure followed in the SDH hospital OPD.

At the hospital the medical personnel were under the supervision of Dr. A., the Fijian Sub-Divisional Medical Officer, who was a Seventh Day Adventist. He was a specialist in Public Health who was very well liked and respected for being impartial in his work with Fijians or Indo-Fijians. In January, 1986, he was replaced by Dr. W., a young Fijian man, with an Obstetrics and Public Health background. He is a Methodist, from the elite groups of Eastern Fiji (his father was knighted by the queen). He has a strongly pro-Fijian stance which makes the Indo-Fijians under his supervision apprehensive about their future. The surgeon, and his wife who is an anesthetist, are expatriates from Southeast Asia. They are Roman Catholic. The Obstetrician is an Indo-Fijian woman of Muslim background. The following Table summarizes the relevant data about the senior medical staff.
These personal characteristics of the staff are included because they are relevant to later discussions. Ethnicity, language (communication), residential status, religion, and status in the medical hierarchy are some of the factors which affect interactions and processes in the official health care system in Fiji. Other differences, political in nature, are those within and between the Fijians and Indo-Fijians and are based in the histories of the two groups, the first indigenous to Fiji; and the latter transplanted there, a majority in the country in actual numbers but accorded "minority status".

The interactions between the two ethnic groups have become considerably more tense since the appointment of Dr. W. Some people thought he lacked experience in the subtleties of keeping the Fijians and Indo-Fijians on amicable terms. Others were not so kind in their judgement. In the first weeks of his appointment, he antagonized the Indo-Fijians and the Peace Corps Health Educator by excluding them when he went on public health trips in the hospital van. One Fijian nurse told me "he wants to do things in the Fijian way". When I inquired what
was, she told me that he likes the *yaqona* ceremonies which are held in his honour. They sometimes go on for hours which means that when he is engaged in public health activities in the rural areas, the health team does not get home until late at night. He also selects those staff members who are amenable to these activities, and his penchant for driving his own vehicle leaves his Indian driver at the hospital doing other work. As a consequence of his preference for public health work, he often does not attend his shift in the OPD, much to the chagrin and irritation of the other staff who, although already overworked, must cover his shift.

The SDMO and the surgeon live in government quarters, with spacious lawns and space for subsistence gardens, on the hospital grounds.

There is also a nurse's residence on the grounds for the Sisters and for the general nurses. During my fieldwork the south Indian Sister-in-Charge (Sister F.) lived in her own home in the town. Her space in the residence was occupied by one of the other senior sisters, a Western Fijian who has high status in the Western Fijian hierarchy. She has a home in her own village where she goes everyday; it is only a five minute walk from the hospital.

During one hospital board meeting, someone pointed out that one of the reasons why there was an acute shortage of nurses at the hospital was because the ministry could not find accommodation for them. The fact that the second building, formerly also a nurses residence, had been allocated to the Fijian dentist and his wife distorted the real needs of nursing staff and compounded the problem. Some staff members complained about the poor allocation of space saying the SDMO could ask the Nursing Sister, who was from the local village, to give up that space so that it could be reallocated to nurses transferred from other places, as it appropriately should have been. It was perhaps because of her high status in the local Fijian hierarchy that she was not asked to use her own home. Time and again, the traditional Fijian hierarchical statuses stood in the way of 'rational' decision-making, much to the annoyance of the
Indo-Fijians (and other Fijians who could not admit it openly). The problem might be solved more easily by providing off-grounds accommodation for the dentist, giving the nurses' residence back to the nurses.

The Nursing staff, made up of 25-28 nurses, was under the supervision of the Indo-Fijian Sister-in-Charge (South Indian). Nurses rotated in three shifts. Usually, three or more nurses were away, several on annual vacation leave, some on sick leave, and occasionally one was away for further training. Thus, at any one time the staff was reduced to between 20 to 23 nurses. Table 11-8 shows the allocation of nurses by Ward and ethnicity.

Several of the older Fijian nurses had the same status as the sister-in-charge. In terms of the authority structure, and because the two ethnic groups were very competitive in bureaucratic settings, this was a problem. One Fijian nurse told me that the Sister-in-Charge was not “officially” the senior nurse. The staff had more Fijian than Indian nurses. The latter were younger however, a situation which reflected the more recent entrance of Indo-Fijians into the profession due to their observance of caste prohibitions in the past.

Table 11-8

NURSING STAFF ALLOCATION BY WARD AND ETHNICITY

<table>
<thead>
<tr>
<th>Maternity Ward</th>
<th>Women’s Ward</th>
<th>Men’s Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Fijian</td>
<td>4 Fijian</td>
<td>1 South Indian</td>
</tr>
<tr>
<td>1 South Indian</td>
<td>on leave (3)</td>
<td>1 Muslim</td>
</tr>
<tr>
<td>1 North Indian</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Theatre</th>
<th>OPD</th>
<th>X-ray/Lab</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Fijian</td>
<td>4 Fijian</td>
<td>1 Fijian</td>
</tr>
<tr>
<td>(1 male)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sister-in-Charge</th>
<th>Senior Sisters</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 South Indian</td>
<td>3 Fijian</td>
<td></td>
</tr>
</tbody>
</table>
It is only with the diminuation of caste consciousness that some Indian women are entering the field of nursing today. Traditionally, Indo-Fijians considered the nursing role as polluting, because of its concern with birthing, with carrying and emptying bed pans, with bathing and washing the sick, and handling polluted laundry and dishes. All of these functions are carried out in India by the lower castes, or by Indian Christians who do not observe the purity and pollution notions. I do not have data on the numbers of Indo-Fijian nurses in Fiji who would be Christian, but in the SDH, the Indo-Fijian nutritionist was a Methodist (her husband was a senior teacher at the Methodist school). The remainder of the Indo-Fijian nurses were Hindu or Muslim. Today, caste does not appear to be as important a factor as it was in the past on the overt level except in some Pandit, and most Gujerati families.

There were acute nursing shortages at the hospital. The Sister-in-Charge, Sister F., supervised nursing and clerical staff, was the liaison between doctors and nurses, was in charge of the laundry, ordering equipment and new supplies, and supervised the pharmacist and the ordering of drugs. She also kept staff records, made up the duty roster, served as a mid-wife, and was in charge of the administration of the Nurses' residence. The SDMO and the Public Health Sister also consulted her about on-going education of the Public Health nurses and their meetings, etc. In sum, she administrated the smooth functioning of the hospital under the supervision of the SDMO, and assisted him in planning the Public Health meetings and activities which were held every month at the Nurse's Residence.

The hospital also had non-medical staff such as the ambulance and van drivers, the clerical staff, the cleaning staff and the kitchen staff.

The shortage of staff was felt most acutely in the labour and obstetrics wards which were in separate parts of the hospital. Until the first few months of 1986 there were times when only one nurse was scheduled for duty for both areas. The Sister-in-Charge was extremely
reluctant to change the duty roster inspite of repeated requests from Dr. B., the obstetrician. Finally, when the Superintendent of Nursing for Fiji visited the hospital, Dr. B. reported the problem to her and demanded that the roster be changed. (The doctors sometimes found it difficult to interact with the Sister-in-Charge. They made requests to which she appeared to agree, but which she would not implement.) In this instance she was humiliated by being reprimanded by both her immediate superior and by the Superintendent of Nursing as well. The request for the roster change was due to a real need that was apparent to all of the staff and especially to the nurses working in Obstetrics and Gynaecology on the evening shifts when the doctors had gone home. During this fieldwork one nurse was allocated to each section. On another occasion, one nurse was in charge of twenty patients in the Men's ward when a serious car accident occurred and she was suddenly swamped with visitors and calls. At that time, staff shortages prevented assigning two nurses for that shift on a Sunday.

During the ante-natal clinics every week, the hospital "borrowed", in what the nurse and the Public Health Sister thought was a rather heavy handed way, the family planning nurse from the Health Center. This created ongoing tension between the Health Centre and Hospital Staff. Understandably the Public Health nurses thought of themselves as part of a team at the Health Centre and preferred to work together. On the other hand the hospital ante-natal clinics were also serving the public and were short staffed. Decisions about staffing were usually raised with the SDMO, and he approved of the exchanges since both areas were under his jurisdiction. Nevertheless, the interactions between the staff in the two units, one hospital based and the other a public health unit, were always slightly sensitive and a negotiated peace existed between them.

It was not until near the end of this research that I became aware of the competitiveness which existed between the Public Health Sister (a "Western" Fijian), and the South Indian
Sister-in-Charge of the hospital. For some time people had formed cliques, some supporting the Sister-in-Charge, and others actively against her, trying to have her replaced. An incident about a shortage of gowns, laundry and blankets (all under her jurisdiction), prompted the Public Health Sister to take it upon herself to go to the hospital and do a count of the supplies. I was never sure (although I believe it to be the case) if she had the approval of the new SDMO (Dr. W.), or if someone else had approved it, but she was certainly overstepping the boundaries of her own duty jurisdiction and deliberately entering that of the Sister-in-Charge. Interactions such as this recurred often enough to undermine the authority of the Sister-in-Charge and to set the stage for hostile feelings between the two ethnic groups, and at another level in the hierarchical structure and organization of the Hospital staff. I discuss these problems in the next section.

Through the year the hospital had visiting professional staff, such as an American Peace Corps Health Educator, a Dutch physiotherapist who was from a non-governmental organization from Amsterdam and was attached to the Crippled Children's Association in Lautoka⁴, and a woman graduate student (M.A.) from Amsterdam, studying fertility. The health educator, a retired woman, after some initial difficulty and frustration encountered in initiating a program at the hospital, moved to the Health Centre and into the Public Health area. From here she travelled by local transport to many of the District Nursing Stations to help the nurses there, as well as with the school health teams. For the first eight months of her stay in Fiji, she was unable to achieve deeper level interaction with the Fijian staff with which she worked and was not often invited to their homes. She did go to visit the Indo-Fijians at their homes and travelled around the island with their families on visits to other parts of Fiji. It took longer to be accepted by the Fijian people, but she achieved that too, later in the first year of her stay.
The physiotherapist usually came every week or two to tend to children at the Crippled Children's School, to consult with the surgeon about amputees and with regard to other general cases needing therapy. Later, on my suggestion, she introduced ante-natal and post-natal exercises to women attending the clinics in the hospital. Her interactions with the people in Fiji were something she attempted to analyze and to be introspective about. Simply, she said she found the Fijian people a happier lot, but the Indo-Fijians were more similar to her in attitudes to work and everyday actions. They also showed the same stresses.

An Indo-Fijian doctor, who was taking his Masters degree in Australia, spent two weeks in the hospital as he researched his topic, prior to going back to finish his degree work. Since he was an SDMO from another hospital, a desk and chair were assigned to him in the Men's Lounge and waiting area during his research at SDH. And a young Anglo-Indian intern from Australia, Dr. N., who was spending several months working in hospitals in Fiji, stayed for several weeks, gaining experience in many different areas of the hospital. Finally, I was attached to the hospital for the year. My role as medical anthropologist was viewed by some as my being a sort of permanent visitor for the year, until I demonstrated through actual work with the doctors in outpatient's, and the ante and post-natal clinics, as well as in emergencies, that I could function competently as a clinical anthropologist, helping as well as recording the activities of others. After I saw how short staffed the hospital was, I proposed that an Auxiliary be initiated, and co-founded it with the obstetrician. I discuss this in Chapter 15. (It allowed me to experience applied medical anthropology, and the role of a clinical medical anthropologist.)

Dr. N. and I were both allowed to use the desk in the Operating Theatre, which we shared with the Surgeon, the Anesthetist, the Obstetrician and the two operating room nurses. Dr. B., the Obstetrician and I shared her locker.
The Men's Lounge and Waiting Room was also used as the staff tea room twice a day by the doctors, the nutritionist, the Men's Ward nurses, the Labour and Delivery room nurses, the Dental staff, and any official visitors. The nurses in the Women's Ward also had a tea trolley delivered to them by the kitchen staff. Both of these wards also had their own kitchens. A tea tray was provided for the Operating Theatre, and one in the Clinic for the nurses. The tea trolley usually had tea, cocoa, milk and sugar and peanut butter (or, occasionally, egg, fish or jam) sandwiches.

At SDH there was one ambulance for emergencies. The same vehicle was used to transport more seriously ill patients to the Divisional hospital some 60 kilometers away. There were two ambulance drivers, one for each shift. Both lived nearby and if one was taking a patient to one of the major hospitals, the other could be easily summoned if needed to drive another of the vehicles. Unfortunately, I did not find out about their training. I was told by a hospital doctor that the ambulance was one of a fleet of ten provided by the Japanese government. Unfortunately, the vehicle was not provisioned with basic necessities such as an oxygen unit; therefore it was little more than a vehicle with the word "Ambulance" written across it. It did however have a standard bed-stretcher. I could not help but think that this was a case of "aid" that had not been well planned. It would have been better to have nine vehicles fully-equipped with all basic necessities for emergency use. The ambulance from SDH hospital served the entire Coral Coast, the primary tourist area in Fiji. Although the hotels had doctors on call and had some emergency equipment on hand, since there was only one ambulance, the service was not reliable, could not be readily summoned, and when it was summoned, it could not be relied upon for resuscitation. During this fieldwork, I was told about a tragic incident at one of the major hotels involving a tourist from Australia and a long wait for an ambulance which was deployed elsewhere. The patient was finally taken to the SDH by private vehicle but arrived too late.
The Sigatoka hospital served as the referral centre for four Health Centers, ten nursing stations, and a number of newly trained community health care workers. The hospital under the direction of the sub-divisional medical officer, provided preventive and primary health care and general public health services.

**Health Centres**

The health centers provided public health services such as maternal and child care and school health services in the zones they serviced.

Health Centers which had an Assistant Medical Officer (AMO) and nursing staff (1 or 2) offered both curative, and preventive services such as mother and child clinics. (AMO's were trained for several years as a type of para-medic but did not have the training of a doctor. At the time of my fieldwork Fiji no longer trained AMO's; the courses were phased out in 1984.) The public health team and the surgeon visited these centers on a regular basis to provide additional services. Most had one or two beds for maternity care as the need arose. Another Nursing Station at Raiwaqa in the Sigatoka Valley was also recently upgraded to a Health centre with an Indo-Fijian Assistant Medical Officer and several (I believe 3) nursing staff. During this research Raiwaqa Health Centre (opposite Loma Nursing Station) was used as a training center for nurses by the Fiji School of Nursing. As part of their public health service curriculum, four to six nurses were stationed there for six to eight weeks of training in the rural villages and settlements. They were supervised by the AMO and the nurses at the Health Center. Many other Health Centers also serve a training function.

Recently, a Fijian doctor was transferred to the recently created Health Centre at Lomawai; in the other, at Kelasi, there was an Indo-Fijian Assistant Medical Officer (AMO) and several nurses.

The outlying Health Centre at Kelasi had recently had an eight-bed facility added which
as of this fieldwork had not yet been officially furnished or opened. Most of the health centers, located at long distances from the township, offered curative as well as preventive out-patient care. Some of them had two beds for maternity use. Regular ante-natal and post-natal clinics were held there. During the last Development Plan, 1981-1985, (DP8,1980:266, sec.12.3.07 and p. 267, sec.12.3.13), emphasis on mother and child health and welfare was a part of government health policy. The new policy for DP9 has been presented in earlier pages in this Chapter.

**Nursing Stations**

The District Nursing Stations offered mainly preventive and out-patient care, with no space for maternity cases. The District Nursing Stations were staffed with one nurse who attended to simple curative services and mother and child health services. The district nurse was the last link in the medical network. She was on call twenty-four hours a day, and attended to minor injuries and illnesses. The area she covered was one of settlements and villages (see Part 1), each of which she visited once a month. The nursing station was unmanned during her absence, when she was making house calls, or when she was on her regular tour of each settlement and village. I discuss District Nursing Stations in Chapter 14. Lack of vehicular support and shortage of supplies and drugs at this level made health care delivery difficult to the population most in need.

**Community Health Workers**

A community health worker (CHW) programme was established in Nadroga/Navosa during 1986 to extend health care delivery to the grass roots level with active participation by each community. The SDH trained 20 Fijian CHWs (during 1985–1986) in two six-week programs. Their training was partly funded by the Soqosoqo Vakamarama, a Fijian Women's organization which was in turn funded by W.H.O. The Soqosoqo Vakamarama worked cooperatively with the
MHSW and conducted seminars in preventive health care and nutrition. Women were selected for training by their villages.

Table 11-9, on the next page, presents the clinical experience and training requirement for the CHW curriculum as used by SDH. CHWs were trained by the medical staff, doctors and nurses, at the hospital.

When the CHWs had completed their training at the SDH the villagers provided them with space in the village for a "clinic" and paid them a small gratuity of twenty to thirty dollars per month. In their dispensaries the CHWs had a small stock of symptomatics such as aspirin and cough syrup and some supplies. CHWs were to look after the basic health needs of the villagers, simple procedures such as bandaging, providing analgesics, and assessing and referring patients to the District Nursing Station or to SDH as the need arose. Their role was mainly preventive and one of monitoring the health of the villagers. The keystone was community participation and cooperation "in a spirit of self-reliance".

I arrived at the hospital setting just as the last group of community care workers were trained. Since I was working in the settlements, I noticed that no Indo-Fijian women from them were being trained, yet the health status of the villagers was often poor. I asked the Sub-Divisional Medical Officer why there were no Indo-Fijians among the trainees. His reply, one I was to hear time and again, was:

Indo-Fijians won't come (as volunteers), they won't let their women come out of the house.

When I asked if they had recently attempted to get any women from the Indo-Fijians settlements, I was told "no". I heard the same response from the Indo-Fijian Sister-in-Charge of the hospital. Often, people in a situation cannot overcome their background assumptions to be creative and innovative, to find new solutions to old problems. My response was to tell them that
Table 11-9

N/N VOLUNTARY HEALTH WORKER'S
WEEKLY CLINICAL EXPERIENCE REQUIREMENT

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Orientation Week</th>
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<tbody>
<tr>
<td>Introduction</td>
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<tr>
<td>Aim of Course</td>
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<td>Function of VHW</td>
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<td>Roles</td>
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<tr>
<th>Week 2</th>
<th>Outpatient Skills</th>
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<tbody>
<tr>
<td>Interview of patients</td>
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<td>Dressings</td>
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<td>Bleeding Control</td>
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<td>Care of Unconscious</td>
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<td>Care of Burns</td>
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<tr>
<td>Care of Fractures</td>
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<tr>
<td>Treat Shock</td>
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<tr>
<td>Keeping O/P records</td>
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<thead>
<tr>
<th>Week 3</th>
<th>M.C.H.</th>
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<tbody>
<tr>
<td>Identifying high risk babies</td>
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<tr>
<td>Growth monitoring</td>
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<tr>
<td>Advice on Family Planning</td>
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<tr>
<td>Follow up on defaulters</td>
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<tr>
<td>Knowing high risk families</td>
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<tr>
<td>Advise on A.N.C.</td>
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<tr>
<td>Knowing good food in some preg/puerperium</td>
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<tr>
<th>Week 4</th>
<th>A.N.C.</th>
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<tbody>
<tr>
<td>Maternal Hygiene</td>
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<tr>
<td>Knowing the risks of pregnancy</td>
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<tr>
<td>Diets during pregnancy</td>
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<tr>
<td>Family planning/spacing of preg.</td>
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<tr>
<td>Methods of Family planning</td>
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<tr>
<td>Advantages of Family Planning</td>
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<tr>
<td>Disadvantages of F/P methods</td>
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<tr>
<td>Care of the breast</td>
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<tr>
<td>Breast Feeding - advantages/disadvantages</td>
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<tr>
<th>Week 5</th>
<th>Environmental Sanitation</th>
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<tr>
<td>In village settlements</td>
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<tr>
<td>Schools</td>
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<tr>
<td>Rubbish and Waste Disposal</td>
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<td>Vector Control</td>
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<td>Water supply</td>
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<td>Drainage</td>
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<td>Housing</td>
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<tr>
<th>Week 6</th>
<th>Medical Conditions requiring Domiciliary Care</th>
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<tr>
<td>Follow up</td>
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<tr>
<td>Care of Diabetic</td>
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<td>Care of Hypertension</td>
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<tr>
<td>Care of T.B.</td>
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<tr>
<td>General Advice</td>
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<tr>
<td>Follow up of Contacts</td>
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<tr>
<td>Supervision of Drug Therapy</td>
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there would be no problem to get young Indo-Fijian women to come as volunteers to the hospital if they were properly chaperoned. There were hundreds of girls in Fiji, Fijian and Indo-Fijian, who would appreciate the opportunity to participate in an auxiliary if they were approached
with understanding of the cultural concerns for their care and safety. I demonstrated some success in this later in my research.

I was unable to find out how the CHWs performed after they returned to their respective areas since there was no formal evaluation of their work available during the time of this research. The programme was new in that area in the Western Division and in the exploratory stage of its development. I mentioned above that CHWs were first trained in 1978-79 in the Eastern Division, with the initial introduction of PHC. The expansion of the program has been slow and uneven. In the area of this research no Indo-Fijian CHW had yet been trained and the CHW training was suspended in early 1986 for a lack of funds. At the best of times, training CHWs at SDH was an extra task for the staff who were already in short supply. Because the hospital was short-staffed, one innovation had been to train a CHW at a district nursing station at Tuvu Nursing Station in the Interior of the river valley, for Bemana village. Here, the villagers were actively improving their facilities. The District Nurse at Tuvu was an excellent example of someone who incorporated the creative use of mime, dance and other theatrical modes to teach preventive health care and village sanitation. She taught the children in the villages to act out the skits she wrote, and presented them as part of ceremonies such as the graduation of the CHW whom she had trained. Recently, with the aid of World Vision the villagers at Bemana had added several large tanks to hold the village water supply. And they had built a small building as the medical dispensary where the CHW would work. Her graduation was a formal ceremony in the Fijian tradition, to which the SDMO, the Peace Corp worker and I were invited to attend, along with the public health nurses who served that area. The CHW wore the traditional Fijian tapa gown and her hair was powdered with turmeric, as is their custom on such an occasion. It was a proud day for the CHW and for her village, and we validated her graduation.
The doctor who was the sub-divisional medical officer was always a specialist in Public Health. He was provided with a vehicle for transport of staff. The van was used by the health team when it traveled out to the rural areas. A small jeep served as his regular transport within the township, on errands, and on rural visits when fewer than six staff members were going with him. Most of the time, the vehicle was used by the Health Sister in the area, although once a month it was also used by the surgeon on his trip into the interior. Throughout Fiji there was an acute shortage of transport for government staff. The funds for fuel and maintenance costs were in very short supply. It was sometimes weeks before a car could be repaired, even if the parts were in stock, which they often were not. Given this situation, transport was highly valued as a status symbol, and its use as a scarce commodity made it the venue of a great deal of antagonism. The politicization of the health care system can be illustrated by my experience during the first weeks of my fieldwork.

On my arrival there, I was well received at the hospital as a doctoral candidate in anthropology. I knew that the health teams went into the interior quite often, and knowing nothing of the problems of transport and the antagonisms they arouse, I asked the surgeon, an expatriate from the Philippines, if it would be possible to accompany them on a trip. He told me that they would be happy to take me on the next trip when a health team made up of the nutritionist, the Public Health Sister and her staff would be going right up into the interior of Fiji to one of the last health outposts. Shortly afterwards, a message arrived for me to be at the Health Centre in the town, on a certain day, early in the morning. I arrived there at the appointed time and the surgeon, the most senior staff person, allocated a seat to me in the back of the small jeep driven by his Nepalese driver. With me sat an Indo-Fijian nurse, a public health nutritionist. We had covered ourselves with towels to protect us from the overflow of the drums of kerosene which we were to deliver to the District Nursing Stations in the interior. As we got
into the vehicle, the Fijian Public Health Sister whose role in the medical hierarchy I did not yet know, looked at me and said sharply "I will go in the van". It was weeks before I learned that I had displaced her in the jeep. That one trip caused enough hard feeling so that in the months ahead she rarely allowed me space in the vehicles except under rare circumstances. I learned this from a retired overseas volunteer, a woman, who was forced to resort to the public bus transportation system because of what she termed arbitrary decisions about vehicle use. It would have been collegial for the Health Sister to have assisted us in our work and research, as well as professionally more appropriate, than to deny us the opportunity of visiting the other health stations when there was room in the vehicle.

The Public Health Sister in charge of the Nadroga District was junior in the administrative hierarchy to the surgeon from Southeast Asia. He carried out his interaction with her without doubt of his status. But fully aware of his need to maintain his residential permit in Fiji he did not usually go out of his way to antagonize the Fijian people. In fact, he was known to sincerely like the Fijians very much; many Indo-Fijians said he was anti-Indian. My experience was that any politically astute person was careful not to upset the Fijian people. Staying in Fiji as a researcher or as an employed expatriate depended on fairness and equity in dealings with both ethnic groups.

From my observations in the hospital, where I could hear the daily telephone calls in the office, I realized that there was an extensive gossip link from the hospitals to the Ministry of Health. Sometimes people relied on friends in high places for assistance in what was a broker-type of relationship (a patronage system). Both Indo-Fijians and Fijians were quick to phone their contacts in government in Suva. The channels were often along friendship lines, kinship relationships, or through the lines of the members of chiefly families, who when slighted could and did try to make life a little difficult. Gellner (1977:4) finds that patronage
flourishes in the incompletely centralised state. According to him, centralization may be of two kinds, territorial or qualitative. He says:

...a state may control its entire territory, but lack the technical resources to implement its will in some aspects of life, say the economy, or education, or medicine. This will then once again lead to the emergence of informal brokers—patrons, controlling benefits which cannot be distributed in accordance with the official rules. The failure to do this may arise from an excessively high level of aspiration, due to some international competition for prestige. For instance, if a state decrees a free national health service without possessing the required number of doctors, the inevitable consequence must be some informal brokerage in the dispensation of scarce but nominally free medical services (1977:4).

In this sense, the situation in the hospital was an ideal example of Gellner’s argument. Both Fijians and Indo-Fijians called patrons or potential patrons in Suva in order to find placement in leading schools for sons and daughters, or to exchange their own insecurity of job tenure for exchange of benefits. In Fiji, it is important to note that the cause of seeking patrons was rampant, BUT in most instances it was as Gellner (ibid:5) states: “A different kind of patronage...when a modern or semi-modern state operates in an idiom as yet unintelligible to a large part of its population, who then need brokers (lawyers, politicians, or characteristically both of these at once) to obtain benefits or to avoid persecution. This may be combined with a situation in which the state is a large or the main employer, and brokers control access to employment”. Often people do not know the process of getting things done through bureaucratic channels, and they must rely on those who do.

Brokers also control access to higher advancements within the bureaucracy. Where the few most senior people are selected on the basis of preferential ethnicity (Fijian) but the minority (Indo-Fijians) form the backbone of the cadre of specialists, we get the situation as in Fiji where promotion and tenure of the minority to the top of the bureaucratic hierarchy is reserved for a very few. Others either content themselves to remain in their most senior posts,
but not at the top, without further advancement, or they seek to migrate. If the person seeking advancement is new in the medical field, then the process of seeking advancement is through pursuing specialist training overseas through intense and brutal competition for a very few available scholarships. The person who receives them must be a master at negotiation and pacification, and thick-skinned, for it is a mixed blessing. These types of transactions are very complex, involving both long term political allegiances and short term exchange of esteem for economic advancement. Since my knowledge of these transactions was usually incomplete (I lacked access to the Suva-based patrons), I leave this suggestive topic as one for further research.

Competition existed throughout the biomedical institution and the various health sectors. For example the interactions between the nutritionist from the hospital and the public health staff from the Medical Centre were competitive. She occasionally was required to travel with them into the interior Health Centers and Nursing Stations. During our trips the nurse/nutritionist usually travelled with the surgeon from the hospital and did not need to interact intensively with the Public Health nurses. I was to find out later that she had actually been hired as a public health person. Much to the displeasure of the staff at the hospital and the health center, she preferred to work at the hospital rather than in public health. When I asked her about it she told me:

Because we are Indian, we can't go around like that all over the place, my husband doesn't approve. When I get my driver's license I can use the vehicle the Ministry has provided for the nutrition staff. Then I'll do it (go out on Public Health duties).

Once she has her license she will be able to use the vehicle assigned to the nutrition staff which is based in Nadi. I assume she will then book the days when she requires the vehicle.

She was competent, her work at the hospital was to run the kitchen, do all the purchasing, plan and supply the food for the nurse's quarters, and to work out the diet plans for
each patient. As well, she was supposed to educate the diabetic patients about diet. (In actual fact, she had little time to do health education at the hospital and rarely did she go out to do so in the rural areas with the health team.) She was good-natured and worked well with the doctors at the hospital.

The problem of transportation was compounded by poorly organized travel plans. In some cases the health teams reached their destination without the very supplies they needed to do their work. One such instance was when they arrived in an interior location in Fiji and realized they had left the vaccine behind. In another instance the health team travelled to a pre-arranged clinic for the elderly only to be told there was a wedding in the village so no one would be attending the clinic. Had the nurse at the rural health unit advised the surgeon beforehand, they could have made other plans and not wasted the day, the fuel, and the vehicle. Still another condition that aggravates the situation regarding vehicular use is that the “new elite” in Fiji as well as in other developing countries will not travel by local transport even when it is good, cheap, reliable and convenient. The health team often could have traveled by bus to the District Nursing Stations, but would not do so. Rather, everyone waited until they could travel by transport.

The examples discussed above illustrate many of the problems of interaction that were to occur during my stay and which I will explore in the pages ahead. These are some of the variables in the organization of the greater society which are also represented at the level of the health care system. One such issue is that of ethnic group membership, the other that of residential status in Fiji. Both the doctor who had seniority over the Public Health Sister, and I, who had years more academic training, were from overseas. Understandably, people in Fiji are not happy about people who “take their jobs away” (the surgeon), or who come to research them (my case). In my case, the problem was compounded by my being an Indian, and also an
expatriate.

Competition for prestige underlies many of the difficulties in interaction which I observed. For example the Peace Corps health educators were not paid workers and were not under the supervision of the medical staff in Fiji. Medical personnel at all levels had to give them respect, and somehow fit them into their normal routines even though they were "outside" of the medical hierarchy. Since they "entered" the system at a senior level such as that of the Nursing Sisters, medical nursing staff felt they had to obey them, or agree with them but ignore them. Whether or not a Health Educator from overseas was accepted depended upon two things; first, self-confidence in her own role, and second on the perceived competence others had in her skills. In other words it was a matter of how one presented oneself, especially during the initial encounter.

Ethnicity was a major factor in the interactions between Indo-Fijians, Fijians and "others". Although the public ideology was that there were few ethnic problems in Fiji, this research showed that one did not have to scratch the surface very deeply to discover anger and hard feelings of one ethnic group against the other. Indo-Fijians and Fijians who worked together in bureaucratic situations worked in a situation of seething antagonisms. It was to their credit that they managed to do so. But there was a cost, and it was apparent in stress levels and related illnesses in the population. (Fiji had made the epidemiological transition to diseases of the circulatory and respiratory systems prevalent in most industrialized societies). The public ideology of mutual tolerance was perpetuated by a government which discouraged free expression of ethnic problems. Although, technically, people had the freedom to discuss ethnic problems, very few of those who suffered from ethnic discrimination in jobs, for instance, complained. Most of those people were working in the civil service and told me that the unspoken rule was not to mention inequities in hiring or work procedures arising out of ethnic issues. The most
distressing was anger and hurt caused by the advancement of Fijians with lesser skills into positions of higher prestige and salary. On the whole the Indo-Fijians kept these things to themselves, showing an immense tolerance of the situation they were powerless to change.

"Expatriate" medical staff in Fiji had many problems. They were allowed by the government to work in Fiji with permits which were renewed for several years at a time. While they worked there, they provided the people of Fiji with an opportunity to learn very skilled health management. They had high ethical standards, and fine mastery of their specialties. Usually, they were also at the top of the medical hierarchy and earned high salaries and lived in government housing. Understandably, because they were part of a small cadre of elites, they were the focus of envy, not only in medical circles but also among the local Fijian townspeople.

The purpose of these examples was to give an overview of a few of the elements in the interactions in the Western biomedical model which people confront in their strategems of work within the health care sector. It points out that factors such as ethnicity, status, sex, citizenship and class, cooperation and competition, processes of transactions, politics, and patronage systems, all have a bearing in the health care process.

As I have mentioned briefly above, Public Health services were carried out by the Public Health Sister and her staff, from the Lawaqa Health Center, under the supervision of the sub-divisional medical officer. The Health Sister was in charge of all the Health Centers, the District Nursing Stations, and the Community Health Workers in Nadroga/Navosa area. The public health services from the Health Centre provided maternal and child health clinics, family planning counselling and carried out school health services. Their mandate included educational programming, but there was a lack of organizational ability or systematic collaboration with other educational systems to carry it out effectively. Two reasons are
apparent; the first is shortage of trained staff. But part of the problem too was that those few people who were motivated and had "a vision", were not allowed to try it out because of the nature of the hierarchical structure of staffing and the authoritative and competitive interaction between them. A case in point was that of the Peace Corps Health Educator who after months of work in Fiji at the Health Center, was finally given space in the trailer beside the building. She felt she could have been given space in the clinical part of the building or in the office of the Health Sister, with just a minimum of rearrangement of furniture. That she was not, perhaps indicates that her presence would have disrupted the normal daily functions in the office, nevertheless she should not then have been accepted for work in Health Center. She had already left the hospital for similar reasons, although she was assigned to work in the Nadroga/Navosa area by the Peace Corps.

The hospital was administered by the Board of Visitors which was made up of leading citizens in the town, mainly Indo-Fijian business men, with a few Fijian men and women. I was told that the board was not very aggressive in seeking change or raising funds. The meeting I attended as a co-founder of the Auxiliary was an extremely vigorous meeting with members of the board questioning hospital activities and expressing critical comment. I found they were very decisive, and forthright. They expressed their concern with the complaints patients had lodged with them, as well as on their own observations on the frequent occasions when they came to the hospital either on unannounced visits, as patients, or when they accompanied a friend or a member of their family. They listened to suggestions made by the doctors and nurses with openness and fairness. They were perhaps conservative in outlook, but that could also be interpreted as caution arising out of years of service on the board, and knowing intuitively as well as through past actions, what the hospital could appropriately undertake and achieve. They approved of the hospital auxiliary and of the fund-raising we were beginning with, and agreed
that the facilities were over-utilized and needed some expansion. Certainly they did not attempt to squash the idea of raising funds for a building. In fact one board member who was also on the city council, informed us that the city council was donating a small building to the hospital auxiliary. The Hospital Board of Visitors was a very influential committee and oversaw change and expenditure. It had the power of veto on hospital activities.

The Public Health Inspection Staff, occupied premises separate from the hospital staff, in a building in the town. They were supervised by the Sub-divisional Health Inspector who was under the jurisdiction of the SDMO. Their work was largely environmental inspection, which one expected to be sanitation, water supplies, etc. During my appointment with the senior staff in the office I was told that their main work was building inspection of new premises. As I pursued the topic, about whether sanitation and water and other environmental issues were inspected, one of the staff members finally reluctantly told me that they could not do so because there was a shortage of transport for the staff. In fact, less than 50% of the staff time was spent on the urgent issues of sanitation, and of concerns about clean and stagnant water, vermin control, garbage disposal, etc. (This was interesting in the light of the problems of mosquito vector pollution which was the cause of dengue fever in Fiji.) Later in my research year I observed the health inspector in another of his duties as he supervised villagers building of water tanks near Nalebaleba, funded by overseas aid.

Other medical services in the town were provided by private doctors. In Sigatoka there were at least seven, of which two were male South Indo-Fijians, two were male North Indo-Fijians (one of them a Sikh), one was a white Christian woman, one was a Muslim woman. Until 1985 there was also one Fijian doctor, who had since closed his practice to work as the director of an overseas medical aid organization in Suva.
Most private doctors had their offices in the town. Additionally, each doctor had another clinic he or she holds once or twice a week in an outlying area; or the doctor worked as the "resident doctor" for one of the luxury resort hotels on the Coral Coast. I was told angrily by a doctor at the hospital that the private doctors also had small dispensaries from which they sold drugs to fill the prescriptions they gave their own patients. During my work in Outpatients', I saw patients come in with small packets of prescription drugs which they had purchased from private doctors. When I enquired about the legal implications of that, I was told that strictly there were a few controls against the practice but they were not adequately enforced, because of lack of staff. I discuss the outcome of this process of dispensing drugs in a wider context below.

Abortion is illegal in Fiji, but people who can afford it are able to have the procedure performed quite easily. I was told by a number of nurses, private individuals and four doctors (one in private practice and three at the hospital) that some private doctors will provide abortion services, a charge which may be due to professional jealousy. Two doctors told me of actual cases of patients who had been prescribed ergometrine or other medication to induce their periods. In one case, widely known of and talked about in the town, these procedures had a fatal result. One doctor told me that one process was that a woman who missed her regular menstrual period and thought she was pregnant, would go to a private doctor who would prescribe the drug to bring about bleeding. When this occurred she would be referred to the hospital and if she was pregnant, she would be advised to undergo an evacuation procedure which would terminate the pregnancy. (If the pregnancy was not terminated, there could be damage to the fetus.)

There was one dentist in the town. An optometrist from Suva held a clinic every fortnight or once a month.

The North Indian male doctor was a specialist in acupuncture. He was trained in Australia and had never been in government employ. His surgery was in the town, but he was
the resident doctor at the largest and most prestigious of the resorts in Fiji, and had accommodation there as well.

The Christian woman doctor was also trained overseas, in New Zealand. She was the first doctor in the Sigatoka area and although in her seventies at the time of this research, she was vigorous and worked from a private surgery in the town. She had a remarkable history. She began her work as a missionary in Bihar, India returning to nurse two parents through terminal illnesses as she began her practice in Fiji. I was told many stories of her going out in the middle of the night, sometimes crossing a river by boat, to attend to a woman in labour in one of the settlements. She served as a justice of the peace in the town, and was on many committees such as the town’s library committee.

The remainder of the doctors were trained in Fiji. I do not know about the training of the dentist. Both of the South Indian doctors were first employed in the hospital system and then had gone into private practice. One of them was quite young and was active on the board of the Fiji Medical Association, and he was resident physician for a hotel on the Coral Coast. He also helped the Director of the Epidemiological Unit of the Wellington Hospital in New Zealand initiate the Fiji branch of the International Physicians for the Prevention of Nuclear War.

There was also a Crippled Children’s School which opened the week I arrived in Fiji, in the summer of 1985. There was much controversy about how it got started and who was responsible for the impetus for building it. Before too long it was apparent to me that the “work horse” was an expatriate man from Europe, but he was not an effective leader and I was told that he antagonized others in the town who were the “leading citizens”. Prior to the official opening of the school, attended by the Minister of Health and the Prime Minister’s wife, I was told he was forced out of the committees. He was still bitter about his treatment and few people blamed him, but they understood he was difficult to get along with. Still, he did much of the work, as well as
drawing up the plans for the school buildings. The school was attended by many of the crippled children in the district. Within a few months, with the help of the physiotherapist, many had already learned how to exercise, and in one case, how to walk. Their daily improvement, mastery over one more small skill, and general learning was a great achievement in a short space of time. The physiotherapist was able to identify those families who most needed a wheelchair for a child and was able to requisition one for a few of the families. The school eased a great burden from the shoulders of many mothers, who once the disabled child was happily away in school, had a few hours of time for other things.

Although there were two private hospitals, at Ba and Ra respectively, one Methodist and the other Catholic, there were no such facilities in the Ndroga/Navosa province. There were however Catholic Sisters (Nuns) who visited the sick and indigent. One Catholic Sister from New Zealand, perhaps in her sixties, visited homes throughout the area, tending to those in need of religious attention and succor.

I have now outlined the major health facilities available in Sigatoka town. Prior to presenting the empirical data on the interactions and processes which make up the health care strategies Indo-Fijians use in the Western Biomedical arena, I have tried to show some of the intervening factors which influence their decisions and choices. Some of the more important factors are status, ethnicity, communication, and transportation. They imply the idea of boundaries and their maintenance and how people make strategies to achieve, and in other cases to provide, good health care within organizational limitations.

It is against this background that the processes and interactions of health care seeking by Indo-Fijians in the Western Biomedical sector presented in the following chapters should be understood. The local institution reflects the social organization of the country, culturally and bureaucratically. Part II typifies Moore's (1978) "processes of situational adjustment".6
Footnotes:

1 The SPHC is mentioned by C. H. Gurd (in Miles, 1984:111) quoting from the 1957 Agreement as made up of the Gilbert and Ellice Islands Colony and the British Solomon Islands Protectorate, and the Government of New Zealand, for the N.Z. Island Territories including Western Samoa. Gurd states they came together "...for the more effective protection of the health of the people of in the Territories under their administration". He does specify what region the "territories" covered in total, but does say that representatives from the New Hebrides, Niue and Cook Islands, as well as from the W.H.O. were "...invited as observers to the annual meeting of the Board, and were encouraged to participate actively in the proceedings."

2 The ethnic categories as officially used in The Report of the Census of the Population 1976, Vol. 1, Parliament of Fiji, Parliamentary Paper No. 13 of 1977, page 56, is made up of the following categories with their code: European (1), Fijian (2), Indian (3), Part European (4), Other Pacific Islanders (5), Rotuman (6), All others (7), and not stated (9). In Medical statistics these categories are collapsed to Fijian, Indian and "others".

3 Dr. W. became aware of the criticism leveled at him from his staff and later told me that his reason for staying out late on public health trips was political. He said major changes to health care delivery to Fijians were going to take place at the time of the next election. These had to do with changes to some aspect of the Fijian administration first legislated in 1969, but not enacted in the interval. He said the changes would be of such a magnitude that he felt he should prepare the villagers in Nadroga/Navosa. He was aware that his interaction with the Fijians, his interest in political processes in anticipation for the 1987 election was not going unnoticed. The Indo-Fijians were certainly cognizant of why they were left out of the public health trips. He was of the Eastern Fijian elite group.

4 This therapist is implementing an innovative program in mobile physiotherapy as proposed and described by L. Oldmeadow in Fiji Medical Journal Vol. 13, No.9 and 10, Sept./Oct. 1985: 203-204.

5 Gellner (1977:4) states: "Patronage is unsymmetrical, involving inequality of power, it tends to form an extended system; to be long-term, or at least not restricted to a single isolated transaction; to possess a distinctive ethos; and, whilst not always illegal or immoral, to stand outside the officially proclaimed formal morality of the society in question....What favours the emergence of patronage? It is a form of power. Where power is effectively centralised, or on the other hand well-diffused, patronage is correspondingly less common. Hence segmentary societies with their wide dispersal of power, or effective centralised bureaucracies, or market economies with a restrained liberal state, are unpromising seedbeds of patronage. It is the incompletely centralised state, the defective market or the defective bureaucracy which would seem to favour it."
In this sense Fiji is perhaps still best described as an incompletely centralised state undergoing growth pangs common to newly emerging nations. Nevertheless, it is meeting the problem of trying to provide equitable health care across a broad spectrum of rural and urban needs and aspirations, with determination; and in a relatively short time has achieved some success.

The interactions and processes in these chapters on the Western Biomedical system as it is used by Indo-Fijians show how situational adjustment as a process emanates from and is influenced by the interplay of factors at the level of government legislation and policy and its interpretation and enactment at the local level, by ethnic relations, by rules or regulatory aspects of the medical field as produced by unions, formal and informal associations, and local bureaucratic practices, as well as by the interactions and processes between healers and patients as interdependent units.

Patients and healers are motivated to comply to the rules of the game, and both have rights and obligations in their exchanges. They have both legal and various non-legal inducements to secure compliance from each other.

On the other hand, the therapy management group (the lineage, the wider kinship group, the neighbourhood, etc.) and the patient are a partially self-regulating or decision-making field of action and has effective control over its members. It may or may not seek treatment in the Western Biomedical System and except in acute cases, exercises the option of seeking alternative medical therapies. (In some instances therapies are chosen which are processes regularized over time and may be healer specific in terms of Indo-Fijian conceptions.)
Chapter 12

INDO-FIJIAN UTILIZATION OF BIOMEDICAL FACILITIES

The research problem which this chapter addresses is the following. What interactions and processes are present when Indo-Fijians (and Fijians) transact therapy in the biomedical health care sector?

In this chapter I examine the attitudes of patients when they seek treatment (i.e. early or late in illness careers). The interactions and processes involved when patients first present the illness, and during diagnosis; as well as their subsequent attitudes to the prognosis, their questions about it, and their response to therapy, are the subject matter for the present chapter. In sum, I examine processes of communication and knowledge, processes of diagnoses, and the therapeutic process.

The processes and interactions of Indo-Fijians as they seek health care in the biomedical sector in Fiji are integrated into a multicultural (although with only two main ethnic blocs) context. The medical staff at the SDH Hospital, the Health Centers and the District Nursing Stations, themselves from a number of different ethnic or communal groups, serve a multicultural population.

The core question is What social, cultural, psychological and religious variables explain the differences in interactions and processes in the biomedical health care sector?
The first area in which I worked in the hospital will demonstrate the interactions in the multi-ethnic Outpatients' Department (hereafter OPD) clinic attended by the Muslim Obstetrician, Dr. B. My role was that of a clinical anthropologist.

Although all of the doctors at the hospital were scheduled to work in the OPD, I was seldom able to observe the other doctors for as extended a time. Most of them felt a sense of unease about my observing their interactions with the patients. And I know with confidence that the primary reason was their poor grasp of languages other than their own. (Personal communication). Dr. B. and Dr. C. (the surgeon) were most at ease with me, and allowed me to work with them. The other doctors, while kindly and helpful, were uncomfortable about my observations of their work. As a consequence those data are not nearly as detailed as that about Dr. B.¹

The facilities at the hospital are used by Indo-Fijians, Fijians, and other ethnic groups. I have shown in the last chapter that the staff at SDH are also from a variety of ethnic backgrounds. Thus the interactions and processes in Part II necessarily include and contrast Fijian with Indo-Fijian behavioural styles (responses and reactions) in health care seeking.

When patients arrived at the hospital for treatment they were given a number by the clinic nurse or by the clerical staff who sometimes assisted the doctor. As the patient whose number was called came into the office, the doctor examined him or her, speaking in Hindi if necessary, or in English mixed with Fijian words if the patient was Fijian. Concurrently, she explained the diagnosis, the rationale for the treatment, and then she prescribed the therapy. She treated my questions with sincerity, was open to my suggesting or asking if an alternative might not be the case, or when I asked her for the evidence upon which she based her diagnosis. I also questioned the treatment regimens she prescribed and she reacted in the same way, honestly, giving me her reasoning and evidence for that rather than some other treatment. Her interaction with me took this form for the duration of my work at SDH, and provided me with a
rich learning experience in the many areas of the hospital in which we worked together during
the year of this research.

In the following examples, I am presenting some of the range of variation in OPD in
patients, illnesses and treatments. They should be understood against the social and political
environment presented above as background.

The examples are from my notes of days I spent in the OPD clinic with Dr. B.:

No. 1

Dr. B has already completed rounds in the Obstetrics Ward, it is nine a.m. on a
Saturday morning. She has been at the hospital since 5:30 a.m. The patients are all
out in the waiting room, lined up near the door waiting for attention, they have their
numbers and come in one after another at the rate of 1 every 2 to 3 minutes. Very
few are emergency cases. The doctor is annoyed, she tells them that doctors do not
have the time to see them like this and that they need to come during the week if they
are sick and not to leave the illness until later when it has progressed and is hard to
treat.

She is quite strict and short with those who have come with minor or chronic
illnesses. One elderly Indo-Fijian woman in her late '60's comes in and sits down.
The doctor asks her what is wrong in Hindi. The woman tells her that she has aches
and pains in her chest and her body. She refers to the doctor as "betai" (daughter).
[Even so, they both know that asymmetry exists in their roles.] The doctor tries to
find out what kinds of pain, Is it sharp pain, dull pain? (Nani means maternal
grandmother - the doctor refers to old women by this term.) How often does it pain?
Does it burn or pain? How long has this been going on? Do you vomit from it? Is it
in the middle of the chest or in what part? The doctor takes her blood pressure, it
is normal. She then inspects her eyes, throat and uses the stethoscope to check her
heart and lungs. She looks at the palms of the woman's hands and shows me how to
tell if the woman is anemic. (You ask the patient to hold her palm out with fingers
well back, if the lines are not a very dark red then she might be anemic, in which
case we check her eyes and mouth, and then if in doubt send her for a blood test.)
She is not anemic and she does not have any fever. The woman quietly explains to the
doctor "Beti" (daughter) the medicine did not work any relief. She is well dressed
with a blue saree, hair neatly groomed and she is wearing her jewelry (she is not
widowed).

The doctor looks cross and explains to me that the woman comes in every few weeks
with the same complaint, (even though she looks quite well) and spends her time
visiting other patients. She does have aches and pains, probably from working hard
in the fields all of her life, and from old once minor injuries which now ache as she
gets older. But they are not serious. This is partly a social problem and partly one
to treat with heat and aspirin-like therapy. [Dr. B. explains that phenylbutazolidin
is no longer used because of the numerous side-effects it caused.]
The woman is happy with the attention, she enjoyed her interaction with the doctor; then clearly relieved to have gotten some advice and attention she soon leaves. The doctor is annoyed - she says she does not have the time to spend with these minor problems but they too must be treated. She has a few elderly women patients who come to the clinic for the same problem every few months and usually on a weekend when they are coming to the Saturday market in town. The trip to town becomes an all purpose one.

No. 2

The next example is a Fijian man with a septic sore foot. He comes in and is seated. He looks so distant that she asks, "Do you speak English"? He raises his eyebrows in the way Fijians do when they mean yes, maybe or I agree with you-no. She is not often wrong in her interpretation of the signals. Later he does quietly, minimally, reply to her questions for the medical history. It is an injury, he did not think it would be bad so left it, then he treated it with Fijian massage and herbs. When it kept getting worse, he came to the hospital for treatment. The doctor explains to me that Fijians will not come to the hospital until all other treatment options have been exhausted. In the case of serious illness it is often too late for any treatment other than terminal care. In this case she scolded the man gently: "Hey boy - this no good eh! You can lose your foot - let me see the bottom - o.k. go to the nurse next door she can clean it and bandage it - you need a shot of penicillin too". Then she gives him a prescription for antibiotics and she shouts for the nurse and tells her how to treat the foot.

No. 3

The next patient is already standing at the door watching the doctor, she calls the patient in. The Fijian man comes in and shows her his head - it has several large boils. This man too is very silent. She treats them very gently and kindly. The Fijian people are so unassuming when they seek treatment. She asks him if the sores are anywhere else on his body. No. Again the nurse is called and asked to lance the boils, he is given an injection of penicillin right away and then he must return for one a day for five days. The nurse takes the man into the adjoining room and cuts away some of his hair. She uses a sharp instrument to open the boil and to drain the pus. She presses the boil with gauze pads. There is a good deal of bleeding. The process is painful but the man hardly flinches - typical of Fijian people he conceals and denies pain.

No. 4

Next patient is an Indo-Fijian woman who is threatening to abort. She tells the doctor that she is perhaps six weeks pregnant and she is spotting. She is assertive about one thing - she keeps repeating she wants her periods back. She is only 22 years old. The doctor asks if the child in her arms is the youngest. She says yes at first and then nervous, she corrects her self and says no the eldest. There is younger one at home. The doctor is annoyed and wants her to tell the whole history - the woman won't, she is reluctant to say anything except that she thinks she is
pregnant and she keeps repeating that she wants her periods back. It is a sad case, the young girl clearly confused and agonizing about having a third child with an infant at home and one in her arms. She does not want to be admitted to the hospital either. Finally, the doctor tells her that she has to decide - if she goes home she can miscarry and will be ill. Otherwise she can do what the doctor suggests, which is to be admitted for observation and treatment. Doctor B. is clearly judgemental about the woman not using some contraceptive method, and having children too close together. My observations of her interaction with these poor unfortunate women is that she sometimes reprimands them even though she feels sorry for them.

She turned to me and said in English "How can I give back her periods! She is going to miscarry and doesn't want to be admitted!" She turned to the patient who by this time looks somewhat sulky as well as upset, and tells her that she is going to complete the forms for her admission and when she has done so, she gives them to the woman. The woman tells us that she will have to go to Cuvu to take her baby home by bus and then she will come back to the hospital. The doctor is powerless to make things any easier for her, and tells her that she will not be responsible if she does not return, that the young woman will suffer complications of the miscarriage if she does not return. The woman wraps her sari tightly around herself and picks up her baby and handbag and leaves. (I learned that she did return later.)

No. 5

A young 17 year old Indo-Fijian boy comes in and sits down. When Dr. B. asks what is wrong and he shows us his hand which has a boil, the infection has spread to his fingers, the hand is badly swollen. The doctor asked him if his family did not tell him to go for treatment. He said yes they had, but he did not want to come to the hospital. She tells him that he will have to have it lanced. His attitude is sullen, nor does he want to have the injection of antibiotics. The doctor calls the nurse who takes him into the treatment room. A few minutes later we hear him scream in pain as it is lanced. The nurse comes in and tells the doctor the boy will not have the injection. Then Dr. B. goes and (I follow her) tells him strictly that he must have the injection otherwise the hand will become so bad that he will have to be hospitalized and could lose it. He has neglected treatment so late that already the skin is stretched taut over his fingers and the back of his hand. The doctor wants to admit him in any case - she is afraid of his neglectful attitude and his fear and stubbornness about the injection. He refuses to comply, saying arrogantly that he was going home today - to a place quite far up the valley road into the interior. He cannot be talked into taking the injection of antibiotics or to stay in the hospital. Finally, the doctor tells him he must wait until the police come to witness his statement that he is leaving and refusing treatment against the advice of the doctor. He tells the doctor that is fine he will wait and sign the papers for the police, but will not comply. The nurse calls the police. When they arrive, they try to tell the boy to stay and he refuses, signs the papers for the police and leaves.

No. 6

Then there is a call from the treatment room for the doctor. We quickly go in just as a young Indo-Fijian couple are bringing in a burn case - their four year old daughter with her whole left chest burnt by scalding, as well as her left arm, hand, and left back. I have never seen anything like this. She is very dark and the flesh
looks raw and very pink and red. The child is crying in agony, the skin burnt right off. The nurse takes down the history. The mother had put the rice cooker on a table and the cord was stretched over to the plug on the wall. The child was playing with her brother and ran through the cord pulling the cooker over herself. They brought her right into the hospital.

The nurse put a sheet on the examining table and with clean gauze the doctor and nurse applied silvikrin, a thick white cream. A light gauze was put on the burns and she was then put to sleep in the Children’s Ward. The shocked parents sat and watched as the child was treated. Then the doctor told the mother she would have to stay to watch over the child, to make sure she took a lot of fluids. The parents were very eager to please, and did just what the doctor ordered. The mother went into the Children’s Ward and the father went home to look after the rest of the family. They were told it would be a few days at least before the child felt better and a long time for recovery.

Later I went to the ward to see if the mother was waking the child to take fluids, but she was reluctant to because the child screamed so. The burn had begun to ooze water and it was running in little droplets. The ward next to the Children’s Ward, is the infectious ward for men. Also, in the Children’s Ward there were children who had diarrhoea. I went back to the doctor and asked her if the child was not at risk and also told her the mother was not waking the child to force fluids. The doctor came and examined the child again; then decided that she would send her to the burn unit in the Lautoka hospital by ambulance. She explained carefully to the mother that the child would be better cared for in the large hospital. The woman was very willing to comply with whatever the doctor said.

The nurse called the ambulance to get ready to transfer a patient. They called a nurse to fill the forms and to accompany the child. Meanwhile the doctor put in the IV drip as I helped her by holding the child’s arm. Fresh cream and gauze were applied and the child and her mother were sent on the hour long trip to the large hospital.

(Finally it is time for the doctor’s tea. We go into the other waiting room where the staff have their tea. It is usually lively with the nurses all chatting about days off, holidays, patients, etc. It is good to have the break. We have seen about 25 patients already as well as the major instances reported above. Then it was back to OPD to see many more cases with colds, flu, respiratory ailments and septic sores.)

No. 7

A young Indo-Fijian girl came in alone, she is about 14 years of age, she complains of stomach pains, but no diarrhoea, or other symptom. She looks grey in colour and is thin. The doctor examines her and gives her worm medicine and tells her to come back in several weeks, after the treatment is finished, for re-examination. The girl is very polite and her demeanour is humble and respectful. The doctor is very kind to the child, explaining to her carefully how to take the first lot of medicine, then to wait a number of days and to take another dose of it. She told me the medication is quite safe for any patient.
Then the nurse calls the doctor into the examining room, where an Indo-Fijian man has just come in with an allergic reaction to lobster. He is also frightened, his throat constricted and his body covered with hives. He is accompanied by two male relatives who are both trying to explain how the allergy 'happened.' (They had got the lobsters and were having a party.) His wife looks worried and is trying to attend to his needs. The doctor gives him the necessary injections and tries to calm him down. He finally lies more still, with his eyes closed and arms crossed on his chest. The doctor is now attending to someone else; his family are waiting. They wait very patiently, trusting the hospital doctor completely with the care of the man. Many of these families have an immense respect for this young woman doctor. She is firm, known to be competent and kind even though she reprimands people for not taking better care of themselves or for not coming for treatment sooner. She discharges him a couple of hours later, once the allergic response is under control. She often cannot admit people into the hospital because of a shortage of beds, although one bed at least, is usually held for urgent cases.

These examples are sufficient to show the range of variation in general processes and interactions in the OPD at the hospital when Dr. B., the Indo-Fijian, Muslim woman doctor was attending. They show the broad spectrum of ailments and patients treated by Dr. B. Some of the examples are of ordinary or common types of illness presented in OPD, while others occur less often.

My primary interest is in examining the common features in the interactions and processes showing the way Indo-Fijians seek health care at the hospital, but in these examples I include Fijian patients for I am also interested in how doctors diagnose and communicate with patients; and in how illness is negotiated or the sick role legitimated.

**Discussing The Examples:**

Example No. 1 is a typical example of the interactions and processes which exist among Indo-Fijians when an elderly woman consults a woman doctor in OPD about chronic ailments. The patient tries to negotiate a role for herself based on traditional Indian values which would place the doctor in a role (that of "daughter") if not of submission to the wishes of the patient ("grandmother"), at least on a more equal footing where the patient could negotiate the treatment she desired. The doctors' unease with this patient might arise out of an understanding
of the potential in the situation to produce a sort of counter-transference, a situation in which she feels their normal asymmetrical roles could easily be unbalanced by the manipulation of the patient. I believe the doctor recognizes that even though (a) the woman is taking up time for a condition which is not empirically evident and about the severity of which she has doubts, and (b) the doctor feels it is something readily managed with home treatment, the woman has a legitimate claim to their interaction and can in fact sanction the doctor through complaints to higher authority if she is not satisfactorily treated. The social process involved diagnosis and treatment in the biomedical sector where a younger woman holds the instrumental and dominant role, by virtue of her training. Her power is at odds with the Indian cultural norms where authority is vested in the older person. In order to maintain the dominant/submissive character of their roles, Dr. B. is sharp and impatient with the woman who creates cognitive dissonance in their interaction.

In cases 2 and 3, the interaction is of several types. First it is between people of different genders in cultures which value male dominance. Dr. B. however, is a female. Thus, the Fijian patient negotiates his treatment in these cases with an Indo-Fijian woman doctor, which exacerbates the situation for as a woman she should be subordinate. On the other hand Fijians ascribe high status to people with higher education, and especially if it is of an instrumental type such as that of a doctor who serves the public.

Interaction between the Fijian patients and Dr. B., a Muslim woman, is inter-ethnic. In this situation, where Indo-Fijians and Fijians are dependent upon each other for goods or services, their transactions are based on asymmetrical doctor-patient dyads. Once their status operations or interactions have been fulfilled however, both withdraw from the interactive arena, the tenor of which is the dominant/subordinate roles. According to the "rules of the game", all patients must be submissive, as are the Fijians in this example. But it goes against the grain on a number of counts so to speak. It is (a) an inter-ethnic situation, b) one in which
communication is sometimes difficult, (c) inconsistent with the Fijian (and Indo-Fijian) cultural values of male dominance. Since there is no other way to get therapy, the incentive to conform to the expectation and accept the doctor's superiority is a strong one and forces them to interact in this way, at the same time defining the status of the doctor too, in a narrow way. The two parties to the interaction are in a stable, narrowly defined asymmetrical relationship which is terminated as soon as the one transaction, that of negotiating therapy for illness, is finished. Their exchange while it lasted was one in which each verified the legitimacy of the status of the other; each was a player in the game. Although in most cases the Fijians came to OPD and were treated by Dr. B., it does not mean that they liked their subordinate status. And in fact, the more politicized Fijians, although they did so, were not happy to assume this status vis-à-vis an Indo-Fijian woman doctor. Fijians also tolerated expatriate doctors, but they did so in order to be treated, not because these doctors were their choice of practitioner.

In both example 2 and 3, the patient is diagnosed by the Indo-Fijian woman doctor, but the actual therapy is carried out by a Fijian nurse. I think these situations, in which health care was carried out by a team made up of the two ethnic groups, reduced the dissonance for Fijian patients. They knew that if the doctor treating them did not understand their complaint, the OPD clinic nurse, who was always a Fijian, would do so. And in fact this was the case. There were occasions when a nurse of the same ethnic group as the patient was called from one of the wards by the doctor in OPD, to act as a translator.

Some Fijian patients went quietly and respectfully to the OPD clinic nurse first to explain the problem. Later, when the clerk called out their number to consult the doctor, the nurse came in and explained the symptoms of the illness to the doctor.

In examples No. 4 and 5, patients try to negotiate the instrumental outcome which they want by trying to manipulate the doctor into adopting their point of view. The young woman's case is most dramatic in content, and she asks for special consideration knowing doctors have the
means to "bring back her periods". In the interaction she attempts to negotiate as much as possible from her legitimate role as patient, as a woman and as Indo-Fijian, while remaining submissive to the doctor. She puts the onus on the doctor to change her situation from 'pregnant woman' to 'patient who is not pregnant'. The young man on the other hand, typical of Indo-Fijian men, resents his role of subordination to a woman, and possibly also to her higher class status. Nevertheless he feels no compulsion to show stoicism in the face of pain—a typically Indo-Fijian attitude. He is openly belligerent, and non-compliant. He negotiates as much treatment as he can without compromising or subjugating his own wishes to that of the doctor.

In this interaction Dr. B. is compelled to treat him, but also protects herself and takes the opportunity to sanction his actions by resorting to the law. In doing this she also shows something of her own desire to be dominant by taking the most extreme action she could under the circumstances. In doing so she puts him in some jeopardy with the police; they will remember him and can pick on him later. He did not defer to her authority and in effect was not "playing the game" according to the rules or the ritual that should be enacted in the circumstances, so she demonstrates that she is able to punish him. There is a fine line between legitimate self-protection and the wish to punish people who transgress expectations. Illich (1976:41) states,

"...clinical iatrogenesis includes not only the damage that doctors inflict with the intent of curing or of exploiting the patient, but also those other torts that result from the doctor's attempt to protect himself against the possibility of a suit for malpractice."

In this instance Dr. B. also has the patient's deteriorating condition as an "advantage" in the interactional arena; he must return here for further treatment (and does so the following week, shamefacedly). On the first occasion I cannot guess why he wanted to return home to the interior of Fiji that day, rather than stay in the hospital; or why he would go so far as to sign
forms for the police in this kind of situation. Perhaps it was because he was unable to communicate his extended absence to his parents; or he lacked even the small amount of money needed to remain in the hospital (fifty cents per day). On the other hand adolescents in Fiji, like those in developed countries, sometimes foolishly challenge authority. They are lucky if it is with someone not personally threatened, someone who allows them to somehow gracefully extricate themselves from their mistake. He was not lucky in this respect.

In both of these examples, the patients are constrained by other social and economic forces. First, the distance to be travelled to the hospital, and the cost thereof, entails that they attempt to transact as much treatment as possible in the one visit. It is fortuitous for the pregnant woman that the doctor in OPD is an Indo-Fijian woman whom she can expect to be more sympathetic to her appeal. "Indianness" in this instance is a potent point of leverage, for the doctor knows the cultural nuances of the constraints acting upon the woman. If in fact she is attempting to keep her pregnancy a secret from her affines or husband; that too is an important factor adding complexity to her transactions.

Another possible explanation for her reluctance to be admitted to hospital is that she may not be able to leave her household, farm chores, and other children in someone else's care very often; at that end too she must transact with someone to be there in her absence. This may involve exchange of money or of the same service in the future for a baby sitter.

Examples 6, 7 and 8 are logically opposite to earlier ones above. Here the patients willingly exchange the submissive role and rely upon the doctor's status and role for treatment. They are compliant, eager to do what she asks of them. The young girl's interaction (example 7) is most congruent with the dominant/subordinate type of interaction in clinics. Both patient and doctor are Indo-Fijian; culturally, the young girl should be submissive and respectful to the older woman. Thus status, roles and cultural expectations overlap. The example 6 type of interaction also takes place with dominance/submissiveness as the mode in which the patient and
doctor transact treatment. In an emergency situation in which only the doctor can help, the parents of the child turn their child and their own effort over to the doctor and hospital staff so as to bring together as much therapeutic care as possible for saving the life of the child. Everyone in the situation suspends their own dissonance, or status conflicts or other concerns, in order to achieve a common purpose, an instrumental task for which they are trained.

After the immediate emergency, the doctor is watchful and takes suggestions from me and others as to the care of the child. In doubt about whether the child is in jeopardy by being in the ward next to the infectious one, she responds decisively to my concern about infection and the ability of the mother to care for the child, by negotiating a bed in the burn unit in the larger hospital. She turns over the care of the child to others more competent than herself. While referral to specialists, or to better facilities, is common practice for doctors, the fear of litigation is one of the factors which contribute to the Obstetrician's decision to take that action.

Example 8, that of an Indian man in an emergency situation also reflects how other judgments are suspended when therapy is urgently needed. The man is fearful for his life and is treated by an Indo-Fijian woman doctor and Fijian nurses. He is frightened and compliant.

Thus far throughout this chapter I have written about whether patients were or were not compliant. Compliance (with medical recommendations) is a concept which is so thoroughly embedded in the expectations of the biomedical model, that it is seldom if ever questioned as a significant variable in assessing the outcome of doctor/patient interaction. Yet, as Mishler (1984:49)² states:

Because it is generally taken for granted that compliance is a valid measure of medical care, it requires a shift in perspective and some reflection to recognize that the concept incorporates a medical bias. This point may be appreciated when one realizes that although a high proportion of the patients reported that physicians did not fulfill their expectations, physicians were not described as "non-compliant" with patient expectations. The term noncompliance is used in a way that makes it equivalent to deviance, and it is this deviance from the questioned norms and values of medicine that provides the basis for interpretation and analysis.
Compliance is usually the variable used to judge whether or not the patient is satisfied enough with treatment from a doctor to follow the recommended procedures to get well. Unfortunately, it was not possible in this research to obtain this type of data. It has something important to say to us however about Indo-Fijian use of multiple therapies. Now I return to the main discussion, that of treatment in the biomedical sector.

Each doctor at the hospital serves in OPD sometime during the week. Now and then, visiting interns and assistant medical officers from the out-lying stations work there. I also worked in OPD with the doctor on duty, or with nurses after clinic hours.

The day I spent with a visiting intern (part Indo-Fijian and European) from Australia provided some insights for me about the training practitioners of the biomedical model receive. The following example serves as illustration:

Dr. N. arrived to work with us for several weeks. One day Dr. B. had the two of us seated with her in OPD. I was working with Dr. N. who was examining one patient, while Dr. B. was examining another. My notes about his interaction with the patients are instructive:

No. 9

We were examining a young newly married 18 year old woman who came in because of abdominal pain in her left side. He asked her where it pained, then felt her abdomen, took her temperature and blood pressure and inquired about regularity of bowel movements, etc. But he did not know what was wrong. We were to report back to the doctor after examining her. Around her abdomen she was wearing a faded dore, so I knew that she had obviously sought treatment from one of the traditional medical practitioners. I asked her if the thread was from an oriah, hoping to add to her medical history by eliciting comment from her about why she had consulted him. She told us that she had been to an oriah because she did not feel well. N. did not know why I was asking, and he laughed and answered for her: “Its to keep the devils away, no need to question her, I have my data”. He is a Catholic and he did not mean the supernaturals as in the Indo-Fijian worldview (he did not know about hawa, bhut, chural, etc.), but the devils of Catholicism. It was obvious that medical history for him was the record of the physical illness which he would have treated as muscular pain due to some injury.

As I talked to her I asked her what work she did and the size of her household. She told me that she worked as a cane cutter in her husband’s family. She was the youngest of three sisters-in-law who had six children between them. There were also her mother
and father-in-law to cook and care for. She did not weigh more than just over 100 lbs. It seemed to me that her social history told us about a newly married woman with too much work and familial stress amongst affines who were new to her. A common enough stress related response among Indian brides anywhere.

Dr. N. looked surprised at the amount of work the woman had to do, and it was obvious to me that he felt a great empathy for her — she looked worried, vulnerable and very young.

It was interesting to accompany Dr. N. in the examination room — he is the product of biomedical training. I was fascinated with his clinical procedure, his impatience already as a young pre-intern, in the questions I asked which to him perhaps seemed not to be essential to biomedical history-taking and diagnosis. Because he did not speak Fiji-Hindi, language was a problem for him — he knew what he wanted to know but had to ask two questions to get at it. He was impatient, overrode the question I asked, and too late realized what I was doing.

Dr. N., Dr. B. and I discussed the case. I told him we should tell her, and more importantly her husband who had accompanied her, that she needed a week to ten days out of the cane fields and as much rest as she could get at home; she was to come back for examination after that. After listening to me, he agreed, told her husband and prescribed some tablets for pain relief. The young patient was obviously relieved with the diagnosis and that her ailment had been confirmed. Her husband would now honestly be able tell his family that she had been examined by a doctor and her sick role was legitimized. She would be allowed the rest she so desperately wanted and the family would probably ease up on her work load. To the best of my knowledge she never came back.

Dr. N.'s interaction with the patient was hesitant but thoughtful and very professional. He was attempting to take as much training as he could while in Fiji and appreciated the wide range of problems he was allowed to treat. He was new to clinical practice and it was apparent that he was trying to recall his training as he worked in the practical clinical setting. Dr. N. appreciated the insights which came out of obtaining the social context when constructing the medical case history of an ailment.
The two "expatriate" doctors, a husband and wife team, also work in OPD. Although they are from the Philippines, the Indo-Fijians refer to them as the "Chinese doctors". They both speak fluent English and are able to use each of the other languages in combination with English to get an adequate medical history. Dr. C. is well liked by both the Fijians and the Indo-Fijians. Although he likes the Fijian easy going style better than the tenseness of the Indo-Fijians who are more serious, his subjective feelings do not intrude into his clinical style which is warm rather than affectively neutral. I have a high regard for his ethics and for his performance. As a senior person at the hospital he is always courteous and has a good conception of what scientific research is about. The Peace Corps health educator, the physiotherapist from Amsterdam, and I, each thought of him as fair, helpful and competent. As far as I could tell, he received the patients in the OPD empathetically. I was not able to spend time with him in there except for five or ten minutes when I was not in the other clinics; consequently, I have no examples of his Indo-Fijian interactions. (I did however observe his wife in OPD.) I discuss him later, with regard to the emergency department and men's ward where I did observe his work.

Working with Dr. C. became almost impossible since the interaction between Dr. B., and Drs. C. and D. were so very poor. Dr. B. resented my working with them and this appeared to reverberate through the institution. In order to establish a good working relationship in the area of most importance to me, I soon learned that it was best to spend most of my time in the hospital with Dr. B. during her hours. On other days when she was off duty, I had the opportunity to work with Drs. C. and D. Dr. C. was interested in my research and made it possible for me to go on Public Health trips with the staff from the Health Centre.

Because of a shortage of doctors, Dr. D. (the anesthetist), worked at the hospital as a general practitioner as well as at her specialty. She was in charge of rounds in the Women's Ward, although she and the surgeon (her husband) appeared to consult about the cases there. In OPD, the Indo-Fijian patients did not like to be treated by "the lady Chinese doctor". They
complained that she was cranky and short tempered. On the other hand, she was well liked by the Fijian people. I was not able to observe her for any extended time in OPD, but on the occasions I did, I found that her style seemed abrasive to the Indo-Fijians because she was so direct and abrupt with questions. She got very angry when the Indo-Fijians did not quickly reply to questions, when they did not want to comply, or they kept coming back for more treatment and at the same time went to orjahs and private doctors. Her annoyance was partly because she compared Indo-Fijians with Fijians. She told me that she empathized with the Fijians who did not have the money to seek treatment from every other source as the Indo-Fijians did. And once Fijians did come to the hospital they wanted to comply with doctor’s orders, and did so without question. (Personal communication). I could not tell whether her reputed dislike of Indo-Fijians was solely a perception, or based on fact; however many felt her ire at one time or another, and were uncomfortable when attended by her in OPD or in the ante-natal clinic. I am not sure that this interpretation some patients had of Dr. D. was not partially a result of her poor interaction with Dr. B., who had recently been transferred from Suva to SDH, and who was a trained Obstetrician/Gynaecologist. Dr. B. also performed surgery. Although she was younger, she was senior in status to Dr. D. Women in the Nadroga/Navosa area were very happy to have Dr. B. attend to them, especially when she began to take pap smears systematically, and explained physiological processes to women. Because of her gender, competence and interactive skills, her clinics were full. By contrast Dr. D. could not easily converse with the majority of the population and was not trained in the medical specialty. Her shortcomings were obvious by contrast.

Her interaction with Dr. B. was extremely strained, the two women openly disliked one another. Nursing staff told me that Dr. D. spent much of her time during tea time “running down Dr. B.” For her part, Dr. B. did not pretend to tolerate Dr. D., and did not like me to accompany her on rounds or in the hospital. On the surface they sometimes interacted with each other in
what appeared to be, if not friendship, at least professional respect. When I returned to the
hospital after a short absence however, I was told their mutual antagonism erupted in a most
unprofessional way when Dr. D. refused to anesthetize for Dr. B., in a situation which later
jeopardized the life of a patient and for which the patient went to court for recourse. An
informant told me that the contentious issue, mediated by the SDMO, from whom Dr. B. took her
final instruction to operate, revolved around whether an operation could be performed without
the full complement of medical staff. The situation, much more complicated than this, divided the
hospital staff, with some taking sides with one doctor or the other.

Dr. D. was a highly skilled and qualified anesthetist who wanted to work in Fiji as she
would have worked in a larger overseas hospital. At SDH she was often without the support staff
which she felt was necessary to the safety of the patient.

Not all Indo-Fijian patients shared a negative perception of Dr. D. and in fact some
preferred her as their doctor.

No. 10

One elderly old Indo-Fijian woman, a Pandit from the Nasavu settlement thought the
"Chinese lady doctor" was very good. The old woman had been quite ill with the flu. She told me that during the day she was so sick that she quietly went to bed rather than bother her family about it. When she started to get a fever and could not get up, she told her eldest son who took her to OPD that night. The "Chinese lady doctor" attended to her; the old woman said she likes that doctor because she tries to heal with love (prem) and kindness. She has had to go back a number of times and each time the "Chinese Lady doctor" is the kindest doctor to go to because she listens and gives her good medication.

The son who took her to the hospital for treatment speaks English very well and he is well known in the township. He works with Fijian farmers in the Nadroga/Navosa Fijian administrative area, as well as with Indo-Fijians.

He probably explained the symptoms well, and understood the doctor as well. Also he knows what the expectation in the biomedical interaction is, and what the expected outcome should be. In many cases, the doctors who do not speak the local languages are misunderstood. And there are cultural misunderstandings in interaction. In this case the process of seeking help at the OPD from the Western biomedical model was effective.
Nevertheless, once the old woman was able, although still weak, she went by bus one day to the Indian oriah/vaid. She had told me about it before hand and asked me to accompany her. As she normally does when she goes to consult him, she took a cooked meal for him. He greeted us warmly. She told him she was there for some medication. They went over to one end of the porch and sat down on the mat. To heal, he lights a cube of camphor and he says a "prayer" or perhaps mantra (magical words), and meditates. Then he filled the bottle she had brought with sacred water which she was to rub on her body.

She also asked him if the time was right for her husband to change the name of a company. The oriah told her to wait for a week or two and then he would advise her. We left shortly afterwards. I asked her why she had come to see him. She said although the flu was over, she continued to feel weak and his medicine and meditation gradually improved her health. This patient is a regular at this healer's. Still, when she had the flu her family advised her to first seek treatment at the hospital, which she did. She firmly believed that the lady doctor's treatment cured the immediate sickness, but not the lingering feeling of unwellness and weakness. She went back to the oriah for the remedy in which she had faith for the long term healing. It took several months before she regained her strength, looked or felt completely well. She had not expected the hospital doctor to cure that aspect.

The interaction of this old woman with Dr. D. raises some interesting points for clarification. First, as a pandit, she might not have wanted to be treated by a Muslim woman. Communal politics within the Indo-Fijian community emerge in these kinds of ways. On the other hand, the old woman would prefer a woman doctor which meant she would plan the time of her consultation to see Dr. D. In Sigatoka town, it was very simple to find out which doctor was on call for outpatients; thus some patients could avoid consulting a doctor they did not like. Dr. D. would feel quite at ease with the old woman's son translating for her in perfect English. In these situations she was naturally most at ease and the patient was satisfied and perceived her as empathetic and kind or as the patient said, someone who treated with prem (love).

It was apparent to everyone in the hospital that Dr. B. (the obstetrician) and Dr. D. (the anesthetist) disliked each other. I could not tell how much this was politically motivated because of problems beyond the local administrative level having to do with the Ministry of Health. Or if their conflicts were purely personal. Dr. B. was new to the hospital and had improved the Labour Ward and the Obstetrics Ward which were her areas, so much that even the nurses in the other wards remarked about it. By contrast, the Children's Ward which is under the care of the
surgeon Dr. C., (Dr. D.'s husband) is at the end of the Men's Ward and is seldom seen by visitors. The facilities for mothers who must room in, and the bathrooms, are in abysmal condition.

Dr. D. was not oblivious of the fact that the Indian patients complained that she favoured the Fijians. She told me on several occasions that she is annoyed when Indo-Fijians won't comply; and that she tells them, "It's your life not mine--you can do as you like it's not my fault!" It was my experience that many patients did not fully understand directions in English; and they did not know how to seek medical care in the hospital. Very few asked questions about diagnosis, prognosis or the prescribed therapy. Since Dr. D. did not use the Hindi language, some Indo-Fijian patients probably found it difficult to describe their symptoms to her, and they did not understand her. Some of them thought she was aloof. I believe the problem was one of poor communication skills which made interaction (at a level satisfying to patients) difficult, made worse by the fact that she was surrounded by a network of staff and patients who kept alive the rumour that she had poor social relationships with others. When Indo-Fijian patients contrasted treatment from her with that received from Dr. B., she did not fare well.

When I arrived at SDH, the first SDMO, Dr. A., served in OPD, working longer hours than any of the other doctors. A Seventh Day Adventist, he was a very religious person, committed to public health service. The Indo-Fijian patients like him. Soon after my arrival in Fiji, he asked me if my knowledge of Fiji-Hindi was good. I told him that I understood the language better than I could frame questions in it. I knew that he was relieved, since he was not proficient in Hindi. He was kind enough to allow me to work anywhere I liked in the hospital. Because he set the precedent, even after he was replaced by the new SDMO, I continued to work in the same way. Dr. A. did not however, feel comfortable with my observing his interaction with patients in OPD. On the occasions when I attempted to attend, it was 'inconvenient'. There were several times however, when I accompanied sick people from Nasavu settlement to the
hospital and I was then able to talk to him and observe his clinical procedure. The following example illustrates one such event.

No. 11
R., a young twenty-six year old Indo-Fijian from Nasavu settlement had looked ill for some time, staying in bed during the day, unable to do her daily household work. Her eyes were ringed with dark circles and the skin on her arms and legs was crepey and wrinkled (the Sister-in-Charge at the hospital had shown me a patient with a similar condition diagnosed as anaemia). When she asked my advice, I told her to go to Dr. B. at the hospital for an examination. I was worried about her health because people from this area had been consulting the pandit for treatment of peri or "yellow fever". I thought that some members of this family could be suffering from hepatitis which is endemic in Fiji (Ministry of Health and Social Welfare, Annual Report for the Year 1984, Parliament of Fiji, Parliamentary Paper No. 1 of 1986, p.42).

I inquired at the hospital about the symptoms the people in my settlement area had such as yellowing of eyes and skin, and yellow perspiration stains, along with extreme tiredness. The SDMO asked me to report the outbreak of peri to the Public Health Sister which I did. I also reported it to the District Nurse at Loma station who was responsible for health care in the settlement. The surgeon at SDH explained the condition to me as a symptom not a disease. He said there is no yellow fever in Fiji, but these people have jaundice which is a symptom of some other underlying physical problem. He said in most cases it appeared to be self-limiting, thus was not hepatitis. In some cases (not in this one), it was caused by liver damage, as a result of alcohol abuse.

The young woman had all the symptoms except the yellowing. She told me that her sister had just recovered from peri two months before. And her family told me the households near the mountains behind their compound had also suffered from the same symptoms. I was worried that there might be an outbreak of hepatitis in the settlement. Since I could not accompany her to the hospital, I told her that I would ask Dr. B. to see her. At first she was reluctant to go, but finally was persuaded by her family, and she went with her aunt. She told me later that she went to the OPD and saw the Fijian doctor (Dr. A., then SDMO) there. She said she felt too shy to ask for Dr. B. even though I had arranged for her to do so. (The woman speaks fluent English so language was not a problem in their interaction.)

She told me later that as part of the diagnosis and treatment, the SDMO asked her to have a blood test and gave her a prescription for medication. When I asked her for details of the diagnosis, she said she did not know what she was being treated for, and did not know the name of the medication. She had given the prescription to her father who would get it for her. I asked her to describe the symptoms to me as she had described them to the doctor. She said, "I told
him my eyes pained and I have headaches and that I watch too much video". When I asked her what the doctor told her, she shrugged her shoulders. (And they never did pick up the medication.)

I was annoyed with her and asked her why she, an educated woman did not tell the doctor what was wrong, and also why she did not ask him for the diagnosis? How was she going to get well if she did not even know what medication he had prescribed or for what illness? I went to the doctor myself a few days later and told him about her symptoms; he was exasperated that she had told him something so different. He asked me to give her a kit for a stool sample. A week later, she was still ill; this time I accompanied her to OPD. Again, the SDMO was on duty. I interacted with Dr. A. on behalf of the patient so that next time she would know how to get treatment and what questions to ask. She watched very quietly. We both learned something about the processes and interactions in seeking health care.

She went back with me the following week for the test results which showed that she was anemic and had a parasitic infection. He gave her iron tablets for the first, and a prescription for the latter. I felt that the health status of the whole family was at risk. The reason that some members in the family had suffered from jaundice (peri which the pandit treated), was because their general health was weakened by worm infestations. Parasitic infections are so common that there was no attempt by anyone at the Hospital, Health Centre or the District Nursing Station to treat the whole family, or to provide the patient with education about how the parasites spread or how they can be prevented.

Many Indo-Fijians do not know the process of seeking health care in the biomedical system. They do not know how to interact competently with biomedical practitioners. There is no model for them to follow. They know that doctors have higher education, more experience and higher status, therefore they are authority figures. This knowledge is not conducive to transactions that will provide sufficient information for diagnoses that are understood by the
patient and that reflect directly on the will or desire to comply with treatment. Traditionally however, the patient role is a passive one of submitting to treatment and following instructions in order to get well.

The doctors in OPD treat many minor illnesses: fungal infections, *dani* (ring worm), sore throats, swollen tonsils, women with various aches and pains of undefined origin, people with high blood pressure, a child whose mother thinks he has swallowed a fish bone, a very dirty man with multiple boils on his neck and arms, diabetics with sepsis.

At one point a Fijian couple came in wanting to admit an elderly chonically ill parent for the weekend so they could go across the island to visit. Interestingly, knowing that Dr. B. was on duty, they went to the home of the SDMO on the hospital grounds to ask him to diagnose and give permission to admit the elderly woman. Then they came to OPD to tell Dr. B. they had obtained permission. She was angry and told them she would admit the woman only if there was a bed available. As the doctor on duty she had the final authority about admissions. She called the SDMO and told him she could not admit the woman. She remarked to me that she could not admit the woman who is a chronic case, not an emergency. The interactions showed Fijians as an ethnic group attempting to secure preferential treatment by going to the SDMO who knew the importance of their attendance at a Fijian function, and who would consequently admit their relative for a short duration. Dr. B. however, would not consider their cultural need a valid reason to utilize one of the critically short hospital beds. The fact that they by-passed her authority to secure permission did not help matters, for she was angry about that and consequently not sympathetic to their need.

One by one the doctors in Outpatients' handle these cases, each one different. Indo-Fijians, Fijians, the 'parts' (part Fijian, part some other ethnic group), and "expatriates", all gather in the waiting room, along with people who accompany them.
Many people, especially the Indo-Fijian and Fijian women, treat the outpatient’s waiting room as a general visiting area. If they accompany someone to OPD, then they will stay around to visit a sick patient, talk to other people they know, or wait for them to be examined so they can all take the same bus back to town to visit and to shop together. At times the waiting room seems to serve as a community center. And for many young Indo-Fijian mothers it is an opportunity to get out of onerous chores and to visit with friends. No one ever appears to be in a hurry to get the bus back to town. Some women will go outdoors and sit on the grass in the shade, relaxing and gossiping as they wait for a patient. The process of getting treatment in the case of minor illnesses perhaps seems slow to patients, but it is sometimes almost leisurely for the family members who accompany them. Both Indo-Fijian and Fijian "escorts" would ask me to allow them into the ward to see the patient, before visiting hours or sometimes afterwards, even though they would have the regular visit. Interestingly, some patients, especially in the Obstetrics section, did not want visitors outside of the visiting hours. Indo-Fijian women, especially, seemed to appreciate their "patienthood", and some Indo-Fijian and Fijian women said so.

One day as I worked in OPD with Dr. B., I heard the nurse’s urgent call for the doctor and I went to see why. My reaction in these cases is to want to run to the OPD. The doctors by contrast make their way to OPD with their usual stride and a cool detached manner. This time a Fijian man and woman had brought in an Indo-Fijian woman who had ingested kerosene in a suicide attempt. Her sister-in-law also accompanied her to the hospital.

The patient told the doctor that she had three children at home. A woman from Suva moved in next door and started having an affair with the patient’s husband. During the course of the day, the two women got into a verbal battle, the “other woman” called her names so she ingested a bowl full of kerosene. As I asked the Fijian couple what had happened—I could see that the patient was very frightened. They said the patient’s husband had a lover and she did this to
punish them. The woman was crying and complaining of the burning as she rolled on the stretcher. She asked the doctor for water, but she was told she could not have it. The doctor gave her two injections, one to sedate her and the other to stop the risk of infection. As Dr. B. treated her she told me that if the patient vomits she will aspirate the fluid into her lungs and get pneumonia—it would quite possibly develop into pneumonia anyway—that happens in these cases. Then Dr. B. sent the woman for a chest x-ray.

After taking the medical history, the doctor sat with the patient and consoled her. She told the woman that her life is more important than that; she had children to whom she had to teach right living. This conduct would be very bad for them. Had she thought about that? She told the patient that "the other woman" and the husband would not be the ones to suffer, but the children would. The woman shook her head in agreement. Then she was admitted to the Women's Ward where she was treated for a few days then released.

In this case because Dr. B. is also an Indo-Fijian, she could communicate with the patient, she knows the cultural context of the patient's action, and she could interact more deeply with the woman than other doctors could, giving her advice and support. At times such as this, true emergencies, she interacts on a more affective level, and can be very sympathetic. She was also able to elicit the personal history and get the details more quickly and accurately than the other doctors who do not speak Hindi to be able to begin treatment.

The doctor told me that the Indo-Fijian men have "started to drink and go around" and they meet other women. They mistreat their wives. The neglected women feel they have no option in life and for some of them, this is the one they take. They attempt suicide, but often more to scare and punish the "wrongdoers" than to die themselves. During my stay in Fiji I was to see other women who for one reason or another attempted suicide⁴.

Immediately after this case, came another, this time a young Indo-Fijian woman brought in by her parents. She had a towel around her head and blood everywhere. She looked apathetic.
Her mother and father told the doctor that her young brother-in-law, who lives with their daughter and son-in-law, hit her on the head with a large rock. The patient told us that she was working outdoors on the farm and she and her brother-in-law argued over the family land. He got angry, picked up a large rock and hit her on the head. Her husband was away at a beach party at the time. This happened at about nine in the morning and they were just bringing her in at one o'clock in the afternoon. Her hair, matted with blood, had to be cut away. After first administering a local anesthetic, Dr. B. stitched the wound and then sent her for x-ray to make sure she did not have skull fractures. The patient seemed to be in shock and did not change her position on the stretcher for more than an hour. I talked to her later and she told me the boy who had struck her was impossible to live with, but she and her husband have him with them because his parents are dead. Her husband thinks they must take care of him because he is his brother. She has a baby that she is breast feeding, and one other child at home. Dr. B. was critical about the length of time which had lapsed between the incident and when they secured treatment for the patient. The woman was very dirty and did not respond or communicate well. It was apparent there were social problems about which we would know nothing. Several days later she was discharged from hospital. No one came to pick her up and I saw her walking to town alone.

A third emergency case in this one day was that of a young single nineteen year old Indo-Fijian woman who swallowed her mother's hypertension pills. She was unco-operative and refused to tell the doctor how many she had taken. She was referred to the hospital by a private doctor in the town, and she was admitted. Her medical chart showed that on admission she was vomiting and short of breath. She was calmer later when I went to talk to her. She refused all day to tell the staff how many pills she took. I saw the little plastic bags in which the family doctor had dispensed the pills lying on her cupboard. She seemed to want to talk to me and she listened as I explained the seriousness of what she had done. I then asked her how many pills had
been in each of the bags and she readily told me. When I told Dr. B. she was surprised, because minutes before the patient had refused to tell anyone.

She told me that she worked at home and had to do all the work in the house because her mother was very sick. She has two married sisters who live elsewhere, but her three brothers all live at home with their wives and children. She has to cook and clean all the time and she says her mother is very harsh with her. Then she started to cry as I sat and held her hand. Later one of her sisters-in-law came and talked to me. She told me the girl was upset because all of the brothers have other girl friends and she is ashamed of that. Also the mother is ill and difficult to live with. She said they all feel miserable about the men in the family, and because of her troubles she has become a Christian and feels happier. She has sent for books and will give them to the young sister-in-law to read.

Both women have reacted with openness to me because I have been able to take the time to listen. I gave them time to talk. The professional staff of the hospital have so little time they want to know only those facts that will allow them to make a diagnosis quickly, and prescribe the treatment to get on with the next patient or task. Because of this, very few patients in Fiji, as in biomedical hospitals in general now, could engage in a satisfactory transaction with the physician. Time management is crucial when they are so short staffed. Their attitudes are not conducive to deeper level interaction. The patient needs to know someone cares to listen to their problems on a personal level. Practitioners of the biomedical model, no matter how empathetic they feel, do not have the time in which to show caring in the same way as the traditional healers. Doctors, with large numbers of patients to examine in the short time allotted for clinics, consequently try to limit the discussion to a single question and answer session, without regard for the social context of illness. This type of depersonalized medical health care service has been criticized by others, but most vigorously by Illich (1976).
In the hospital, the staff are often of a different ethnic group from the patient with all that entails in the way of difficulties in communication; and they are of a different social class. Both attributes alienate the patient from his or her own cultural context. Social facts are considered unimportant by health care staff and are not elicited in a way that is satisfying to the patient.

Men's Ward

The patients in the Men's Ward are attended by Dr.C., the Surgeon, unless a patient wants to be looked after by another doctor. The ward is divided into surgical, cardiovascular, general and infectious areas. At times I accompanied the surgeon on daily rounds. He usually had at least one nurse with him and sometimes two, one Indo-Fijian and the other Fijian. His process of consulting about the patient was first to read the chart, and then to talk to the patient.

When he was attending to the surgical cases (often due to diabetes), he asked the nurse to undress the wound and he inspected it. Then he talked to the patient in English, with some few phrases in Fijian or Fiji-Hindi as was appropriate. His interaction was always empathetic and usually genial. He then told the nurse who was of the same ethnic group as the patient to ask the more in-depth questions or to give advice, or the prognosis. On the ward, he took time to elicit comment from the male patients and they did not seem to hesitate to interact with him. As the most senior physician, he was very sure of himself and this was reflected in his work in OPD, on the wards or in the surgical clinics. His style of interaction was friendly, he commented on the illness, and discussed it with the patient, with the result that it seemed to allay the patient's anxiety. He was one of the few doctors with whom patients could carry on satisfying exchanges and transact both illness and treatment which articulated with their situation and level of understanding. I felt that although he did not know the languages well, through his work on Vanua Levu (the other island) and a natural intuitiveness, he understood the two ethnic groups, was caring and was perceived as such.
On the first day of daily rounds with the surgeon, the first patient I saw was an Indo-Fijian (Sikh) diabetic who had one leg amputated just below the knee. The doctor examined him using the process outlined above. The patient and I spoke the same North Indian dialect, something which gave him some comfort.

In the days to follow, I often stopped by to talk to this patient. He was always attended by his wife. His main concern was whether he would be able to be fitted with a prosthesis. I communicated this to the surgeon who then asked the physiotherapist to stop in to see the patient and to give him exercises so that he would not lose muscle tone from lack of use of the limb. The physiotherapist and the surgeon told the patient he would need to retain good muscle tone in order to be fitted with the prosthesis. It would be six months before he could be considered for one; in the meantime he was to keep up the exercises. This patient, in his interaction with the doctor and the physiotherapist, asked questions, appeared well informed and was willing to comply with treatment.

I was surprised when he told me that he did not know anything about diabetic diets. From the nurses and doctors I had learned that the standard treatment for diabetes in Fiji is through diet control and oral medicines. Insulin is rarely used. Dr. C. did not know why the patient was ignorant about special diets, he said the patient should have received instruction the last time he was hospitalized. He subsequently spoke to the nutritionist and asked her to make sure the patient was fully informed about diets before his next discharge from hospital. She did not remember doing so on his other visits to the hospital.

In spite of the warnings about diet control, the patient was back in the hospital within three weeks of his discharge from hospital with several pustules at the amputation site. He was readmitted for observation, treatment and diet control so as to prevent gangrene and further amputation.
This case made me be very aware of the other diabetic patients I saw during the remainder of my stay in Fiji. Very few people fully understand how diet is linked to their disease. Their knowledge of the values of foods such as sugars is rudimentary at best. And, importantly, few are taught that this is their condition for the rest of their life, not just for the duration of the symptoms. Diabetes is widespread in Fiji and the results of the ravages of the disease are massive amputations, blindness and disability until finally the patient dies. In spite of this, in the area where I worked, there were very few preventive educational programmes for the public. The curative aspects are emphasized. In 1984 a Diabetes Centre was opened in Suva. The first Director of the Centre, Dr. Parshu Ram kindly showed me around the facility which will serve to coordinate education and treatment of diabetes for Fiji. Since it opened, the center has published information on diabetes in English, Fijian, and Hindi for public distribution through the District Nursing stations, Health Centers and Hospitals.

According to a parliamentary paper, the activities of the centre for the next three years:

...would include in order of priority, the development and continued assessment of diabetes education, preparation of education materials, conduct more training courses and development of resources, facilities and research activities.4

Whether its programs from a central location in Eastern Fiji will have any impact on other parts of Fiji, and to what extent, remains to be seen. Meanwhile, Indo-Fijian (and for that matter, now the Fijian) diet is rich in sugars. (I was interested to see that Morris Hedstrom stores stock shelves full of canned fruit with HEAVY SUGAR SYRUP imported from Australia. In this area, as well as in others, it was plain to see that consumer groups have not yet started their much needed activism in Fiji!)

After this brief digression, I return to the processes and interactions in the Men's Ward of SDH where Dr. C. is the physician in charge.

Dr. C. joked with the patients, and humored them, bantering with one older Indo-Fijian widower who was sick, that “you just need a new wife to look after you”, much to the amusement
of the nurses and other patients. The patient, respectful of the authority and judgement of the
doctor replied, "yes, doctor I will think about it".

With another patient, a young Indo-Fijian of about 18 years of age, he was especially
caring. The man was admitted for observation and treatment of depression. On this occasion the
doctor sat beside him and asked him why he was feeling so badly. Was it because he was in love
with someone and it turned out poorly, he asked. Or, did he want to get married to someone and
could not? Then he teased the boy in front of the nurses, saying that there would be lots of
others to marry! Perhaps that was not the patient's problem at all, but Dr. C. had involved the
nurses and other patients in showing caring and affection for the boy. The nurse told me that the
boy was extremely shy; we had at least seen him smile that day.

When I asked the surgeon if men in Indo-Fijian culture have priority of treatment as men
in India do, he said male Indo-Fijians do not seek treatment readily. In this culture, it is the
women who are quick to visit the doctor. He could not elaborate on the reason. It may have to do
with the way Indo-Fijian males have responded to Fijian values. Fijian men deny pain, and do
not seek therapy from doctors until it is very late in the course of an illness or injury and the
condition has advanced to a serious one. Doctors throughout the medical systems in Fiji assume
that Indo-Fijians have a much lower pain threshold than the Fijians do, and that Indo-Fijians
express their pain without shame.

When male Indo-Fijians are sick they are shown a good deal of care by family and friends.
Wives stay with their hospitalized husbands during the day, attend to their bed baths and bring
them food from home. Other friends and relatives are frequent visitors; and any one patient will
have a number of visitors at any one time. The family of a patient will criticize those relatives
who do not show their solidarity by going to the sick relative's bedside. Visitors travel from
great distances to show they care about the health and welfare of the patient who is a member of
their family.
Nurses rarely complain about the inconvenience the visitors cause. The extent to which Indo-Fijians visit can be very annoying for the nurses as well as sometimes interfering with good patient care and compliance with doctors' orders. One such case was that of an elderly male patient who had suffered a stroke. One afternoon he had five visitors around his bed, three of whom were gently and carefully trying to prop him up on a number of pillows, in the appropriate position to visit with them. He was limp, unable to communicate his wishes. As an onlooker I thought he looked as if he were made more uncomfortable by the pushing and pulling of his visitors. They knew he was critically ill; he died the next day. At that time the nurse was attending to a ward with nineteen patients. A number of accident cases, and their more-than-fifty visitors, were more than she could cope with.

The accident cases were three men who were admitted with lacerations and bruises as a result of a motor vehicle which went over a steep embankment. Two Indo-Fijian men were killed, one of them a young man from my fieldwork settlement. His wife, who was expecting their first child any day, had gone home to her natal family as is the Indian custom for the month before the delivery. When she was told of her husband's death, she went into psychological shock which resulted in the onset of labour and delivery of a baby girl, just hours after the man's death. The case is discussed further below.

When I found out that people from "my settlement" had been in an accident, I went to the Men's Ward in the hospital and checked the patients' charts to see who was involved and what injuries they had sustained. Then I talked to the nurse and went to see the patients. They were heavily sedated and quiet except for one young man who was very anxious and who recognizing me, asked me to please help them. He complained that they were not getting good treatment and asked me to find out about his injuries which he thought were more serious than he was told. I told him that the nurse would do everything she could to make sure he received good care, but that I would ask her what his injuries were. The nurse, an Indo-Fijian, told me that he was not
settling down, and in spite of his medication, he was anxious and nervous. She showed me his x-ray and assured me that he had no broken bones, although he had some painful bruises. She went and reassured him. He finally did settle down when his mother arrived. The interaction between the mother and son was warm, and she showed caring by hovering over him massaging his arms as he lay in bed. Later, she quietly talked to him as she sat beside him, and he settled down. Now fully sober, he was obviously frightened by the deaths of his friend and relative and the injuries sustained by the other men and one small boy. A family party had turned into a tragic situation, touching the lives of so many people in the settlements.

As visitors in Fiji often do, the visitors were even at the open louvered-glass windows outside the Men's Ward, trying to see the patients, and to find out the health status of the accident victims. The nurse asked me to chase them away from the windows and to lock the door to the Men's Ward so that she could put visiting hours off by an half hour in order to attend to her patients before the influx of visitors. Finally one of the non-medical staff was stationed at the door to let in only a few visitors at a time. His strategy was to let in as many as went out, thus putting the onus on the visitors to regulate the length of their visit.

**Children's Ward**

Dr. C. is also in charge of paediatrics located in the adjoining ward. I did not see his interaction with the patients there. The ward is one of the poorest in the hospital, outdated and dirty. A number of children's cots, each with a small straight backed chair beside it for the mother who must remain at the hospital with the child to care for it. There are fold-away cots for the mothers to use at night. One dirty bathroom, without a shower curtain, serves for ambulatory patients and for the mothers. Many of the children I saw had diarrhoea or were malnourished. A few were more seriously ill with kidney ailments, burns, or as a result of accidents. Children who are seriously ill are sent by ambulance to Lautoka hospital. There too, mothers accompany them and remain at the hospital to care for them.
Dr. C., in a discussion about childhood diet, told me that the nurses make the mothers who come in with the malnourished child feel guilty about the condition of the child. He felt that what was needed instead was better interaction between staff and caretakers; and non-judgemental training for the mother about the diet the child should have. Many such patients are from uneducated families who live in the rural villages.

In the interior villages of Fiji, the impact of processed foods is making itself felt. On a trip to Kelasi Health Center, I saw severely malnourished children. When Dr. C. asked the Fijian mother of one sixteen-month-old girl what the child had been fed that day, she replied that she had given it white bread dipped in black tea and sugar. And the day before? The same food. The nutritionist who was along, spoke to the mother and showed her graphically with posters, what foods the child should have every day. But many people are poor and cannot afford the variety.

CONCLUSION:

In these pages I have examined instances of interactions and process which were apparent when Indo-Fijian and Fijian patients consulted doctors as they attended OPD, Women's Ward, Men's Ward, and Children's Ward of SDH. More briefly I have discussed interactions between doctors, and some of the interactions of doctors and patients with other staff and with members of the community.

The two questions set out in the first two pages of this chapter focus the concluding remarks which follow. In them, I discuss a number of variables which produce differences in the interactions and processes when patients are transacting therapy in the biomedical sector of health care.

Doctors and Patients:

In general the processes and interactions in the biomedical sector at SDH reveal an asymmetrical situation where the doctors are in the dominant role, and patients in the
submissive one. This is based on the usual technical-scientific assumption in biomedical practice where doctors hold the power. Doctors are also part of the power networks within a community, they have links to the local and national bureaucratic structures. Most patients whom I knew, were aware that the doctors, teachers, lawyers, bankers and accountants, and other professionals were part of the same social networks. If one antagonizes a doctor, other areas of life may be negatively affected. Friendship with a doctor could open doors not only to better medical treatment but also other benefits such as placement in a school for education for one's child. Most people in the settlements, and in fact in the small town, attempt to link into such patronage networks.

Some patients demonstrated their lesser status vis à vis that of doctors by giving them special merchandise in the markets and by bringing vegetables, eggs and other choice items to them at the hospital as gifts. People gave gifts because they thought that these types of transactions would ensure that they would receive special care if they became sick, or for services already rendered. From the perspective of patients such transactions were exchanges, or a form of insurance. I am not sure that doctors viewed them in this way. Rather, they seemed to me to be received as status markers.

Doctors also receive preferential treatment within other interactive arenas of the greater community. They are asked to give talks, open community buildings, and to perform other prestigious social services as a mark of their prestige and dominant status in the community.

A patient's submissiveness is emphasized by the fact that when seeking therapy, his or her entire body is exposed to the doctor. The patient requires the services of the doctor in order to get well therefore must also comply to treatment. Many doctors treat non-compliance as a
sort of deviance. And patients who do not comply do not get sympathy from a doctor. (To a patient, satisfactory treatment includes sufficient and adequate therapy as well as their perception of whether or not the doctor has empathy.)

I have shown that 'detached concern' as taught to medical students can prevent doctors from taking the details of the social history which led to the development of the illness into account. Medical training focusses a doctors' attention on the patient as an agent of a pathological condition, rather than in humanitarian terms of the total lifeworld (i.e. worldview and situational context) of the person. Contextualizing medical history can assist doctors in providing better treatment and empathy for the patient.

Throughout this chapter reference has been made to the notion of empathy in interactions. Mishler's (1984:14) distinctions of the twin concepts of "voice of medicine" or of "voice of the lifeworld", is a useful one. In his study of the dialectics of medical interviews, he defines a doctors' use of the voice of the lifeworld as the "natural attitude of everyday life" in which "A general line of interpretation is developed through the several stages of analysis that gives primacy to the voice of the lifeworld and to patients' contextual understandings of their problems. In this way, the study moves beyond the assumptions of the biomedical model and its expression in the voice of medicine." This is what I intend empathy to mean. This research showed that "the voice of the lifeworld" of the patient was rarely heard. The primary mode of interaction used by doctors was that of the "voice of medicine" and the technical-scientific assumptions of that perspective.

A number of other variables affect doctor/patient interaction. I have shown that time management in hospitals is an important factor in the style of interaction a doctor is able to use. Large numbers of patients awaiting treatment puts pressure on the physician, who must attend to as many patients as possible in the clinic he or she is responsible for, prior to returning to other duties on the wards or in surgery.
The doctors who do empathize with the situational problems of the 'person' (as opposed to the pathology), are hampered by a lack of mediating service agencies such as social workers who can follow-up the patient care after discharge from hospital.

Doctors fear litigation, and to a large extent this fear can determine their actions. In Fiji today, as in many developed countries, institutions and the doctors in them are careful in their interactions and treatment of patients. Some doctors are cautious because they fear litigation arising out of medical treatment. Other physicians protect themselves, but jeopardize the patient by labelling some cases "a social problem" and reporting them to the police force. This is true not only of suicide attempts and assault cases, but also, as in the case reported above, when a patient has refused to comply with treatment.

Doctors in their interaction with patients denigrate their use of alternative medical therapies. At best, other doctors disregard them, instead of viewing them as a viable part of the holistic health preferences of the patients. Many doctors lack the knowledge to appreciate the use and value of alternative therapies in the total life of the patients. As I have shown above for Indo-Fijians, and as is true for Fijians as well, both ethnic groups have highly elaborate systems of indigenous health care practices, linked to complex world views and in the case of Indo-Fijians, an ancient philosophical system.

Interactions between doctors and patients are refracted through the personalities of doctors who have their own psyches to contend with. I have suggested in one case how threatening it can be when patients pressure doctors to interact in the traditional ethnic mode based on age differences and all that *gemeinshaft* encodes, while the doctor values interaction in the *gesellschaft* type of interaction.\(^8\) Perhaps the struggle is of a type where there is a fear of counter-transference, which must be contained. This is I believe a possibility when the traditional values and modern values conflict.
The processes and interactions also reveal that it is more difficult for doctors to maintain social distance and asymmetry between themselves and patients intra-ethnically than inter-ethnically. Most patients within an ethnic group attempt to show their similarities with doctors (common communal membership, origin and relatives in a certain geographical locale, age or other characteristics) rather than their differences (class differences based on education, wealth). And they want to identify with people with status and prestige. As a consequence, many patients tried through these means to reduce the social distance between themselves and the doctor, in order to receive better care. Mention of common associates, friends or relatives is one way that Indo-Fijians attempt to do this. Another way is to show that one has one’s own power networks and links to the capital.

Patient/Doctor Interaction

I have tried to show that patients categorize the dominant role of nurses and doctors in terms of the ethnicity, residential status and other personal attributes (cranky, kind, etc.). At times patients attribute certain stereotypical behaviour to one doctor. For instance Indo-Fijians think of Dr. D., a Southeast Asian, as prejudiced against them, Dr. B., a Muslim woman is said by Indo-Fijians to be “too fancy” because of her command and use of formal Hindi language instead of the vernacular. Her dress, a smart salwar/kamiz worn without the ordne, also adds to the image they have of her. (The image of a woman without her headcovering, emphasizes her power, independence and individuality.) Fijian patients think she is kind. But Fijian nurses think she is authoritarian (or “bossy”). Dr. A is “kind” and “fair”; but Dr. W is pro-Fijian and does not pull his own weight. Dr. C., one of two “Chinese doctors”, is disliked by most Indo-Fijians, and liked by most Fijian people except those who feel all foreigners should be repatriated. Indo-Fijians, sensitive to their own situation never said this, although in some situations they emphasized their commonality of interest with Fijians rather than with expatriates or any other group in Fiji.
Ethnicity emerges as an important variable in the interactions and processes in the biomedical sector because it affects health care seeking, communication, diagnosis, and ultimately proper treatment, and patient satisfaction to Indo-Fijians and Fijians (and to a lesser extent the "other ethnic groups") who have different languages, religions and worldviews.

Social and economic costs also affect interactions and processes in the use of the biomedical sector. Time is one such factor and it is linked with other variables such as transportation and the economic situation of a mainly rural population. For both patients and doctors, time (as I quoted from Belshaw [1959], in Chapter one), is a commodity with value. People cannot easily leave their work or their household and farm duties to seek health care. Their economic situation may not allow them to go to biomedical facilities and if they do, time and money may be important factors in the frequency with which they can obtain treatment. This may reflect on whether a physician thinks a patient complies with treatment or not. For instance a patient who waits a week before returning for treatment may have cost, availability of transportation, arrangements to make or permission to obtain for absence from home or work, as factors to contend with as real constraints to obtaining care.

I have brought out other factors such as conflicting religious values, gender of doctor and patient in interaction, and stereotypical attitudes one group holds of another, as important factors in the way interactions and processes in seeking health care unfold.

Values encode key variables which influence health care. Indo-Fijian values show their solidarity and committedness to familial life styles by attending the bedside of someone who is ill, and they do so in spite of the practice in the biomedical sector to gain custody of the patient, and to limit interaction with friends, family and the use of traditional therapies within the institutional setting. Time management, technical procedures and therapeutics take precedence in the hospital over the social needs of the patient and family, or their traditional values.
Comparatively however, the hospitalized patient in Fiji has much more interaction with family than is allowed in North American hospitals.

Patients' lack of knowledge about the proper use of facilities affects the interactions of patients and doctors. Access to services normally goes through certain well established processes which are not easily side-stepped. For instance it is not easy to admit a chronically ill person to the hospital at will. I observed that biomedical interventions sometimes lead to dependency and that in both Fijian and Indo-Fijian societies, both with strong traditions of self-care, "hospitalization" of the elderly, the chronically ill, and worse, the pregnant woman (documented in the next chapter), was becoming more and more acceptable as the dominant form of health care.

Doctor/Doctor Interactions

The interactions between doctors at the hospital reflected many of the same concerns as those of the patients such as conflicts with regard to ethnicity, status, religious differences; as well as differences arising out of professional specialties, competence as judged by patients and peers. Doctors were competitive with each other in terms of advancements and had networks through which they attempted to find out what was happening at the bureaucratic center, Suva.

Within the hospital itself, doctors sometimes became unintentionally involved in political issues, such as the SDMO giving permission to the Fijian couple to admit an elderly relative. I am sure the SDMO had not intended to override the authority of the doctor on duty - a rather serious affront if it were deliberate. Situations arose and in the solving of them, doctors frequently became unintentionally involved. The gossip network carries the details of an episode to people at the hospital and in the community who then take sides with one or the other of the parties involved; and this in turn reverberates back to affect doctor/patient interactions.

At times doctors, too, were very conscious of their ethnicity and Indo-Fijian and expatriate doctors knew that they were at a disadvantage inasmuch as, politically, they had to
cater to the wishes of the Fijian staff. It was a way of life about which Indo-Fijians rarely commented. The expatriates who were new to the country noticed, and sometimes objected to or commented about the preferential treatment received by Fijian doctors.

Interactions between doctors could be quite tense and doctors gossiped about each other to the nursing and other staff. During the latter part of this fieldwork, after the new SDMO arrived, all staff including doctors were uncertain about their own positions. Hoping to influence him favourably, some used the basis of common status as residents of Fiji, others the basis of common ethnicity, others the basis of their personal social interactions with people in high places (Ministry of Health and the Military). It was a time of uncertainty; the doctors and senior nursing staff thought of themselves as disadvantaged in some way with regard to the SDMO.

I have shown that competitive interactions between doctors affected their interpretations of rules, their relationships, and also unfortunately reflected on the health of the patients. Clinical iatrogenesis according to Illich (1976:36) "...comprises all clinical conditions for which remedies, physicians, or hospitals are the pathogens, or 'sickening' agents." He (Ibid:41) quotes Ralph Audy with regard to iatrogenesis saying,

He recognizes that iatrogenic 'diseases' are only one type of man-made malady. According to their aetiology, they fall into several categories: those resulting from diagnosis and treatment, those relating to social and psychological attitudes and situations, and those resulting from man-made programmes for the control and eradication of disease. Besides iatrogenic clinical entities, he recognizes other maladies that have a medical etiology.

On the basis of my own observations, comments by physicians, and conversations with them and between them, I would say the biomedical sector in Fiji probably produces as much or perhaps more iatrogenic disease as any other country, through bureaucratic muddles, and the politics of professional transactions between staff, and physician errors.
Finally, there were interactions which involved the anthropologist. These interactions and processes involved acting as an advocate for patients; as a clinical anthropologist in the wards where I accompanied the doctors. Because these interactions are brought out more clearly in the interactions with women in all of the wards where I worked, they are discussed after the data of the next chapter are presented.

The core question stated at the beginning of this chapter (p.256) was set out to attempt to focus on the main variables in the interactions and processes in the biomedical sector as Indo-Fijians utilize it. The difficulties of such an endeavour are as Barth stated (1966:31-32), when he said "Admittedly, ...it is very difficult to maintain any great rigor in the comparisons...Each new case introduced in the comparison compels one to introduce new factors as variables". It is this problem which has led me to begin to focus analysis on several specific factors more than on others. They are the interactions and processes regarding communication and knowledge, processes of diagnosis and the therapeutic process.

Moore's (1978:32-33) question When discrepancies exist between ideology and social action what do people do?, is appropriate in this thesis. She shows that a focus on processual analysis of actual situations and events show a dialectical relationship between the desire towards making life orderly and outcomes predictable by obeying rules, on the other hand for every rule which facilitates that, there are numerous situations which contain enough paradoxes and ambiguities which make goals unachievable unless people say "This is a special case and those rules do not apply". It is this side-stepping of the determinate or regularizing processes in the face of uncertainty and manipulative processes, to overcome competitive, ambiguous and contradictory occasions and situations, which make it difficult for individuals to achieve goals through strategies linked to regularization processes alone. Moore's framework which takes ideology and action into account is appropriate for this thesis; it allows me to account for
emergent factors and change as well as to attempt to identify the continuities in the lives of an indentured peoples, the Indo-Fijians.

In this chapter I have discussed interactions and processes during general treatment at SDH as carried out in the biomedical sector. Women and the biomedical model are the topic of the next chapter.

Footnotes:

1 I was told by the doctors themselves that they felt embarrassed about their language skills, and I assured them mine were no better, in fact I could not speak Fijian at all. I also knew intuitively that some doctors were uneasy. Others made it quite plain by absenting themselves for a few minutes and generally not being there when I was. And, too, if you are not invited to attend, but are accepted at the doctor’s seminars and other functions, as a researcher it is difficult to insist on observing doctor/patient interactions.


4 See British Journal of Psychiatry, Oct. 1984:433-8, for an article by R. H. Haynes: *Suicides in Fiji: a preliminary study*, about Indo-Fijian suicide rates which are amongst the highest recorded in the world.

The rates for Fiji in the two years 1981-1982 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cases</strong></td>
<td><strong>Population</strong>*</td>
<td><strong>Annual rate per 100,000</strong></td>
</tr>
<tr>
<td><strong>Indian</strong></td>
<td>78</td>
<td>86,302</td>
</tr>
<tr>
<td><strong>Fijian</strong></td>
<td>14</td>
<td>76,071</td>
</tr>
</tbody>
</table>

*1976 Census, Population aged 15 and over
Source: Police Records, Central Office, Suva
Note: Population projections for 1981 assume an increase of approximately 10%, therefore these rates are slightly high.

(Table from R. H. Haynes, 1984:434)


6 See Janice Margaret Morse (1981) for a paper on the experience of pain during childbirth by Fijians and Indo-Fijians. Morse uses the framework first elaborated by M. Zborowski (1952), in his paper *Cultural Components in Responses to Pain*, IN *Journal of Social Issues, Vol. VIII, 1952*. In his research he used four "ethno-cultural groups", Jews, Italians, Irish and "Old American stock" for a study of reactions to pain. Zborowski's work has been brought to my attention recently by Dr. M. M. Ames.


8 William A. Dobriner, *Social Structures and Systems: A Sociological Overview*. Goodyear Publishing Company, California, 1969:260, discusses the primary/secondary group (Gemeinshaft/Gesellschaft) dichotomy saying, "...primary groups are small, durable systems whose role definitions are characterized by affect, quality, particularism, diffuseness, and collectivity-orientation. Larger, formal, associational groups (secondary-Gesellschaft) are characterized by roles and linkages marked by affect neutrality, performance, universalism, specificity, and self-orientation."
Chapter 13

WOMEN AND THE BIOMEDICAL MODEL

In the previous chapter I have described the processes and interactions in the institutional setting of the biomedical hospital. That chapter also described the SDH as an institution, and the staff which serve in it. In this chapter, I focus on women and their use of biomedical treatment.

The core question used in Chapter 12 also focuses this one. What social and cultural variables explain the interactions and processes in the biomedical health care sector? In that chapter I identified variables such as ethnicity, communication, knowledge, economic constraints, and traditional values which encode many factors including time, empathy, on-site familial support, fear, as well as many other aspects of life which canalize choices and influence decisions. In examining these social processes and interactions I am interested in how regularities are generated and in the processes of situational adjustment; in the behaviours which make up societal patterns in spite of indeterminacy, ambiguity, discord and contradiction. Throughout, the focus is on transactions, on processes of negotiation which highlight the interdependencies of people in roles (statuses or positions).
We now examine interactions and processes in a wide variety of phenomena which show how women use the biomedical system. Broadly, the phenomena encompass statuses, communication, values, environments and institutions.

The main areas within the hospital, other than OPD, where women seek health care are the ante-natal, post-natal, and gynaecological clinics; and in the Labour, Obstetrics and Women's wards. The majority of women who seek care at the hospital are pregnant or have recently had a baby.

Many settlements no longer have a dai; those who are still living in the settlements are elderly and are not called upon to deliver a child unless it is an emergency. Their numbers are further declining for several reasons. First, dais had no formal recruitment or training practices, women interested in the practice learning their skills by accompanying an older woman. Secondly there has been little government interest in building up a core of trained traditional or indigenous midwives. Earlier in the 1900's, in an unusual decision in a rural country where many children are still born at home because many women cannot get to a hospital, The Ministry of Health had prohibited Traditional Birth Attendants (hereafter referred to as TBAs) from practicing. The prohibition was aimed at lowering the maternal mortality rates and improving the health of both mother and child but Morse (1979:20) states that this 'ineffective law' prohibiting traditional midwifery was abolished in 1966. She gives no reason, but I suggest it was because Indo-Fijians and Fijians who lived in the rural areas, unserviced by the biomedical health care system, continued to use their traditional practitioners. Even today public health care does not reach all of the outlying areas of Fiji. For many women, transportation is not available when the labour starts, and if it is sudden, the child is delivered by a TBA. (TBA assisted births have gone up from 2.4% in 1984 to 4.1% in 1985.)

The annual report of the Ministry (1986:44,45) shows a decline of TBA births from 6.5 percent in 1975 to 2.4 percent in 1984. The report states:
The number of births attended by Traditional Birth attendants has shown a remarkable decline since 1975 as seen in Table XX. This decline is a true indication of the success of the maternal and child health services. Although all pregnant mothers were advised and encouraged to have their confinement in hospitals some of them failed to do so. This was due mainly to rapid labour and therefore have (sic) to resort to Traditional Birth Attendants’ assistance.

World Health Organization recommends that wherever possible traditional medical practitioners should be given further training, and their expertise used alongside the biomedical practices. In some cases traditional healers might even be retrained and used as Community Health Workers (CHWs). Some district nurses have found that the traditional midwives and healers (both Indo-Fijian and Fijian) provide them with a support system in the settlements; and they respect and cooperate with them. The District Nurse in the area where I worked told me that she appreciated their expertise in midwifery, in psychological kinds of cases, and in their knowledge of herbal and massage treatments.

In general, my impression was that biomedical practitioners did not respect indigenous healers. And there is a lack of any clear government support of traditional systems. Many physicians, Assistant Medical Officers (AMOs) and nursing staff openly derogate the practice of using traditional healing systems. The following telling excerpt from an Assistant Medical Officer explains the general attitudes of biomedical practitioners:

> If the traditional healers treat pain - maybe it will go away... they treat migraine headaches and do massage and treat manic depressives. I have no time for them, they just grab the customers and fool around! They treat cases like if a man is having an affair with his elder brother's wife - that is bad and the other relatives find out - so he gets depressed and goes to live in a Fijian village and withdraws from contact with his own people. Then his people later go and get him and they take him to an orijah to try to cure him of his deviant behavior........

This outburst is an example of how many doctors, AMOs and nurses thought about patients and healers. Many physicians and AMOs do think of a patient as a 'customer', not only in the District Nursing Stations where this AMO was stationed, but also at SDH. Second, this practitioner, like many others in biomedicine, said that treatment by an orijah is valueless, and
they do not attempt to understand why a family is motivated to consult a traditional healer, either concurrently with, or rather than the biomedical system. At the same time many biomedical practitioners exhibit a sense of competition with traditional healers. Indo-Fijian physicians and nurses have a good deal of first hand experience within their own families with relatives who resort to traditional forms of therapy.

This attitude in Fiji is in marked contrast to the Alma-Ata (1978:63) Primary Health Care declaration which states with regard to Traditional Medical Practitioners:

82. Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have high social standings in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well worth while exploring the possibilities of engaging them in primary health care and of training them accordingly.

Since 1978, many other countries have however attempted to incorporate traditional healers, although sometimes without success. The integration of traditional and biomedical healing is most likely to be successful in the case of traditional birth attendants who are already cooperating with District Nurses. They have continued to practice, often because they must, in areas where in an emergency no one else is available to assist with birthing. For the same reason, women in the settlements who are not dais often assist with births. Many of these women would make excellent CHW’s. (There are of course families who prefer not to allow hospital confinement, as well as women who prefer to have their children at home. Modesty, and/or religion, as well as fear, are factors which often contribute to these preferences.)

I think it would be more difficult to integrate magical types of healers who engage in both practices of witchcraft and sorcery, as well as of healing, with biomedical practice. Solicitor General J.R. Flower, in his paper "Medicine and the Law in Fiji", delivered at the 27th Medical Seminar on the Coral Coast in Fiji, (7th and 8th December, 1986:7) states:
On the other hand there are provisions to protect the profession, in so far as section 34 created certain offences; for an unregistered person to practice, or profess or hold himself out as able to practice any branch of medicine or surgery, for which he may be fined up to $1,000 or be imprisoned for up to 12 months or to suffer both fine and imprisonment.

He is drawing here from: "Act No 44 of 1971, which is the current Medical and Dental Practitioners Act Cap.255 of the 1978 Edition of the Laws of Fiji" (Ibid:5). It is highly unlikely that orijahs or pandits would ever be treated as traditional medical practitioners and integrated with biomedical practices.

The Ministry of Health and Social Welfare Annual Report for the Year 1984 shows that maternal deaths increased from 7 in 1983 to 9 in 1984, that is a rate of 0.44 per 1000 births. I do not have the incidence of maternal deaths by race. Morse(1979:21) however, after reviewing figures in an unpublished Ministry of Health document, stated:

Overall, the most common causes of maternal death were listed as: postpartum hemorrhage (40% of total), abortion, and pre-eclamptic toxemia, but details of cause of death are not reported by race and place of delivery. This is unfortunate as Fiji-Indians have a maternal mortality rate that is 5.9 percent higher than the national average and 26 percent higher than Fijian mothers (Maternal Mortality, 1976-1979, p.2)

She stated (1979:24), "some error may exist in these governmental statistics ....The 1979 census estimates that the completeness of the birth registration is only 88 percent (Parliament of Fiji, 1977a, p. 232)". Undoubtedly these figures have improved since Morse's work. In 1985 at SDH (the figures represent hospital births only), there were no maternal mortalities. However the incidence of complications of pregnancy during 1985 as shown in the Annual Report of the Obstetrics ward 1985 (unpublished), were as follows:
Table 13-1

COMPLICATIONS OF PREGNANCY
SIGATOKA DISTRICT HOSPITAL, 1985

<table>
<thead>
<tr>
<th></th>
<th>Fijian</th>
<th>Indian</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaemia (10 G. &amp; under)</td>
<td>18</td>
<td>81 (81%)</td>
<td>99</td>
</tr>
<tr>
<td>Essential hypertension</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Pre-eclamptic toxaemia</td>
<td>15</td>
<td>22 (59%)</td>
<td>37</td>
</tr>
<tr>
<td>Eclampsia</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

These figures suggest that the Indo-Fijian woman is still in the higher risk category for complications associated with anemia and pre-eclamptic toxaemia, during pregnancy and childbirth\(^1\).

A problem in the hospital setting was that although I had access to the patients it was exceedingly difficult to find women in the clinics with whom I could actually sit down and conduct interviews. Most were in a hurry to leave. A further problem was that in both OPD and the clinics, I could not successfully interact with them.

An early attempt to employ some of the questions outlined by Kleinman (1980:106) resulted in a disheartening failure. (I had painstakingly translated the questions into Fiji-Hindi and had checked them with a medical practitioner as well as with an Indo-Fijian friend.) They appeared to be capable of eliciting an explanatory model of the patient's illness. The women I interviewed however did not respond well to the questions. I think my lack of success may have been due to two things. First, the setting was too officious. Indo-Fijians do not like to reveal their innermost concerns during formal interviews with a stranger. Second, most patients did not want to commit the amount of time that was involved. In OPD, most of the women with whom I talked were sick, eager to get treatment, to go to town for medication and then to go home—a lengthy enough process. In the Women's Ward the patients were just too sick to participate in
formal interviews even though they did talk to me later as I visited their bedside. I was eventually able to elicit their interaction. Partly too, our poor interaction during the interview was the result of the crowdedness of the setting, and partly with their expectation that I was connected to the biomedical institution.

The women I could most easily interview were always those who had already been admitted to the wards as patients, and who saw me going on morning rounds and interacting with the medical staff for a day or two. These women were warm and open in talking to me. For the most part I found that my work was concentrated in the Labour and Delivery areas and the Obstetric Ward as I followed the same woman through the process of birthing. In these wards, connected with pregnancy and birthing, I participated in the birthing event and observed and helped as needed. The interactions were those of all of the people involved in facilitating the birth. The nurses, doctors, patients and myself were all part of an interactive arena of action.

Until this fieldwork, I had never before witnessed a birth taking place. The process is awe-inspiring and I felt a bond with the women who were the main actors in the participant-observation experience, as well as with the Obstetrician and the Nursing Sisters who so ably and compassionately directed the process from the onset of labour through to the delivery of the child. I was part of the "communitas" that is engendered by 'experiencing' the birth with the mother, as one of her helpers. (This is communitas of a special type, linked to same-gender experience.) I wiped brows, held hands and rubbed aching backs and patted stomachs and encouraged the woman who was delivering. I listened as the midwife or young nurse directed the woman, kindly, patiently urging her to push when it was time, or to relax and rest by turn. Dr. B. the Obstetrician treated me as an professional colleague, and allowed me to observe all of the activity in the labour and delivery rooms. I was grateful that she kept up a dialogue with me, explaining her procedures and the reasons for them every step of the way.
During the whole of my fieldwork in the hospital while I worked with her, she facilitated my work, taught me by always explaining her actions, and by sharing the diagnoses with me.

I found that I could not act in a non-interventionist role in a setting where my intervention was requested and my judgement solicited. Consequently, I helped when the doctor inserted intra-uterine contraceptive devices (hereafter referred to as I.U.C.D.'s), held the hand of a woman (see footnote 7) who was nervous while in labour, resuscitated a baby while the midwife attended to a mother who was bleeding, and donned the green surgical outfit to go into the operating theatre during a tubal ligation (also referred to as a TL). In an emergency, I acted as the non-surgical nurse in the operating theatre, frightened but assured by my knowledge of some basic principles and procedures. As in the O.P.D. I was an inter-actant in all of these processes. I also surprised myself with my ability to be detached in situations of utmost stress. I was not a trained medical professional accustomed to blood, births, amputations, and deaths.

PART I - THE CLINICS

For pregnant women the hospital clinic is the beginning of the medicalization of the process of pregnancy and birthing, in which the allopathic medical paradigm defines and treats pregnancy as a pathological condition. This conceptual shift was especially apparent to me as I changed my location of work from the settlements to the hospital. It began for me with the change in the terminology I used as we worked in the ante-natal clinic. Women who attended were referred to as patients.

As an Indian woman anthropologist, I have had some trouble in talking about the women who come to the clinic as "patients". Within traditional Indian culture, we do not think of pregnancy as a disease. Any process situated within the biomedical institution (viewed as curative) has important implications for how we view those who attend it (in this case women who attend the clinics). Furthermore the woman herself (the patient?) must undergo a conceptual shift about the condition of her 'self'. This is as true of the Fijian as well as of the
Indian woman. For both, the natural fact of pregnancy is restructured by biomedical institutional concepts and procedures to be conceptualized as 'a medical condition', constantly checked for blood pressure levels, iron deficiencies, and toxaemias, amongst other ailments.

But was a pregnant woman attending the pre-natal clinic really a patient? How is this transformation accomplished and how do women respond to it? What is the outcome? I will try to outline some of the answers to these questions and others in what follows.

Dr. B., the Obstetrician at SDH conducts the weekly clinics (Ante-natal, Post-natal and Gynaecological) and is in charge of the Labour and Obstetrics Wards.

The clinics are held in a small room 11'6" x 10'2" (117 sq. ft.), which accommodates a desk, the examination table (with a curtain immediately in front of it), cupboards, a double sink and drainboard, two chairs, a stool and the doctor's scale. There is one set of glass-louvered windows which are kept closed because otherwise the soot from the hospital smoke stacks falls on the urine samples awaiting analyses.

The general process is that women who are pregnant arrive at the hospital by private vehicle any time after eight o'clock in the morning and check in with the clinical nurse. Those arriving by bus (the majority) come on the first bus in the morning at nine o'clock. The bus to the hospital leaves from the station in the market area of the town every 20–30 minutes during the day. The cost is sixteen cents each way. Women arriving from the Sigatoka Valley, or from most rural areas, have already travelled for miles to reach the bus station, at costs ranging from sixteen cents to more than a dollar each way. Many arrive by earlier buses, and wait at the bus station until the first bus to the hospital. There are other costs as well, which I have mentioned in the previous chapter, such as familial or social costs. Costs are those incurred by being absent from the home or the farm; and some women have the cost of finding a replacement such as a person to stay with the family, or to keep the small family store open. The latter is
usually worked out as a reciprocal service between neighbouring householders if one does not live in an extended family setting.

Once at the clinic, if it is a first visit, the clinic nurse fills in the chart and gives each woman an attendance form (appended). After the initial visit, women come to the ante-natal clinic once a month until they are at the 28th gestational week. After that, they are scheduled every two weeks from the 29th to the 36th week and then every week until delivery\(^3\).

**The Ante-Natal Clinic**

The Ante-natal Clinic is conducted every Tuesday morning, after morning rounds in the wards and after any scheduled tubal ligations have been performed. It is usually held from about 10 a.m. to 1 p.m., and often times later. The Ante-natal Clinic is the most heavily booked with patients, with the same women attending at set intervals throughout the pregnancy.

When the women attending the ante-natal clinic arrive at the hospital early in the morning, they check in with the clinic nurse who gives them a number for their examination. She usually takes the urine sample they have brought for analysis, and she checks their weight and fills in the chart with their current gestational week. In those cases where on-going monitoring of blood pressure is indicated, the nurse performs this function as well. It is also the responsibility of the clinic nurse to phone for any blood or other sample results which have not yet been received from the Divisional Hospital at Lautoka, and to check the urine samples. Packets of iron and folic acid are prepared prior to the clinic. Ideally, the clinic nurse is in charge of having the clinic prepared and set up for the doctor, and of having completed some tasks relating to the patient charts.

Three staff members are usually present, the doctor, the clinical nurse and the family planning nurse. The latter is on loan every Tuesday from the nearby Health Centre. I was also present for several months, helping the staff with the charts, and calculating the gestation
weeks, calling Lautoka Hospital for test results, calling the patients in by number, and sometimes packing the packets of pills.

In addition to staff, there are usually at least three pregnant women in the room. One is on the examination table awaiting examination or being examined while a second woman is quickly undressing and putting on one of only two available gowns. A third woman is completing her charts, dressing to leave, or waiting for her iron and folic acid pills, etc. Or a woman may be consulting the family planning nurse and doctor about birth control. The room is a flurry of activity, hot, airless and very smelly. It is crowded with women, sari, sulus, gowns, handbags, shoes, and clinic staff.

The ambience is in stark contrast to that described by Morse who carried out the major portion of her research at Ba Methodist Mission Hospital (see Fig. 2.1, page 32). The population in the town of Ba is 80% Indo-Fijian and the hospital was established to serve the Indo-Fijian people in 1926. She states (1979:89):

The knowledge of the new pregnancy is kept as a close secret by the wife and her husband. They feel too "shy and embarrassed" to inform others, so that even the mother-in-law does not know of the pregnancy until increasing abdominal size can no longer be concealed, at the fifth or sixth month. Thus prenatal care for the Indian woman is delayed until mid or late pregnancy. And even at that late stage, she is reluctant to come for care, especially if this requires an examination by a male physician. One lady doctor reported "It is impossible to examine them (Indian women). You cannot see what you are doing, juggling all that sari." Even if a vaginal examination is performed to assess pelvic adequacy, frequently the woman is too tense for the examination to provide meaningful information.

At SDH, one of the remarkable things for me was to see women standing in various states of bareness, as they took off sulus or sari and put on the hospital gown, or as they dressed after examination. Often, a woman would be talking to the woman doctor or the nurse unconcerned about nudity, as she put on her underclothes, in full view of the other women in the room. Although both the Fijian and the Indo-Fijian are shy, neither hid in corners or turned her back as she dressed. And the shyness dissipated as the pregnancy advanced and as the women
became accustomed to their bi-monthly or weekly visits. (This ambience could be quite different in the case of a male examining physician.)

The vaginal examination is something most women do not like to submit themselves to, and this is especially true in those cultures, such as the Indo-Fijian, where it is not traditional practice. Thus we can expect the first experience to be traumatic in some cases. (It is not less so here in the West where such examinations are common practice.) Among the Fijians, traditional birth attendants do practice bi-manual examinations (sili); a woman is seated in a large bowl of water as the TBA performs the vaginal examination to determine pregnancy.

The most common words coming out from behind the curtain in the examining area is that of the doctor telling the women over and over again in either English or in Fiji-Hindi to relax, or of the doctor calling the Fijian nurse to tell a Fijian-non-English speaker to relax in the Fijian language. This was true in the case of nearly every vaginal examination whether Indo-Fijian or Fijian.

After this brief digression, I return to the description of the ante-natal clinic. Outside the clinic, as many as seventy women are pressing against the door, and are crowded into the narrow hallway waiting for their examination. Pregnant women of all ages and ethnic groups wait together. Many are accompanied by children, friends or relatives. Some mothers-in-law accompany their daughters-in-law.

Because the clinic is off the central corridor in the hospital, the clinic door must be kept shut for privacy since there are no change rooms inside. At times, due to the extreme heat the door is open and an attempt is made to keep the heavy green curtain drawn across it. The waiting women, impatient, peek in from both sides of it, occasionally drawing the curtain open right where the women are undressing to change. The nurses occasionally shout "No peeking!" and the curtain is released to its position of partially covering the doorway.
Immediately behind the doctor’s desk is a green curtain which partially shields the examination table. On her left is a portable fan which hums noisily and blows directly on her and the papers she is working on. There are numerous blank forms in heaps on the desk and the one needed at the moment is always at the bottom or the nurses have taken it over to the counter. There is a constant rummaging for forms, or the doctor calls out for them when they cannot be located. One nurse is coming and going from the room with one or two of the three speculums in order to put them into the sterilizing bath located across the hall in another room. She returns with one but not as quickly as it is needed. I felt doubtful about their sterility after the short immersion.

When a woman comes up to the desk for examination, the doctor looks at her medical chart and then examines her. The fetal heart beat is also checked. The examination can detect any abnormalities and also sexually transmitted diseases (STD). The doctor may ask to have blood pressure checked or blood tests done, in the latter case, the woman goes into the adjoining room. As soon as the woman has been examined she is free to leave. Unless there is something wrong, the doctor has very little time to engage the expectant mother in conversation. The physical examination is thorough, impersonal and rushed. There is no time to discuss how a woman feels about her pregnancy or the child she is carrying.

When and if there is a problem however, the doctor is very empathetic and concerned about the welfare of the pregnant women who attend her clinic. In those cases she will go to great lengths to explain the situation and its complications, as well as to answer questions raised by the woman. Some of the more common problems during pregnancy detected during the clinics are fungal infections, pregnancy induced anaemias (10 gm. or less), essential hypertension, pre-eclamptic toxaemia, eclampsia and occasionally, STD (sexually transmitted disease). In the first case Dr. B. prescribes a lotion. In the case of anaemia, the clinic nurse gives the patient iron and folic acid pills free of charge and monitors the woman’s iron levels on return visits.
The doctor carefully monitors patients for hypertension, pre-eclamptic toxaemia, and eclampsia through blood tests, blood pressure readings and physical signs and patient complaints. It is not unusual for a patient at risk to be admitted to the ward for observation and to have her condition monitored if she shows any sign of aborting, or until the risk abates.

In the case of sexually transmitted disease (STD) the doctor advises the pregnant woman to return with her husband, for both must be treated together. Dr. B. carefully explains the disease and its treatment and she explains to the patient the seriousness of not treating STD's. She tells the couple that she does not care about the moral issue but that they must get treatment. Many women do not know anything about the disease, but contract it from a husband who works in one of the hotels. In these cases once the couple returns together, Dr. B. discusses the disease and its treatment with them. She emphasizes to the man what the outcome of it can be, in terms of the health of the mother and of their child. The treatment is fast and efficient, usually consisting of several shots of penicillin. As she is talking to the couple she also explains to me and the clinic nurses that the incidence of STD's has risen sharply in the last few years and that its occurrence is reported even from the interior of the island. The response of most couples is to want to comply with the treatment the doctor sets out. Women rarely have anything to say and they do not ask any questions, but listen to the doctor's explanation of the illness. Men who accompany their wives back to the clinic look acutely embarrassed. In most cases when she asks the man where he works it is in the tourist industry and hotel related work, where promiscuity is common. There is little secrecy in the clinic. The nurses and I usually are a part of the medical team in these cases and are allowed to listen and to watch the interaction of the doctor and the couple. Nurses rarely show any emotion but continue with their work, largely ignoring the interactants but attending to the conversation.

Following examination, those women who have no problems are sent home without much comment after they get the date of their return visit entered on the attendance form. There is
very little time for idle chit chat. Although there is a camaraderie between the nurses and staff and some patients whom they have got to know from their weekly visits, there is no intimate warm interaction with each woman who comes to the clinic. Although clinic staff talk kindly to new mothers to be, we do not know their personal concerns about their pregnancy, the child they are carrying or their hopes or fears. This kind of interaction occurs only between those women who are personally known to the staff, and who actively seek such interchanges.

There are several reasons why women who are from the higher classes, and women who are European, receive more attentiveness than do the ordinary women who come to the clinic. First because of their class. Second, because it is more satisfying to staff to interact with someone who knows the physiological process taking place and who asks pertinent questions (those that nurses and doctors can answer from their training experience). Both doctors and nurses are anxious to show expatriate (European) patients that the treatment offered, while not as good as they are used to overseas, is not bad, and staff are willing to compensate for its shortcomings. Some younger staff also resent having to do this and they criticise staff who interact for too long with Europeans and make their favouritism obvious. The other patients, whatever they think, rarely complain or say anything about this.

The Gynaecological Clinic

The Gynaecological clinics are for consultation with women who have a gynaecological problem not related to pregnancy. Here, women are examined and advised about treatment, family planning and sexual problems. Pap smears are taken during this clinic, and sent to the Divisional Hospital at Lautoka for analyses. From May to December, 1985, 344 women attended the clinic: 111 Fijian, 231 Indo-Fijian and 2 "others". Pap smears were taken from 476 women at all the clinics in SDH during 1985. (Figures from unpublished Gynæ/Obs. Report, May –Dec. 1985, SDH.)
This "gynae" clinic is held by the Obstetrician/Gynaecologist once a week. Since the arrival of Dr. B. at the hospital more women come for checks and for pap smears than ever before. In her clinics Dr. B. emphasizes that all women should have the test once a year, and this has become known in the area. The response has been very good. The test results are returned from the Lautoka Hospital in several weeks. Other problems such as suspected breast tumors, ovarian cysts, etc. are caught during these general gynaecological clinics where the doctor has more time to interact with the patients. Couples with problems in sexual relations, women suffering from secondary amenorrhea or dysmenorrhea, or other problems, are all treated.

The Post-Natal Clinic

At the weekly Post-natal clinics the doctor examines women and their babies for the six-week check-up. This is perhaps the happiest of the clinics as the new mothers bring their infants back for the doctor to examine. Dr. B. remembers each of the cases and their names and the interaction is warm and friendly. She scolds women whose babies have rashes and the nurse and the doctor talk to the infants as they undress, weigh and examine them. She talks to the women again and seriously about their family planning, encouraging them to take an active part in their own protection. The women all like to be attended by a woman doctor and have great respect and admiration for her.

During the post-natal examination a woman can discuss any problems she has encountered after discharge from the hospital. After the six-week check-up, the mother and child are referred to the nearest local Health Center or District Nursing Station to the Mother and Well Baby clinics in the rural area where they live. (Fig. 2.1, page 32, shows the location of health services in the Nadroga/Navosa area of this research.) At the Well Baby clinics, an infant is given immunological injections and its health, nutrition, and general growth are monitored up to the end of the first year. From May, 1985 to December, 1985, 69 Fijian and 79

**Family Planning**

The clinic nurses advise the women who visit the clinics about family planning as a matter of course. Newly married women, having their first child, hear the doctor's interaction with other women and the advice she gives to them. Every woman listens to the advice the doctor gives in the clinic and thereby learns from the experience of others as well as having her own direct consultation. In the clinic we hear the doctor reprimand women who have more than three or four children. She tells women with three "its enough!", especially if there is one child of each sex. The doctor and family planning nurse urge women with a number of children to use a contraceptive. Contraceptives such as condoms (10 cents per dozen), birth control pills (20 cents per month), and Depo Provera injections (80 cents per 3 month injection) are readily available from the District Nursing Stations, Health Centres and hospitals where they are dispensed at a very low cost.

Dr. B. and the family planning nurse implore the women, cajole and tease the patients to think about their bodies and to examine how they will care for too many children. The doctor takes time to check the patient's chart and to see how many children the woman has borne. She and the family planning nurse advise the pregnant women about birth control and she encourages women to space their children. Some women are advised to have tubal ligations (TLs) performed, while others are told to have IUCD's (intra-uterine contraceptive devices) inserted, for others she suggests the pill, or injections of Depo Provera. In each case she carefully weighs and discusses why that is the best method for that particular woman.

At SDH, the labour room is also usually used when a woman is having an IUCD inserted. The patient lies sideways on the bed with her feet in stirrups and the doctor selects the most suitable type of IUCD from the large glass container. The Labour ward nurse assists the doctor
if she is not attending to women who are in the Labour Ward or the Delivery Room. When she was busy, I was called upon to assist. Dr. B. keeps up a running commentary with the woman about the IUCD as a contraceptive, when it must be replaced, how to check to see that it has not been accidently discharged. She explains carefully that there will be more bleeding during menstruation with an IUCD but that after the first few months it will settle down. Indo-Fijian women are very conscious of blood loss and think of menstruation as weakening and a time of low energy when other diseases cannot be easily fought off. For this reason Dr. B. explains very carefully and emphasizes those aspects of birth control which she knows patients are afraid of or which are potentially stress producing so that they do not mitigate against the use of the device. At all times she is educating as well as treating her patients.

Indo-Fijian women are eager to have family planning advice and they follow it. The Fijian nurse explained to me that they even use the condom successfully. (I was fascinated to see their lack of shyness when talking about condoms and sex.) The Fijian women however are first, shy about discussing matters related to sexuality, and second, they will usually say they must consult their husband. An overseas volunteer and I found that the Fijian women, nurses and patients, were extremely shy about discussing family planning and sexuality. The volunteer, a nurse educator, was having trouble training the Fijian family planning nurses to speak up because they usually talk in whispers to each applicant for family planning. (I cannot explain this reversal of shyness between Fijians and Indo-Fijians in the biomedical setting. In their own communities Fijians are very open, whereas Indo-Fijians are extremely shy and private about these processes. Perhaps one ethnic group is more able to internalize professional detachment during their socialization into biomedical health care practices.) Most Fijians are reluctant to use family planning. Five older Fijian women who were pregnant were advised by Dr. B. to have some type of family planning. All five were difficult to talk to and did not want to commit themselves to any birth control, until finally the Gynaecologist angrily referred them to
the Fijian SDMO hoping that he could convince them of the necessity. The physician told me that with each birth Fijian babies are larger. The danger of the uterus rupturing increases after many pregnancies; especially when it is the ninth or tenth child.

In general among both Indo-Fijians and Fijians, the younger women are eager to have family planning advice. For economic reasons it is more difficult for many young Fijian women to use family planning. Although condoms and birth control pills are easily available, even the low subsidized cost is beyond the economic capability of many women. Cost and the fact that most Fijian men want many children mitigates against the woman successfully using family planning. Religious conviction also intervenes in the decision. Some Fijian women are Catholics and will use only the ovulation method, while some want to rely only on traditional methods. I discuss family planning again later, in the context of the Obstetrics Ward.

While discussing family planning with an Indo-Fijian and Fijian nurse one day, as we were sitting and packing dressings, I was able to get an interesting dialogue started on family planning in Fiji by asking Why is family planning not working? The views of many Fijian women with whom I talked were summed up by the very bright young Fijian nurse. She had just returned to hospital work after an arduous public health posting on an outlying island from which she was recalled after she had sent urgent radio-telephone calls to the SDMO about continuing harassment. An evening attack of stone throwing at the health station precipitated the SDMO recalling her to the mainland. As punishment the island was without medical services for some time thereafter.

She said there are several reasons why family planning is not effective in Fiji. First, there is not enough public health education, and little about family planning. Second, the people are lazy. Third, the men don't enjoy sleeping with their wives if they have to use family planning. Fourth, the men want to satisfy themselves - the wife is the one who has to worry about how to feed the children, even though the husbands will have to do more planting and
farming. This will provide just the barest of basic needs. Fijians value large families, but essentially it is the satisfaction of the man's basic sexual urges. She said, "there is only one way - the wives have to be more hard and say no or use some protection".

I think women should protect themselves and be sure to do it - men are too moody, they are often in a bad mood or drunk. They try to get the women pregnant because they do not want them to go to parties or talk to other men and if they are pregnant there is no time for parties.

She went on to say that Fijian men use pregnancy as a means of control if the woman is getting too independent. And women too, know that if they have the TL then the husbands can always WIN because they can take another wife who can have a baby and then they taunt the wife who cannot, so she is the loser. (This issue has been voiced to me before by Fijian women who use the win/lose idiom in discussing their relationship with their husbands.) Consequently, she said, the woman would rather feel that she is a good sexual partner for the husband and keep him happy. The woman is there to satisfy the man and if she won't there is a price to pay for it. If she has a tubal ligation and saves her physical health then she has to pay a psychological price for her unwillingness to continue to bear children and to be under the control of the husband.

I'm always on the losing side - my husband wins, or we can both remarry but I can't have babies after a TL, but he can remarry and have babies so he wins.

She cites the case of many older Fijian women "with gravida 10 or more" who come to the clinic.7 On the ward at the moment there is a 47 year old gravida 10 who is 5 months pregnant with her 11th child, and experiencing difficulties carrying the child. This nurse believes that menopausal women have a higher sex drive and with the irregularity of their periods they are also more fertile. (According to a doctor this is not accurate and is part of folklore). At the other end of the age scale, younger women who are breastfeeding often think they won't get pregnant as long as they don't have their periods--this is not the case and they get "caught".
The young Fijian nurse felt basic education about family planning methods was severely lacking.

They have some odd beliefs about the loop - they are myths but they gossip together and they tell each other these things and frighten each other a lot. One is that it will go right up into the body and choke them causing death. I tell them yes, it goes into your body, but it will only go so far, and it will come down again. Some want to practice the ovulation method, I ask them "On those days (the fertile days) can you say 'no'?" Some men get stubborn and violent! Fijian men want lots of children to help with the work.

She did not tell me that many Fijians are very politically motivated to retain their high birth rate because of their fear of the growing number of Indians in Fiji who already outnumber the Fijians. I knew of at least one Fijian SDMO who, in a subtle shift from family planning objectives outlined in health policy, asked the Fijian people to space births, not reduce them.

One of the obstacles to achieving family planning as set out in Development Plans 8 and 9, is the opposition from key Fijian leaders. I was able to obtain a copy of the report of the Task Force set up by the Ministry of Health which met on 14 January 1986 and which stated it would have to convince the

...Council of Chiefs and Provincial Councils, Community leaders especially Governor General, Prime Minister, Deputy Ministers etc...that they should discuss the significance of family planning for the direct benefit of the Fijian people and the country as a whole. This special effort to convince the Fijian leaders on the value and importance of family planning and the necessity of its acceptance is being done in the light of the following observations:

"Among the major reasons for the decline in family planning are the declining acceptance in family planning by Fijians as shown by the decrease in acceptance rate from 16.9% in 1972 to 15.6% in 1977. Indians on the other hand increased their rate of acceptance from 24.0% to 28.6% in 1977. This decline in acceptance by Fijians might be attributed to such factors as:

- a negative attitude toward family planning based on the mistaken belief that available land is still plentiful.

- fear of political domination by immigrant Indians, who outnumber indigenous (sic) Fijians.
The interactions and processes in attempting to get this task force report implemented show the sensitivity of trying to implement an unpopular policy which has deep political undertones. The Task Force of the Ministry of Health would need to convince Fijian politicians that the intent of the report is not political but social and economic. Those within the Ministry of Health understand the need for Family Planning and are more apt to support it than are Ministers holding other portfolios, or the Fijian Administration whose interests are more overtly political. I return now to discuss Indo-Fijian attitudes to family planning.

The Indo-Fijian nurse is an aspiring midwife, currently working as an obstetrics nurse. The comments from her were very simple. She said Indians are good acceptors of TM and of other forms of family planning. She said they usually accept family planning early. Those few who have four or five children today are eager to have family planning. They are still cautious acceptors of Depo Provera injections because they believe that menstrual blood is polluting and should be discharged otherwise they may get sick. (That this is no longer true is evident in the statistics of use by Indo-Fijians, See footnote 6, and see below). With education they understand the menstrual cycle better and are not as easily frightened. The Sister-in-Charge of SDH told me that there were 75 Indo-Fijian acceptors of Depo Provera in 1985, but few Fijian acceptors.

The Ministry of Health and Family Planning groups strongly advocate the use of Depo Provera, and it is used extensively in Fiji. When I asked the obstetrician about the use of a product which is banned in the United States and much of the Western World, she was unconcerned. She said the value in these countries far exceeds the unknown costs. She felt strongly that multiple pregnancies were more dangerous to the health of women, especially the Fijians, than the unknown risks of taking Depo Provera. Although Fijian women still show some
reluctance to use of Depo Provera, I was told the injectible contraceptive is especially effective for them because contraceptive pills are contra-indicated due to the size and condition of Fijian individuals. Obesity, cardiovascular and other circulatory problems, and a high incidence of diabetes, make the pill especially dangerous for Fijians. Also the Fijian attitude towards medication is one of forgetfulness, thus increasing the chance of unwanted pregnancies. They are reluctant to have TL's for they fear being unconscious during the operation. Other forms of family planning are not used because of cost or the bother of going to get the necessary items. With the injectible contraceptive, once it has been prescribed by the doctor at the hospital, it can now be continued at the outlying district nursing stations, every three months for a cost of only sixty cents. Dr. B. has been successful in convincing Fijian women to begin using Depo Provera.

The physician prescribes the use of Depo Provera only after careful consideration of the general health status of the patient and within the qualifying guidelines provided in the country. However as with many pharmaceuticals in third world countries, the directions of use are poorly understood by other medical staff such as nurses, District Nurses and Nurses at the Health Centers. On two occasions, while travelling with District Nurses, I heard them talking to patients about the use of the contraceptive; they were misinformed about who would qualify as a potential user. Instead of evaluating each case, the nurse was attempting to apply a general rule about age and number of children at which Depo Provera could be prescribed. My subsequent query at the hospital led to an educational session on family planning for the District Nurses and Health Center personnel.

Nurses in the clinic are more interested now in attending to education about family planning than in the past. During this fieldwork year the government reported a lack of success in its family planning programmes during DP8 and asked that medical personnel emphasize birth control practices in order to reduce the population growth rate from the current 2% per
annum. The major growth is in the Fijian population; there has been no reduction comparable to that of the Indo-Fijians in the last five years. This was especially the case in the Western Division. A frustrated overseas volunteer working with Health Center personnel explained that at first they spent weeks denying and recomputing their statistics, rather than planning an effective educational campaign. Until finally, with continuing pressure from Suva, they started a renewed family planning campaign.

Social problems

There are many women who attend the clinic who are termed social problems. Many of these are unmarried pregnant women, pregnant retarded girls, separated women who are pregnant, or pregnant women who have previously put up children born out of wedlock for adoption. I discuss only a few such cases here, as illustrative.

A few of the women who attend the clinics, and who are referred to as “social problems”, are women who have been abandoned by their husbands. They have formed liaisons with other men and have children with them. In these cases the doctor gives them advice about life-styles as well as about family planning. She is encouraging and attempts to help them to make sound decisions. In other cases she is not. In the case of one Indo-Fijian woman who had delivered her child recently and who wanted a TL, she was absolutely unwilling to do a tubal ligation without the consent and signature of the husband. The husband however was away working in New Zealand. Her comment was that if he is away then family planning was not even necessary, unless she was “running around”? The patient should either wait for his return or send him the papers for signature.

In another case the young Indo-Fijian woman (D.), who has three children is accompanied to the hospital by her father-in-law. She wants to have a tubal ligation or to have Depo Provera. Her husband however has been overseas for three years or more. There is every indication that he is not coming back to her. One of the other doctors comes in and tells us in a
whisper that "the old man is pinching her!". (This is the gossip in the hall about the woman; one patient reported it to her doctor who came in and told us.) Whether it is true or not, again a judgemental decision about a moral issue outweighs the woman's personal need for a contraceptive. Dr. B. does not give her an outright refusal, but lectures her and tells her to come back in a week, after she has thought over the implications of her request, and that with her husband away she should not even need a contraceptive. Under the circumstances, it is doubtful if the woman would return to be humiliated in the clinic again. I do not know how she will recover from the stigma attached to having been made known to a wide "public" gossip network at the hospital.\textsuperscript{11}

In cases such as these a doctor's authority as a physician and personal judgemental values appear to guide medical decisions more than they would in the Western countries. The heirarchical nature of society, as well as that within the institution, places high status people in a paternalistic relationship to lower status people.\textsuperscript{12} Certainly, the medical staff would be libelous if they were to be charged with the use of such language to a patient. In general however, clinic staff attempt to help people see all the choices and options before they make decisions that are irreversible. Usually confidentiality is not an important issue in the clinics. But when it is necessary, the staff do not always remember the rights of the patient to protection of privileged communication.

The women who attend the clinics respect the decisions of the staff. Although there is some talk amongst some professionals in the hospital about being "feminist", they do not have a clear understanding of the stance. Some of the staff seemed to think that if your work focuses on treating women you are a feminist. Upholding a supposed morality still outweighs non-judgemental support of women in dire need; and understanding of the situational context out of which many of the problems poor women encounter, is not yet part of the social consciousness.
In some instances however, the whole staff is judgemental and show a morbid curiosity. When a young Fijian woman of sixteen years came in for examination and denied she was pregnant, even though the doctor could detect a fetal heart beat, the staff were all angry with the girl. The doctor and nurses gathered around the frightened girl and asked her who she had been with, when and where, in chastising tones. One staff member told the girl that if she refused to tell, it would mean that she was hardened, unrepentant and would be bad forever! The woman stubbornly refused to tell the staff anything until later when finally an older Fijian nurse talked to her in private. My response in these situations was to tell the shocked staff that the woman was right to refuse to tell them those details, they had gone on a tangent, side-stepping the real immediate issue which was how to help the girl accept her pregnancy and to care for her health. This was especially true in the Fijian culture which is quite accepting of children born out of wedlock; there is no stigma attached to illegitimate children.

Another type of case seen by the clinic staff under the rubric of a "social problem" are the unmarried mothers who want to place the child out for adoption. This is arranged through the hospital. I also observed two cases of mentally retarded Fijian girls who were pregnant, one with a second child. These problems are dealt with by the staff with empathy for the girl and her family. In both cases the infants were adopted by relatives who wanted them.

As my research year advanced, I started to feel that some of the moral issues that emerged and interfered with medical treatment had partly to do with the ethnicity of the staff treating the patient, and with previous interactions of a Fijian doctor with an Indo-Fijian patient or an Indo-Fijian doctor with an Fijian patient. Sometimes the dynamics of the personnel in the small group involved in the interaction also determined an outcome as in the case of D. above. Although I have not been able to examine this problem quantitatively, it is one for further research on how ethnicity impinges on health care. For in Fiji, it surely does. It is subtle, indirect and appears to be a balancing of slates, or one group getting even with another.
do not believe it affects critical medical decisions, but if it occurs in the clinics and wards, there are important implications of this for the bureaucratic structures in the medical field.

In the ante-natal clinic, which is rushed, crowded and uncomfortable Dr. B. calls all Indo-Fijian women by the same term, muni (girl). This is especially obvious when she is reprimanding a woman. In the other clinics, she addresses the older women by the term nani (grandmother). In the rushed ambience the terms sound cold and superior, emphasizing her authority, and her superior class which is already demonstrated by her dress and speech. I have discussed this briefly above, in Chapter 11, with reference to dominance and subordination.

Interactions between Dr. B. and the clinic nurse were in the form of requests by the doctor for forms, or requests to know the response from Lautoka hospital about blood tests for patients attending the clinic. Most of the time the clinic nurse did not perform the routine tasks needed to set the clinic up in the morning prior to the arrival of the doctor. Dr. B. was then forced to direct the nurse’s activity by a demanding, nagging tone to ask for things which should have been provided as a matter of course. The clinic nurse acted as if the cutting remarks did not bother her, smiling broadly, all the while seething in anger. She found recourse in upsetting the doctor’s schedule by sudden long absences as she went to look for a patient or talked to the nurse across the hall as she went to get a speculum. Only later, when the hospital volunteers began to work with her did she change her style of work and become efficient in her work, appearance and manner. I believe several factors contributed to this. First, the volunteers were quick to learn and eager to help. Second, the work of the clinic nurse consisted of far too many small tasks, each requiring her to be in a different spatial area, in very cramped quarters. Third, in order to teach her volunteers she had to show her own competence. The ambience in the clinics was calmer and the staff worked cooperatively as long as the volunteers assisted. Dr. B. no longer had to constantly upbraid the clinic nurse (much to everyone’s relief).
During fieldwork and more especially in the writing of this dissertation, the process of inquiry leads to more and more questions than are answered. Can a doctor in Fiji become engaged with resolving social problems as well as medical? Who is responsible for staffing problems such as inadequate preparation and short staffing? What are the boundaries of the physician's professional task? How can a biopsychosocial approach be introduced? These questions are beyond the limitations of this work, but are real issues faced by Fijian doctors, who have little time but large numbers of patients, with social, economic and medical problems. There are few social workers in Fiji.

Sub-Fertility

In the clinic, women who have not been able to conceive, come for advice to the "lady doctor". As I have discussed in Chapter 7 above, this is a most stressful and unfortunate circumstance for Indo-Fijian women who are valued in the culture for their ability to reproduce the lineage. Sterility is a major form of adversity in Indian culture. Indo-Fijian women suffer in silence thinking they are to blame for their misfortune. I have seen the relief on the faces of women when they are told that in 50% of the cases it is the man who is sub-fertile, not the woman. Dr. B. usually asks the woman to return with her husband to discuss the problem with her. She gives the information clearly in Hindi, with a forthright and empathetic expression.

One woman who had been married for eight years without conceiving, arrived because her husband directed her to go and have tests. After her initial discussion with Dr. B., she and her husband returned for consultation. The man was clearly surprised that he might be the cause rather than his wife. Dr. B. advised him to go to the Divisional hospital to have his semen checked. The doctor does not take any chances with Indo-Fijians mistaking the meaning of "semen", she explains carefully that it is the pani (water), not the urine (pisab), but the water that contains the baiu (seeds), that is to be checked to see if they are alive. She tells him the sample must be given at the hospital on the appointed day. Dr. B. tells the couple that that is
the first thing to do, since the woman has already been checked and further examination of her would be of a more serious nature. Once the man has been examined and eliminated as the cause, then they can if need be, proceed with other tests. The women are so obviously relieved of the great burden of guilt, that we felt a great empathy for them. We knew that for years perhaps, they have been the center of familial recriminations.

When an Indo-Fijian (or Fijian) woman wants to get pregnant but has not been able to within two or three years of marriage she will come to the clinic and quietly ask the doctor what she can do. Careful explanation follows these requests as she is told that she is more fertile at certain times during her menstrual cycle. Indo-Fijians are advised in the Hindi language; the doctor will talk to Fijian women in English if they have a reasonable grasp of it, or she asks the Fijian clinical nurse to translate for her. The women go away at least reassured and willing to try again, before going for more elaborate tests.

Abortions and Other Complications of Pregnancy

In Fiji as in other countries where abortion is illegal, there is a flourishing black market in providing them. A doctor at SDH told me that many private doctors perform abortions for large fees. The rich can afford them. It is the poor woman who cannot and whose life is at risk from the various processes that are available. A common practice is to go to a private doctor and tell him that menses are delayed and to get a prescription of E.P. Forte. It will frequently start the bleeding and, in the case of early pregnancy, sometimes induce an abortion. The drug usually starts withdrawal bleeding in the second half of the cycle by interfering with hormonal levels. At that time the private doctor has a medical reason for referring the patient to the hospital or to a clinic for an evacuation procedure. If the pregnancy is not terminated, the drug causes serious fetal abnormalities. Some private practitioners have clinics where they will carry out the procedure themselves.
Other women are able to get an injection of Depo Provera which acts in much the same way as E.P. Forte. Dr. B. said this upsets the hormonal balance of progesteron which usually supports pregnancy, and thus causes an abortion. Another drug used to induce abortion is ergometrine which is a vaso-constrictor and is very dangerous unless used as prescribed. During this fieldwork I was informed about a young mother who died as a result of prolonged use of ergometrine which caused extensive brain and other vascular damage.

Doctors are not always sure if bleeding during the early stages of pregnancy is a result of an attempt to abort the fetus, but usually they can elicit the history from those patients who come into hospital with sepsis. My fieldnotes show one such case:

J., a 26 year old Indo-Fijian woman was admitted for examination. Her medical history reveals that she is pregnant for the sixth time - she has four children and has had two miscarriages. She is very sick and frightened. She has taken E.P. Forte which she obtained from a District Nursing Station and subsequently went to Suva and received an injection of Depo Provera from a physician there. The diagnosis is septic abortion. The patient's chart also shows that there may have been digital interference with the pregnancy. She will have an evacuation procedure today.

In these cases the interaction of the doctor and patient is intense. The woman is obviously frightened, and knows abortion is illegal. The doctor is anxious to know the complete medical history and must try to elicit it from the patient. The doctor handles the situation by being brutally frank, she tells the patient that she feels this is an attempted abortion and that the risk of sepsis is life threatening in some cases. The patient must tell the truth about the medication or process used to induce the abortion in case the treatment is contra-indicated. As with this patient, most patients willingly comply so that they can be treated and given medication to relieve the pain. Many of the staff feel a sense of embarrassment in these cases, and other patients come to know what has transpired.

Fijians have an extensive herbal tradition and have knowledge of abortifacients. (Indo-Fijians do not have any home 'treatments' to induce abortion, but some women knew that
the Fijian people have methods which 'work'. One informant told me that Fijians use them in the case of unwanted pregnancies and also use mechanical interference of the pregnancy.

As in most countries where abortion is illegal, there are no statistics available which accurately reflect the incidence. At SDH, only two abortions are recorded in 1985. On the other hand the figures for evacuations show the procedure carried out on 28 Fijian women, 33 Indo-Fijians and 1 "other", for a total of 62 in 1985. (SDH Gynae/Obs. Report unpublished, 1986.)

Another complication of pregnancy is the ectopic pregnancy, which can result in hemorrhage. It is often a recurrent problem in those women who have once suffered an ectopic. The procedure is to surgically remove the tube in which the pregnancy is implanted. A thirty year old Indo-Fijian woman who had just had an ectopic pregnancy told me that they have been married for four years. She suffered from pain in her right side and went to the hospital where the doctor did a scan and discovered the ectopic pregnancy. "They told me to have an operation because the tube can bust out". She was given anesthesia and the tube was removed. The doctor told her that her chances of conceiving were reduced to 50%. When I asked her what she thought about that, she said:

"I felt that was my first pregnancy, once the doctor told me then I was worried... they had to remove the right tube and I was going to be left with only one and a fifty percent chance of pregnancy,... I was checked two weeks after the operation and then after two months and after six months. Then the doctor gave me Clomid Merrill pills to help you conceive. The ectopic was last May. They explained about conception, that there are ten days when I can conceive. I am to take the tablet on the sixth day after my periods and take them for five days. I am to try for three months and then come back in May. I have also had a laproscopy done in 1984 when I had been married over two years, and they thought that my ovaries may be weak. They found them to be normal. I haven't told my mother, but my sister-in-law knows. She is not worried, and I am not either. It is now in God's hands.

In the foregoing pages I have discussed the processes and interactions when women secure therapy in a number of clinics at Sigatoka General Hospital. Now, I go on to focus specifically on the interactions and processes in the Labour, Delivery and Obstetrics wards.
PART 2 - THE LABOUR/DELIVERY, OBSTETRICS WARDS AND WOMEN'S WARDS

One of the most notable things about these two wards is the cleanliness, tidiness and the immaculate appearance of the wards in contrast to other areas of the hospital. Doctor B. is in charge of these areas and since her arrival in 1985 she has had them cleaned, had new dark green curtains put up around the beds and on the lower halves of the louvered windows. The general effect is of coolness and semi-light. She keeps a strict control of the procedures performed by her nursing staff. The equipment and supplies are all immaculately kept and are well supplied. She has had glass jars sterilized and labelled for the small items. Under her direction the staff have begun to pack and autoclave the supplies used during the deliveries, on site. All in all, she is strict and expects her staff to perform at a high level of skill and expertise. They appear to respond enthusiastically under her direction.

The Biomedical Process of Birthing

When a woman starts labour she begins to get ready to go to the hospital for the delivery. Indo-Fijian women are very late in arriving at the hospital, their mothers (or other responsible family members, the therapy management group) usually time the contractions carefully at home before letting the woman leave for the hospital. In a number of cases, babies have been born on the way to the hospital and in one instance recently, at the hospital door.

In general, Indo-Fijians do not like to turn over the control of a family member to the custody of an institution. A woman is often accompanied by at least one member of her family and sometimes two, who wait on the hospital premises or on the grounds for long hours, or go home and return frequently to check on the patient. Many times nurses told me that Indo-Fijians admit themselves into the hospital late, and want to leave as soon as possible. Most Indo-Fijian women say post-natal care at home is one of the best times of a woman’s life, one of the few times when she receives nurturing care, attention and familial support.
The labour and delivery rooms at SDH are in a section of the hospital away from the Obstetrics or Women's Wards. The staff think of the birthing process as made up of three steps.

The first step is the onset of labour; the second, delivery of the child; and last, delivery of the placenta.

When a woman is admitted she is in a separate room from the delivery area for the first part of her labour. Here, a nurse "prep's" her, monitors her condition and if she has time, treats her with massage and gentle conversation. With women who are delivering for the first time the nurses are very considerate.

There are some subtle differences in the interactions between Indo-Fijian patients and Indo-Fijian nurses. Indo-Fijians do not interact as intimately with each other as Fijians do; nor do Fijian nurses interact as intimately with Indo-Fijian patients. On the other hand the Indo-Fijian nurse had no reservation in showing a great deal of caring for Fijian patients. I believe this is because Indo-Fijian women are more reticent in their communication, more private about bodily processes, thus they also do not receive the reassurance they need. They are more fearful, and they show their pain.

I often observed a Fijian nurse sitting on the bedside of a Fijian patient who was in pain or who appeared frightened, rubbing the patient's stomach or back and talking soothingly to her. It was more rare to see an Indo-Fijian nurse stop to interact this intimately with women, although they showed caring through speech, eye contact and massage. Indo-Fijian nurses appeared to be more at ease with Fijian patients than with Indo-Fijian.

As the contractions become more and more severe a mother-to-be is moved into the delivery room for the actual birth. She lies on the high delivery bed, on her back or moves onto her side until she is close to delivering. While stirrups are not used, the child is delivered in the lithotomy position, with feet flat on the bed, knees flexed. In order to push the woman put
her hands under each thigh and pulls. The nurses all interact with the woman verbally, by touching, as well as by eye contact.

It is common practice in Fiji to administer syntocinon intravenously, while the woman is in the labour room. I was told that "drip" is given so that the person will not be in labour for too long, to hurry the contractions because the hospital does not have sufficient beds in the labour room. Other medications such as analgesics are also used during delivery, but I did not see anesthesia being used. The following excerpt from my field notes describes the process in the delivery room where one Indo-Fijian woman has just been delivered; and the experience of another woman, a Fijian, who came into the clinic and was admitted because of edema. In both cases it is a first child.

As I entered the labour room Nurse R. (an Indo-Fijian) called me into the delivery room. She was in the middle of a delivery, the baby's head had almost crowned and with two more contractions the baby's head is almost out, but face down. The Indo-Fijian midwife, Sister H., turns the baby's head a bit and then the shoulder too comes out and the baby comes out suddenly along with watery fluid and blood.

The baby's hands and feet look bluish - the midwife quickly takes it, suctions it and wraps it in a blanket while blowing on its face and slapping it on the feet. The baby cries and is then quickly placed in the incubator. This has been a problem case for the nurses and has been safely delivered. The midwife explains to me that the infant was stressed from the birth process and blowing in its face and slapping the feet makes the child take deep breaths and expand its lungs and get them working.

Then the placenta is left and Nurse R. has been working on delivering it, but it won't come so she calls the midwife who puts on her gloves and works it out as she presses quite hard on the woman's abdomen. As she is doing this she is talking to the moaning woman, "Just a bit more my dear, just a bit more..." Then it was out and in the pan. She examines it for any abnormalities and to see that all of it had been delivered. Satisfied, she leaves the nurse to clean up while she checks the baby. And then it is time to deliver the next woman.

A. was admitted from the ante-natal clinic because she had edema and she was due. As she entered the labour room she was prepared and given the "synto drip" intravenously. Now, as she is about to deliver, her hand and stomach area are swollen from retaining fluid. Her pains have become more severe and Sister H. tells me that the contractions are now every 4 minutes but that it will be good when they are about every two. She leaves me with the woman and I time the contractions as I sit with her rubbing her arm. Sister tells me that if, as the baby is about to be delivered, the cervix is not properly dilated, there is the danger of it rupturing
and then bleeding can occur. The pains are now every three minutes and Nurse R.
brings the trolley with the autoclaved instruments and they are ready to deliver the
baby. Nurse R. is very warm towards the woman as she directs her in the position
she should take on the delivery bed. The woman is lying on her back, uncovered
except for the top, with her knees flexed, legs close to her buttocks, her feet planted
flat on the bed. There is no use of stirrups in this ward. As the pains start, Nurse
R. says to her "push my dear, push now! No! No! you must push more! Your have to
push your baby out!" Then the woman is told to relax and wait for the next
contraction.

Nurse R. has a nice way of interacting with the delivering mother – she smiles
warmly at her and they have frequent eye contact all through the delivery. A. even
manages to smile back at the nurse, in spite of the pains. As the next contraction
begins Nurse R. asks her to hold onto her thighs and "push down! push some more –
when the pain comes you must push! push harder – keep your legs apart – what did
I tell you! Now push! OH! OK next time you push harder." Soon the baby's head is
clearly visible and the midwife is assisting too. Nurse R. turns the baby but it looks
like it might not come easily, she is pulling and asking A. to push! push! Then Sister
turns the baby the other way and soon the shoulder finally comes out with a gush of
fluids.

Sister takes the baby and slaps it feet and hands and blows on it face – it is very blue
and white – they quickly take it to the resuscitator and give it oxygen and then it is
fine! Sister had the mask on the infant and then took it off and slapped its feet and the
child let out a good strong cry! Sister smiles "that is good!"

Meanwhile, Nurse R. has given the woman an analgesic by injection and the placenta
was delivered and checked with the help of Sister. I was asked to administer to the
baby on the resuscitator, to keep the oxygen mask on it as Sister attended to the
mother and watched me from a few feet away. Sister told us that oxygen must be
administered with care, that overuse can result in brain damage and blindness in
new infants. She watched the baby's colour, as twice I slapped the babies feet to
make it wake up and breath deeply. Then, as the nurse advised me, I wrapped the
baby and put it into the small waiting cot.

The SDMO came in to check on this patient – they had been expecting her he said, it
was a problem case and he was relieved that all had gone well. Soon the patient's
aunt, a nurse at the hospital, came in with food from home for her and bent over her
with affection and caring. The birth had gone well in spite of the edema. It was the
woman's first child.

I was not in the delivery room when the women were first admitted so I do not know in
these two cases if the membranes had ruptured or if the nurse had broken them surgically. In
this hospital I have seen the doctor clip the membrane with an instrument on one occasion.
Epilatotomies are not too common although they are performed on occasion. Nor does the doctor
often resort to the use of forceps. The annual report for the hospital shows only two incidences
of repair of vaginal lacerations. Caesarian sections are rarely performed at SDH. Women requiring them are usually sent by ambulance to the Divisional hospital which is an hour and a quarter away.

In SDH, a baby is not put on the mother's abdomen after birth but is placed at the foot of the bed and suctioned immediately to remove mucus from nose and mouth. After the cord is cut, the baby is wrapped, placed temporarily in the adjoining incubator, and soon after birth taken to the nursery to be bathed. The mother who has usually been sedated, rests after the birth. I believe this is the practice with Indo-Fijians so that the impurities of birth can be first washed away. It is my understanding that the Fijian mother usually does not want to have the child immediately after birth, but first rests. The practice of immediate contact for bonding has not taken hold here yet. When I discussed this with Dr. B. I felt that I had inadvertently criticized her birthing procedure. She did not comment.

The mother is not allowed to have any family member present during the birth although Dr. B. said she would be happy to allow a husband to be present if a request was made prior to the birth. The layout of the Labour and Delivery Ward however is not entirely conducive to this becoming common practice at present. It is a private space for women, nurses and doctors since throughout it women are lying on their beds quite uncovered in the hot climate. There is very little sense of modesty even with the normally extremely shy Indo-Fijian women. There is a feeling of commonality, of warmth and sisterhood here, and of working together towards a shared goal, that of birthing a baby.13

The nurses say that Indo-Fijians and Fijians each react to the pain of contractions in their own ways. It is an accepted fact now that the Indo-Fijian women are prone to verbal expression of pain, moaning and even crying out as the contractions become severe. I heard only one woman cry out while I worked at the hospital. Another woman repeatedly called softly "oh! amma". Fijian women do not like to let it be known that they are in pain, they will moan quietly
or roll a little. Everyone admires the Fijian woman for her attitude which is one of stoicism and acceptance of the pain. (I was unaware of Morse's (1981) doctoral dissertation on parturition pain and anxiety in Fiji until my return from the field. In it she compares Fijian and "Fiji-Indian" responses to pain and provides a general review of the literature on pain, and cultural responses to pain.)

My impression from watching Indo-Fijians in the hospital was that they did not feel shame at showing their pain. This might be because they have a great regard for injections of all kinds, including those for relief of pain. The expectation of Indo-Fijians appears to be that if pain is demonstrated, then the medical staff will respond to the exhibit of the emotion and relieve it. The Indo-Fijians on staff, nurses, doctors and non-medical staff, know that this is the stereotypical image of Indo-Fijians. They have also worked with Fijians and they know from actual observations that Fijians will not show signs of pain, nor will they come for treatment during the early phases of illness or injury. Rather, they attempt indigenous treatments first and usually seek treatment from the biomedical sphere very late. One Indo-Fijian AMO said:

The difference between the Indians and the Fijians is that the Fijian patient must be listened to, take immediate action if they say they are in pain, they don't pretend to have pain! The Indians they seek care for every small pain..."

I was told this in every ward and every medical institution I visited in Fiji and had it demonstrated over and over again. (In OPD a Fijian person would say that he or she was sick but beyond that it was difficult to elicit symptoms but when a person complained of pain the doctors were attentive.) In the labour and delivery rooms the Fijian woman rarely showed very much pain at all. This was as true of the new mothers as well as of those who had had children before. As I asked Indo-Fijian women about pain of childbirth they said it was the most severe pain you could feel.

An unfortunate stereotype exists of the socialization of young Indian girls which has become a myth and continues to be perpetuated by researchers in spite of the evidence at hand.
today. This has to do with the knowledge young women in Fiji today have of the physiological processes of birthing. First, most young girls go to school and in the eighth grade Fijian schools teach a biology course that includes human reproduction, sexuality and birthing. In addition, home economics courses include childcare and discussions of pregnancy. This has been the case for many years, so that women marrying today have learned in school, and they talk to each other about it. Even those girls who drop out of school before the eighth grade learn from their peers.

Granted, traditionally, childbirth was discussed amongst women who had had children but rarely in the presence of adolescent girls. Nevertheless, most young girls knew a great deal about childbirth and the pain because they were never very far away from the women who were conversing. This is as true today. Often there is a pretense of not discussing childbirth as long as the unmarried girl is visible. But even in earlier years most mothers although shy to discuss the matter, preferred their daughters to learn at least the basic knowledge in the home, and did not mind the young women overhearing their conversations. In actual fact, given the structure of Indian homes, most young women hear all of the conversation as they go about their household tasks in another room or an adjoining space. They also have a great deal of experience with the fact of birthing as it happens in home births in the settlements when a woman cannot get to a hospital in time. Girls know the preparations are taking place for a birth and they know that afterwards there is the cleaning and aftercare. The midwife talks about the birth with other women, and women discuss it with each other in the homes. We know that children are curious, intuitive and questioning, and that they share their knowledge even if it is incomplete and thus extend it and correct it.

Furthermore, when an Indo-Fijian girl has a sister-in-law, she finally has an information source. It is traditionally the role of the sister-in-law to instruct her husband's unmarried sisters, at the appropriate time (late teenage) about sexuality and reproduction. The
foundation of the growth of intimacy and sharing between a brother's wife and his sisters is frequently that the former shares her new and intimate experiences with the unmarried girls. She is their source of information about physiological processes and about the early days of marriage, about "love".

I feel quite certain that most young women today know about childbirth. The expectation of young women is that it is very painful, but the pain can be relieved in the hospital. And, for Indo-Fijians, that is one of the attractions of birthing in the hospital at the present time.

In home births, both Indo-Fijians and Fijians have extensive support systems. The Indo-Fijian woman normally goes to her own parental home for the birth; therefore she is assisted at birth by her own relatives and a dal whom she has known most of her life. The hospital's ante-natal clinics give her a feeling of belonging to a group of women in the same situation as herself and of supportive medical attention from doctors and nurses all through her pregnancy. She learns about her own body and its function (physiology and birthing); more than she ever knew when home births were practiced. There is a hiatus however between the regular ante-natal visits at one hospital where the Indo-Fijian woman gets to know her doctor and the nurses, and where she should be developing trust for the actual birthing; and her transfer at this critical time to another hospital. A disruption in the process of building a support system happens because the Indo-Fijian goes home to her parents in another community and hospital for the actual delivery. In this case her medical charts are sent on to the hospital where the birthing will take place. The child is delivered in a strange hospital, amidst strangers, new doctors and nurses. At the end of the post-natal period, she then transfers back again to attend the Mother and Well Baby Clinics in the area of her married home.

Most young Indian women today prefer the hospital birth and value the sterile procedures and the aftercare. But importantly they value the fact that there is relief of pain. Some of the women who have had multiple births and those who have had home births as well as hospital
confinements, said they preferred the home birth. The reasons given were that at home they could bathe immediately after the birth and have the sake (heat) treatments, massage and special diet, all of which are culturally prescribed post-natally. There are other reasons as well; I have mentioned this preference in Part II. Recall that some women also felt that the nurses were not available when they needed them in the hospital. And there is always the fear that the nurse or doctor will not be there when the child is to be delivered. I believe this has come about because the hospital is short staffed, and the Labour and Obstetric wards which shared one nurse were in separate areas of the hospital. Middle aged rural women who have not had formal education about physiological processes, and have not been socialized to value western scientific practices, are the most ambivalent.

For the Fijian woman the support network of the Fijian community which begins with the immediate sharing of the fact of pregnancy and with special treatment of the pregnant woman throughout the nine months of pregnancy, is extended by the supportiveness of the antenatal clinics. Birthing takes place among people she has learned to know and trust. When I asked Fijian women who had experienced both home births and hospital births, where they preferred to have the baby, all of them were unanimous that "The hospital is best". (Again my data contradict that of Morse [1984:105].) They gave a number of reasons for this. First, the hospital has all the technology in case there is trouble. Second, most women emphasized that the hospital is cleaner. Third, the mother has time to rest quietly, something that is impossible in the hub-bub of the Fijian home. Many women enjoyed the communitas of the ward, and some did not even care for visitors.

Dr. B.'s interactions in the Labour, Delivery and Obstetrics wards are in stark contrast to her style in the clinics. Her easy conversational style relieves tension and fear as she goes about her work. Here she calls the women by name and personalizes care as much as possible.
Her interaction with the nurses too, reflects their competence and the professional ambience of the wards under her direction. The first of these is the labour ward which I present next.

Women in the ante-natal clinics who are pregnant and are experiencing serious difficulties are admitted to the labour ward. There, the doctor and the nurse will try to detect the fetal heart beat. The doctor teaches the nurses that they must carefully discern the fetal heart beat from that of the mother by taking the mother's pulse at the same time. A young Fijian woman was admitted for observation; the fetal heart beat could not be detected—I asked the doctor if she was aborting. She replied that this was a miscarriage—the fetus had already died. The woman did not appear to be in any discernable pain and when I asked, the nurse explained to me that the woman had been sedated. Soon the fetus is expelled with the characteristic offensive odour which accompanies such cases.

In the adjoining bed is a 23 year old Indo-Fijian woman who was admitted in the early morning hours. The nurse has already scanned her attempting to locate a fetal heart beat without success. Now there is a show of blood. As I talk to the patient she tells me that she had also miscarried last year. This time the pains started as she was in bed and she told her husband who then told his mother. They decided to bring her to the hospital immediately. She tells me she did not do any heavy work during this pregnancy, except cooking, washing clothes and cleaning for a family of five. (This is HEAVY WORK in Fiji where women carry water, wash clothes by hand at the river or in wash tubs, and cook over open fires.) She is four months pregnant. Her mother-in-law is waiting out in the corridor and as Dr. B. tells her of this miscarriage she begins to cry. Later she went in to see her daughter-in-law and soon both women were holding onto one another, sobbing. Soon the older woman dried the tears of the younger and consoled her saying she is so young she can try again. We leave them.
The Obstetrics Ward

Once a woman has delivered her child, the nurses transfer the mother by stretcher to the Obstetrics Ward. The Obstetrics nurse has already bathed and dressed the baby and put it into the nursery. The ward has six beds for women who have delivered; and the nursery which is directly across the hall, has two incubators and several baby cots in it. A small room off the nursery is the bath and scale room. The nurses prefer to bathe the babies in a large bowl in the sink. They use the molded sink (which is actually the baby bath) to soak and wash baby laundry.

Another six beds are located on the other side of a windowed wall, for women with some complication, infection or for an overflow of patients from Obstetrics. As well, there are two beds in an adjoining room, which are sometimes used for pregnant women with complications of pregnancy or birthing. Their babies too, room-in with them. Two beds in Women's Ward are reserved for women returning to have tubal ligations, for women who are aborting (i.e. cases of sepsis), or for women with other gynaecological problems.

In the Obstetrics ward, the nurse on duty actively instructs the mother, either at bedside or in the nursery, on how to breast feed the new infant. Babies spend all of their time at the bedside of their mothers, where there are small cots. The mother can attend to and feed her child or have it in bed with her, as she likes. It is a common sight to see both mother and infant asleep with the infant still at the breast. The hospital advocates breast feeding the child immediately so that the child receives the immunological benefit of the colostrum. Bottle feeding is not allowed. Although it is against the cultural practices of both the Fijian and the Indo-Fijian, who usually withhold colostrum for the first few days, Dr. B. is adamant that 'her' new mothers start to breast feed immediately and for as long as they can. (I have discussed the cultural reasons which may explain why colostrum is withheld by Indo-Fijians in footnote 5, pp.101-102.) She talks to each one during rounds in the morning to encourage the practice and she educates the mothers on the reasons for her beliefs. The ward is small, and the early morning rounds become an
excellent forum for exchanging information and for education. Most Indian mothers are not reluctant to breast feed. It is only later with the daily round of work within and outside of the house that they enter into bottle feeding and mixed feeding. A great deal of the work of Indo-Fijian women in the rural areas is "shadow work" in the agricultural fields, both on cane farms and in market vegetable growing areas. Their labour is indispensable - this militates against their being able to breastfeed on demand. Babies are rarely taken to the fields with the mother. A second factor that intervenes in the care and breastfeeding practice of the new mother is that the Indo-Fijian mother-in-law often wants, and takes control of the baby. She encourages bottle feeding for this reason, although the ostensible reason is to free the woman for labour activities. Indo-Fijians can usually afford the bottles and baby formulas so they are not reluctant to do so. The mother-in-law may remain in the home and take care of the infant as she does the chores associated with the farm such as selecting and packing vegetables for shipment, or running the hawker's shop. Because this leaves little time to take the child to the fields to be breast fed, people begin a mixed-feed regimen for babies.

The Fijian Nursing Sister in charge of the Obstetrics area told me that the Fijian mother is very stubborn and will always breastfeed her baby, although it becomes common property when they leave the hospital. The Fijian baby is held and carried by everyone in the household and by friends and family outside of the home. Nevertheless the baby remains the mother's in terms of feeding practices and general care.

The resumption of marital relations after childbirth is quite different amongst the two ethnic groups in Fiji. The Fijian father-to-be is very solicitous of his wife and child. Cultural proscriptions which taboo early resumption of sexual relations after birthing are stringently observed. The couple refrain from sex in late pregnancy and for months after the child is born. The Nursing Sister told me:
"The cause of the premature infants is social, the Indians make the women work too hard and Indian women won't say no. Oh! We Fijian women can be very stubborn, we can say no. The Fijian will fight with her in-laws and then tell the husband so that the husband ends up hating his sisters and mother. The Fijian won't work if she doesn't want to do it. We can be stubborn about other things too! We do not let people take advantage of us like that. Our young women won't take it—but you Indians are different—those girls are too scared, and they have to work!"

She went on to say that in the Indo-Fijian family the mother-in-law takes control of the new baby and discourages breastfeeding.

The nurse said the Indo-Fijian father-to-be is inconsiderate and puts sexual demands on his wife close to the time the child is delivered and soon afterwards. Another nurse explained to me that many Indo-Fijian women come in with ruptured membranes because of sexual activity during advanced pregnancy. It was her opinion that the large number of premature births amongst the Indo-Fijians was at least partially due to this practice.

The nurse continued that recently one Indian woman who had been discharged re-admitted herself to the hospital because of such demands and non-caring. After her discharge from the hospital she went to her mother's home for six weeks. Dr. B. concurs with the nurse's comments about Indo-Fijians. I believe that this is a more recent development in Indo-Fijian life. I talked to one very jovial older woman at the hospital who told me:

I got pregnant and it was my elder brother-in-law's wife who told me that I was pregnant—I didn't even know such things. She knew that I had missed my period. After the baby came my mother-in-law kept me away from my husband very carefully, she explained to me that the body is not fit for sexual activity just yet—the body is very weak in the post-partum time (body both narm ha saurie). After that I was allowed to go to my husband—they told me that a woman does not get her periods right away—sometimes for six months—but I got pregnant right away. I went to the dai because I thought something was wrong, and she felt my stomach and said, "Oh! you have a baby there!" So that was my second pregnancy. In those days the woman did not have to go out to do farm work soon after the baby was born.

Dr. B. interjected, and the woman agreed, that in the early days in Fiji, the new mother usually slept with her mother-in-law for the first post-partum weeks for just this reason.
One young 20 year old Indian woman on the ward has recently had a premature baby girl (at 7 months, one week) weighing 1.2 kg (2.6 lbs.). The child is in the incubator, but is breastfeeding well and appears to be in reasonably good health. I talked to her about her pregnancy and her baby; the following excerpt is from my field notes:

She tells me that she was admitted because her water broke and she motioned that it was coming out. She is very proud of her baby and wants reassurance from me - she asks me if other babies that are born premature live. She points and says her baby is in there (in the incubator in the nursery). I tell her that they do. Then I asked her why so many Indian women have early babies. She says the Fijians are healthy, their food doesn't have so many spices in it, they boil everything and the food has vitamins. We cook and fry everything and what the baby requires does not fill it with that food. She tells me that the baby is feeding well but for the first two days it was not sucking well at all. Then suddenly she asked me if having sex would bring the baby - she said, “We had sex and then my baby came- should pregnant women stop having sex?” I told her no and we talked about overseas practices and beliefs. She then went on to say, “We just got married a few months ago, and its like that eh?....” She was obviously looking for understanding and reassurance, afraid she had harmed her baby. I went to see the baby - she is so perfect and beautiful.....the smallest of perfectly chiseled features....

I found out from her chart and from the doctor that the mother had problems carrying the child. Prior to the birth she had been treated with steroids because the physician thought she might miscarry; and she had been told to refrain from any sexual relations. (Steroids help the unborn baby’s lungs develop more quickly in case it is born prematurely.) Dr. B. is very caring with this young girl and explains carefully how this baby is to be looked after.

She interacts differently with the mothers of the premature infants. It is as if the birthing is not yet complete and the team of women who are delivering the child are still in charge of the function, the task is unfinished. Perhaps this explains her intense emotion later when a premature baby who was doing so well suddenly went into crisis and was transferred with the mother to the Divisional hospital I arrived in time to see the preparations for the transfer being made. The ambulance was at the door but the transportable incubator could not be hooked up and doctor and ambulance driver were in the back of the vehicle working with the
attachments. It was several minutes before they successfully got it working. The doctor learned later the next day that the baby did not survive. It was the only time I saw her weep. She had personally nursed the baby along and it had seemed to be well.

(Of the 49 premature births at SDH during 1975, 46 were Indo-Fijian babies. This group also has the highest incidence of stillbirths with 9 out of a total of 11, and 6 neonatal deaths out of 10. See Unpublished Annual Report, SDH, 1985. Indo-Fijians also have more low birth-weight babies, as the Annual Report for 1985 from the Lautoka Divisional hospital shows: 368 of the 420 babies with a low birth weight [under 2.5 kg.] were Indo-Fijian.)

In the hospital the diet of the new mother is not supplemented in any way from ordinary hospital diets. In the case of the Indian mother however most families bring a bottle of sont to the hospital for her to drink as soon as the child is born. As I have mentioned in Part II, this is a drink to induce lactation and to "warm" the mother. Some families also bring meals. Many Fijian families also bring prepared meals for the new Fijian mother.

Most women who have had normal deliveries are discharged within about three to four days of the birth. Mothers are shown how to care for the stub of the umbilical cord, by pulling it up and out and cleaning carefully around it everyday. In some cases if the child develops a rash or pustules then the doctor will treat it before allowing discharge. The mother is reprimanded for not taking better care of the baby and for not being clean enough about her hands. (Sometimes a rash is caused by putting synthetic clothes on the infant which chafe in the hot and humid climate.) The Nurse gives the child a Severin bath and treats it with antibiotics as ordered by the doctor.

Dr. B. attempts to limit visitors to the patients because the facilities are inadequate and the chances of infections are too great when there is a mixture of types of patients on the ward. On one occasion the women's lounge, which is nearby, was used to house an overflow of patients from the Women's Ward. Two diarrhoea cases were put on cots in there. On her return from
her days off an angry Dr. B. moved patients in Women's ward, discharging some, thereby making room for the two cases. Then she asked the nurses to wash the beds with a carbolic solution. She left a standing order that such a thing was not to happen again, so close to the Nursery and the Obstetrics Ward.

On the Obstetrics ward too, each patient is reviewed with regard to the family planning method that will be used after discharge from hospital. Each case is discussed openly so that the process is educative for all the mothers within hearing. Her interaction, decision-making and advice are of interest here.

The first woman, an Indo-Fijian of 28 years of age wants to have a TL. She is advised to wait for three months when they will do a "cold TL" at some time after the birth. Dr. B. explains that there have been so many neonatal deaths (more than 1% of live births) recently that it would be safer in her case to wait until the child is a little older. She tells the nurse and I that she takes into consideration the age of the woman, the health and the age of the previous children, to see if they are over the critical years. (The infant mortality rate in 1984 was 22.1% for Fijians, 22.7% for Indo-Fijians, and 24% for "others". It is highest in the 1-2 year old category. Parliament of Fiji, Parliamentary Paper No.1, 1986:116-17, Appendices XIX (a) and XIX (b). They appear in this work as Appendix 3.)

The next Indo-Fijian woman is in her late twenties and has five children, three home births and two in the hospital. She is booked to return for the TL after her discharge from the hospital. At that time she will be admitted to Women's Ward.

An Indo-Fijian woman of thirty-two years of age has just had her second child. She wants to have a TL. She is a "defacto wife", of a man who has a wife who is sick and who has two children. The two wives get along well together. Doctor B. advises her to use Depo Provera and tells her that she is probably sub-fertile since she has not got pregnant more often under the circumstances. The doctor advises her that these days, after men take additional 'wives', they
can continue having children until they are into their 60's or 70's; and they discard women at will. If this man leaves her she may want children with a man who may marry her. The woman is adamant that she is to have a TL, her 'husband' wants her to have it. The tone is getting argumentative. Finally the doctor refuses to do it, telling her that the man is not her husband and her body is her own responsibility, not his in these circumstances. The contraceptives most suitable to her circumstances are to have an IUCD or to take injections of Depo Provera. The woman hesitates until the doctor advises her that the Divisional hospital will not do a TL either, under these circumstances. The woman finally settles on the Depo Provera injections which she can get at her District Nursing Station every three months.

During these interactions all of the women in the ward are privy to the conversations and they discuss the decisions with each other. They respect their doctor and enjoy listening to her advice. I observe too that the Fijian Nursing Sister explains or emphasizes the doctor's discussion, in broken Hindi with the Indian patients, without embarrassment. She also translates for the Fijian patients.

The next patient, an Indo-Fijian, after a lengthy discussion about whether to have a TL or to use Depo Provera, decides on the latter, but tells the doctor that she is afraid of her periods stopping. The doctor takes the opportunity to tell her that it is not true that the stopped menses are bad for her - and that during her pregnancy she had not had her periods either. This woman too, is an unmarried woman (who was previously married) who is in a relationship with a man. The Obstetrician advises her to use Depo Provera, emphasizing that she must get the next injection at the right time, for although she may stop menstruating it does not mean that she won't get pregnant. She will. Dr. B. advises against the TL because the woman is still anaemic following the birth.
As an aside, Dr. B. tells us that even in the case of a young 22 year old who has four children she would be hesitant to do a TL because if the woman’s husband leaves her, she would need someone to support her. And another husband may want children by her.

Then we talk to an Indo-Fijian woman of 26 years of age who had lost her first child and then had had two miscarriages. With this pregnancy, the doctor had put in shirodhar sutures; the child was carried for the full term. The birth however, was not a clean one, it had been difficult to save the child who had swallowed a lot of blood. Today, the woman wants to go home but the doctor tells her that she will have to stay until they are satisfied that the baby is completely out of danger since it is the only child out of four pregnancies to live. The woman cries as she is told she will have to remain in hospital for several days yet. She decides on the loop for her family planning method.

There are several other patients on the ward, one an Indo-Fijian who was admitted with a blood pressure reading of 140/100. Today it is down to 130/90. The doctor checks the chart and discusses her case with me: there is still albumin in the urine so she is going to be kept in hospital for observation. She had abdominal pain and bleeding and she can easily have an abruption, then it would be necessary to do a caesarian section or vaginal delivery to save the child. There is danger that she can have a fit while her BP is high.

As we continue rounds we go into the room with the two beds. Here both women have babies with O positive blood type. She advises both mothers that they will have to watch for signs of jaundice and to feed the babies with glucose and water and to watch for signs of lethargy. One of these babies was born with a splotchy face because the cord was tight around its neck — she takes this baby’s two hands in her one, and lifts the baby just off the bed and lets it fall back — it immediately starts to cry loudly. She laughs kindly saying, "Good! that’s what I wanted to hear, your cry!" This indicates the baby is fine and was not damaged during delivery.
Throughout the morning rounds the doctor is cheerful; the patients clearly have great regard for her. They are not afraid to ask questions or to differ with her suggestions, but they comply after she explains her reasoning. She usually tells women there is some latitude of choice in family planning method. Nor are the women self-conscious about the other women hearing “their story”, there is obviously great room for differences and few are judgemental, at least while they are in the hospital.

**PART 3 - THE WOMEN’S WARD**

The general Ward for women, and the nursing station, are in the same wing of the hospital as the Obstetrics Ward, separated by the women visitor’s lounge. The nursing station is separated from the ward by glass partitions; the nurses can see the patients and can observe the whole ward at the same time as they complete charts, answer phones or prepare the drugs for the patients. There are sixteen beds divided among four glass window enclosed spaces. The “rooms” have glass windows which serve as dividers but which do not quite go up to the ceiling. A corridor runs down the center, so that two ‘rooms’ are on either side. Across from the nursing station is the nurse’s tea room and kitchen. The bathrooms are across from the women’s lounge.

Dr. D., the anesthetist, is the doctor-in-charge. She consults with her husband, Dr. C., the surgeon, about cases on Women’s Ward. All doctors however are relieved by others on their days off, and they in turn also work in other areas such as OPD and the many clinics. However, their main responsibility is on the wards to which they are assigned.

Dr. D., communicates in English, although she is accompanied by a nurse who speaks English as well as either Fijian, or Fiji-Hindi. The doctor also uses some common Fiji-Hindi words and some Fijian language as well. During rounds she is sometimes accompanied by both a Fijian and an Indo-Fijian nurse, in which case communication is made much easier.
Patients suffering from all types of diseases are admitted, diagnosed and treated on the ward. Two beds are used almost exclusively for women who are being treated by Dr. B. for gynaecological problems.

In the case of acute illness, patients are often transferred by ambulance to the Divisional Hospital in Lautoka for more sophisticated treatment. A nurse accompanies the patient. Mentally ill patients are treated in this ward, but if they do not respond to drug therapy, they are transferred by ambulance to St. Giles, the Institute for the Mentally Ill in Suva. In the latter case, the patient must be accompanied by one of the physicians before the transfer will be accepted.

The most common type of illness treated on the ward is diabetes. Many women come in with septic sores on the feet, legs or body. The doctor orders the treatment so that the sores are attended to and the patient's blood sugar levels are monitored by taking urine samples. The patient is put on a diet. Ideally, the nurses and the dietician discuss the disease with the patient and attempt to educate her about self-care once she is released from hospital. Nevertheless, there are powerful barriers to the understanding patients have of diabetes; and in their ability to follow a maintenance program once the diabetes has been brought under control in the hospital. For instance, many patients I talked to did not realize that the condition can be controlled, but not cured and that the diabetic diet and the pills will have to be continued throughout their life. Diabetes is treated with drugs in Fiji, insulin is not used. (Religious reasons prevent Muslims from using insulin prepared from pigs; some Indo-Fijians also resist treatment with insulin prepared from cattle, for religious reasons.)

Lack of knowledge of physiological processes and poor knowledge of English contribute to the poor communication between patients and doctors. There is also a complacency among nursing staff about those women who have very severe diabetes. I wondered about the attitude of the nurses and found it difficult to decide if it was in fact complacency or uncertainty. And if the
latter was it because of their imperfect mastery of the field or due to the limitations in the field of medical knowledge? My training does not allow me to answer these questions. Nor do I know the medical reasons why insulin is not more widely used for the treatment of diabetes in Fiji.

One elderly Indo-Fijian woman was in the hospital for almost a month when her daughter approached me and asked me to help her. The old woman was despondent because in spite of her diet, her blood sugar level went up every day, at mid-day. I looked at her chart and discussed it with the nurse, asking her opinion about what the medical staff thought was the cause. The nurse offhandedly said, "Oh! her daughter brings her food everyday and she won't stay on the diet, that's why!"

I asked the mother and daughter if they were bringing food into the hospital, at the same time telling them that it was a serious matter if that was happening to her diet. Both mother and daughter were shocked. The older woman said she was sick, had been there for one month and wanted to go home, why would she take prohibited foods? Furthermore, she said she was now certain that she was going to die and not go home, since they could not bring down the levels of her "sugar", and she had been told she would have to stay until it was down. They both swore that they had observed the hospital diet. The daughter came everyday to sit with her mother and to attend to her, at great cost and inconvenience, leaving her own young children in the care of others.

When I asked two doctors their opinion about her, I also told them that she was despondent. Then her treatment regimen was re-evaluated and her diet changed. The Sister-in-Charge and the dietitian took rice and bread off the diet and they decided to try augmenting her diet with an Indian vegetable, saigan bhagi, known in India for its curative effect on diabetes. (They did not try karela (bitter melon) juice which many diabetics in Fiji use as a home remedy.16) When her diabetic sugar chart was re-evaluated, it could be easily seen that her blood sugar had gone up after she had the meal of bread at breakfast and the mid-day rice
During the night when she rested it returned to near 'normal'. The nurse on duty told me that the stress the patient was feeling about her treatment, and the standard diabetic diet which was not suited to her, contributed to the pattern of fluctuation in her blood sugar everyday. She was released the following week. I have commented before on Illich's ideas about clinical iatrogenesis; this case well shows how the patient is blamed for not getting well.

Amongst the variety of cases in this ward there are accident cases, a woman with a broken leg, an elderly woman who has had a heart attack, a middle aged woman terminally ill with cancer, a young girl with a back problem, a mentally ill woman, a septic abortion, etc. There are both Fijian and Indo-Fijian patients as well as nursing staff. In the foregoing pages I have pointed out that the issues of ethnicity and equity in health care are never far below the surface of interactions and processes at the hospital. I will not discuss this any further here for in Chapter 17 the analyses will attempt to bring all of the threads together into a more comprehensive discussion on the topic.

Attempted suicides amongst the Indo-Fijians have a high frequency rate and in fact the rate is the highest in the world. During 1986, the newspapers have once again written articles stating that many people who attempt suicide ingest the easily available insecticides and weedkillers. For many years, the physicians and concerned people in Fiji have attempted to have insecticides and herbicides banned, but to no avail. I was told that there was a slim likelihood of banning them when some of the politicians in the country sit on the board of directors of the firms that manufacture and distribute them.

As I arrived at the hospital one morning, I went into the OPD just as the surgeon was directing a police officer to the women's ward where he was going to take a statement from a 40 year old Indo-Fijian woman who had ingested the herbicide "gramazone" in a suicide attempt.

The officer gave me permission to accompany him as he interviewed the patient. I read her chart which was lying at the foot of the bed. She is conscious but very sick. The officer tells
her he must get a statement from her and she agrees to talk to him. She readily tells him the circumstances which he takes down on a form:

She tells him she is forty years of age and her address. She has four children...one son is married. She ingested the gramazone because her husband accuses her daily of having a lover which she says she does not. At one time her husband lived away from home (he was incarcerated) - at that time she did have a lover and she names the man. Her breathing is laboured and she is in pain as she talks. The officer asked her if anyone had given her the poison to drink. She replies no, she had taken it on her own, one bowl from the gallon container and then she had sat down. She said she is having trouble with her husband, he will not buy food for them. Her husband brought her into the hospital. He told the nurses they had had an argument. The officer is satisfied and asks for her signature. He is kindly and speaks softly as he bends over her to ask her the questions. It is difficult to observe her, her breathing is now fast and her heart pounding. The officer has finished his report.

The Officer tells me that if someone had given the gramazone to the woman then he would have had to write down her reply exactly as she gave it, in Hindi script. As it was, he wrote his form in English and allowed me to read his comments. He observed that "Indo-Fijians have certain beliefs and values, when they abuse the values they do this..."

One Fijian nurse commented about the case saying "they have social problems - we do not know these things eh?" She had talked to the woman when she was admitted and knew the medical history.

When I discussed the patient with the surgeon he said in cases such as these the kidneys are affected either by acute renal failure within 48 hours or by chronic kidney failure in which case later there is swelling and secretion is affected. In some cases only one kidney is affected. The staff are monitoring her blood to see if the urea or the creatinine levels are rising. The damage depends upon the amount of gramazone ingested. The patient had vomited and may have thrown it up. When admitted, she was conscious, vomiting and her bowels were not open. She was given Fullers earth 1200 or 200 ml. 2 hourly; milk drip - 1pint/4 hourly; IV drip Dextrose saline solution and Dexacrotin 6 hourly (a steroid) and Penicillin (crystalline 2 mg./6 hourly. Today the Fullers earth has been discontinued and they are treating her with
magnesium sulphate 15 mls./2 hourly. In these cases the hospital advises and consults with the Divisional Hospital in Lautoka about the treatment to be given. Lautoka has advised SDH to continue the treatment. There is close liaison between hospitals in the serious cases. The senior consultants are in the Divisional hospital and it is their responsibility to advise the doctors in the local hospital. Medical interventions in the case of suicide attempts have their own bureaucratic procedures which are in place so that doctors and staff cannot be held responsible in any way when and if there is a litigious action. Ideally at least, the bureaucratic structures are meant to function in this way.

Medical litigation is a factor doctors in Fiji are very conscious of and at the present time, the reality of it has made itself felt at this hospital. Shortages of staff (poor patient/practioner ratios), overwork, and lack of technology; as well as out-dated procedures and a poor general health status of the population, can and do result in error. Can litigation resolve the issues? It is doubtful.

The way the nurses interact with "the gramazone case" is warm and caring. They feel quite sorry for her because she has a "bad" husband. The nurse tells her that she should not have "done this thing", the outcome of her action is that she is the one suffering, and her children will suffer, not her husband. Later the Fijian nurse tells me "even now this woman is a mother-in-law, and the daughter-in-law will learn "this thing" from her,... it is not good".

Four days later the patient is still in the hospital but she looks much better, she has survived the critical 48 hours. I asked Dr. B. if she would have a complete recovery now. She said the fatal dose of this herbicide is very small. Often these cases survive but the drug has already done such damage that any extra strain will frequently undermine the health of such patients. As we talked she said the important thing is to give Fullers earth right away. During my research I found that the rural people in Fiji have had enough experience with this method of
suicide that they will immediately administer ordinary earth even though it does not have a clay base. The doctors feel that even ordinary earth has a beneficial effect.

Two patients in the Women's ward were admitted after a bus loaded with passengers plunged into the river. One elderly woman who is a diabetic has lost several toes in the accident and the injury is septic. She is very old and has a kindly face and does not appear to be in too much pain. The Fijian nurses are very warm and kind in their caring of her, (although the doctor has had to ask them to clean the injury). The other accident victim has a minor injury, mainly bruising, she will be released in another day or so.

Another patient, an Indo-Fijian woman was admitted from the emergency room where she was treated for severe bruises, the result of being beaten by her husband. This is not the first time he has beaten her. Finally, her parents have taken her out of her husband's home and brought her to hospital for treatment and for recourse before the law. She has a sore neck and shoulders from the beatings. Crying, she tells the nurse and I that she has not been given enough food to eat and that her husband pushed her out of the house to sleep out-of-doors. Her mother has often had to provide her with food and shelter. This time it has been reported to the police.

It was my impression that by the time that women who are the victims of "wife-beating" are forced to admit it by admission to the hospital, they are willing to divulge the whole problem. They interact with the hospital staff and the police quite openly, even with relief, that finally, someone might intercede to help them. The nurses in these cases treat the patient for injury or illness and they also listen and provide verbal comfort and sometimes advice. This case presented an interesting observation about the interaction of doctors in cases where police are brought into the situation.

The doctor on OPD at the time of this woman's admission was an AMO from a rural District Nursing Station. He was at the hospital to attend the weekly doctor's seminar. Because the hospital is short staffed, while he was waiting for the seminar to convene, he was asked to
administer to patients in OPD. I was observing his clinical practices. When I advised him of the reason why the woman was seeking treatment, he quickly asked me to ask the SDMO to attend to her. He explained to me that if he did so, he would have to fill out the forms for the police intervention and could be called upon to go to court as a witness. Since his practice is in the interior of Fiji that would mean that he would have to be absent from the station and could not administer to the sick in his area. The SDMO, well aware of the implications, agreed and attended to the woman. Her treatment was not neglected, but the doctors are ever conscious of the bureaucratic hassles which may accompany their interventions.

Again, staff told me that the response of Indian women in the assault cases is in marked contrast to that of Fijian women. An Indian woman can rarely expect help from others of her sex when she is victimized. Not only is she held in contempt for being a victim but she is held responsible in some way. Fijian women have a strong commitment to their gender, they stand together to protect one another from any such abuse and are quick to put a halt to it, if it is likely. This research offers suggestions for further research and does not present this as a definitive statement of the reality of the lives of Indo-Fijian or Fijian women. Nevertheless I would say that I have a strong impression that this is the case. Indian women in Fiji seem to be unaware of their power – that in making things public, and by exposing abusive men to ridicule, they can exercise some control of these circumstances. Fijian women know their own power.

Many Indo-Fijian women patients in the Women's ward have some family member who stays with them for long hours, massaging arms, legs or backs or just quietly sitting with them. It is a rare Indo-Fijian woman who is left alone while in hospital. Members of the family arrive well before visiting hours and hover at the door to the ward, often asking permission to enter before visiting hours. Some are allowed in, if the nurses think it will benefit the patient. Some patients are allowed to have meals prepared and brought from their homes. During visiting hours, as mentioned about the men's ward, many visitors come to visit the sick woman. They are
mainly relatives, who want to come to visit, but also who are obligated to show their solidarity and concern by attending the bedside of the sick person. The family member who does not attend must have good reason not to do so, for within the traditional system of assigning causality for illnesses, they can be blamed for causing disease through envy, or longing for the attributes of the sick person.

In general, women who are admitted to SDH, and remain in this ward for treatment, are those who are ill, but not acutely so. The very sick are transferred by ambulance to Lautoka hospital for treatment and then returned for recovery later.

**CONCLUSION**

In this chapter I have made an attempt to describe a wide variety of the interactions and processes which are the most prominent features of when women seek health care from Sigatoka District Hospital.

Interactions and processes in the clinics are markedly different from those in the Wards. The social processes apparent are those created by constraints such as over-crowding, time-constraints, lack of sufficient trained staff. Interactions of Dr. B. with the clinic nurses were stressful and at times went beyond the usual nagging to rather abusive criticism. The immediate cause was the result of carelessness and unnecessary ineptitude on the part of the clinic nurse on the one hand, made worse by the general environmental conditions of work, and the nature of time management of doctors duties which assigned them almost overlapping work. If the clinic was properly set up when the doctor entered, the interactions often went smoothly. It usually was not however. The doctor went from wards, to operating, to clinics, usually appearing late, and often interrupted by other calls and staff meetings. The result was often chaos in the crowded clinic, which left little time for intimate interaction with each pregnant woman.
I have discussed how the introduction of a new challenge and assistance in the form of the Hospital Auxiliary changed the interactions between staff, resulting in a more efficient clinic nurse and more time for the doctor to interact with the patients. I discuss the formation of the Hospital Auxiliary in a later chapter.

Interactions between doctors and patients are marked by their asymmetrical roles, with the former dominant and the later subordinate. The extent of the asymmetry depends on the status of the patient, her knowledge, age, ethnicity, ability to communicate, state of health, and her willingness to comply to doctor's orders. Other factors (or variables) intervene and help to determine the actual interaction at each clinic however. Among these are heat, humidity, interaction with other staff, or with Lautoka District Hospital, availability of supplies such as gloves for examination, forms, blood test results, number of waiting patients, and the success or lack of it in the duties which immediately preceded the clinic. These are of course refracted through the personality of the doctor.

I have shown above that doctors value interaction with knowledgeable patients who ask the right question in the appropriate language. There is thus a preference for the highly educated European woman and for those women who understand biomedical physiology and treatment. The doctors' interactions with some of these patients engenders hostility and tense interactions between her and other staff.

Indo-Fijian women today are handicapped with respect to knowledge of allopathic medicine or the physiology associated with it. They do not have the education yet to understand the processes of pregnancy, birthing, labour and delivery as conducted as the hospital. Nor do they know the implications of such factors as lack of iron or of high blood pressure. Thus the interactions between doctor and patient are constrained to some extent by lack of knowledge on the part of the patient and becomes an educative exercise for the physician, when and to the degree that she has the time and is inclined. Indo-Fijian women are learning about physiology and
bodily processes about which their cultural knowledge is quite different. They are not shy, they respond to knowledge given to them and they understand and use it effectively (as shown by family planning statistics). They receive communication about family planning, IUCDs, contraceptives, operations to sterilize and to increase fertility, as well as receiving advice and support in making decisions which will have an effect on their life styles.

The family planning process shows how existing ideas are slowly changing and how processes become regularized as part of social organization. Indo-Fijian women have accepted birth control, use of Depo Provera especially has meant that they have had to change centuries old ideas about human physiology - such as the idea that menstrual blood is impure and must be discharged to maintain good health.

Other indo-Fijian women can make decisions and choices to have TLs and elect not to have any more children if they so desire. These processes signal important changes in relations between women and their husbands, as well as in interactions with their affines. Women gain a new kind of independence which comes with taking control of their bodies. They are empowered with decision-making. Out of these new situations have come ambiguities and inconsistencies which must be resolved. Women can go to work, earn their own salaries and have a new freedom. They are not as dependent as they once were.

But freedom comes at a price. For example, recall that I show women may choose abortion, but do they have the knowledge to choose well? Apparently not always, as the death of the young mother showed. Indo-Fijians have yet to learn that pills and pharmaceuticals have powerful iatrogenic effects unless used with caution. The small circle of women in the area of Sigatoka town, shocked by the death of their friend, were alarmed and talked about the indeterminacy or ambiguity between the value of what might be ideally possible (control of family size, even if through abortion), and the actual reality of such circumstances as death through the process of procuring an abortion.
As Moore (1978:48-50) states, what is negotiable in reality, encodes"...a multiplicity of alternatives and meaning within each [situation], which may accommodate a range of manipulation, interpretation and choice". In the example of abortion, some women may exercise that as a new choice, but other women may also be exhorted to use it. What the new and "intermediate" form veils is the unchanging cultural regularities which still invest the husband (and mother-in-law) with power and decision. The new element in the situation is that a man and wife have new considerations, they negotiate or transact today what was a concrete reality yesterday. Furthermore they transact their requisite health status with others (physicians and nurses).

I have shown that numerous types of interactions and variables are involved in transacting optimal health status, in such different areas as fertility, pregnancy and sterility and treatment for STDs.

Interactions of the doctors and patients in the clinics range from those between near equals to a paternalistic and overbearing attitude of doctors with some patients. In the instances referred to above as "social problems", I have shown how moral issues often still outweigh humanitarian ones. Some patients suffer defamation of character, rebuke and hostile attitudes when their circumstances are already harrowing and they are in need of social assistance and understanding which will not be forthcoming since there are few social workers in Fiji. These attitudes, I have shown to be hurtful and they are prevalent among doctors and nurses of all ethnic groups.

Pregnant Indo-Fijian women take the patient role, in a situation which was a normal one in their culture previously. The mothers of women who are pregnant today know nothing of biomedical ideas of anatomy, consequently are unable to instruct their daughters. And unhappily, they know their shortcomings. Many are further hampered by not having dais in the settlements upon whom they can rely to instruct, massage and care for their pregnant daughters.
Many Indo-Fijians retain cultural notions of purity and pollution, therefore they prefer to take the pregnant woman into hospital for delivery by medical staff rather than attempt a home birth themselves.

These data based on my observations and those of mature nurses conflict with Morse's (1984). She shows that many Indo-Fijian women arrive at the hospital with false labour; and they arrive early when in genuine labour. At SDH, nurses told me that Indo-Fijians women arrive late, sometimes having their babies along the way.

In the Labour and Delivery Wards, this research, again contrary to Morse, showed that all women (Indo-Fijian and Fijian) removed their covers during labour and were unconcerned if their garments did not cover them completely. I think this reflected the attitudes of the young nurses (Indo-Fijian and Fijian) who bared and rubbed the stomachs of the pregnant women as they talked to them using 'birthing talk' during labour and delivery. They were not embarrassed by their semi-nude patients. During childbirth the short gowns were thus necessarily raised. I saw no stressful abandonment of garments as Morse suggests, although I do not doubt the possibility of the occurrence she reports.

In the place of embarrassment, since this was my first research experience with pregnancy and birthing, I can only refer to the ambience in terms of communitas. In this my work concurs with Jordan's (1983) humanitarian description of the birthing experiences during research. Morse's account on the other hand appears uninformed by the complexity of the Indian culture and the Indo-Fijian situation in Fiji, or the assumptions which shape behaviors and response by both constraining them, and challenging the integration of new material into the cultural ways. Her limited explanatory efforts do not do justice to the knowledge or actions of the Indo-Fijian woman. Unfortunately the account seems unsympathetic and unresponsive to the situation of the Indo-Fijian.
Today, these women are in a transitional culture and their uneven knowledge, reflects the inconsistencies and ambiguities they must confront and resolve. The regularities of life which gave meaning and explanation to life in the past, are today confronted with indeterminacy introduced by rapid social change, influenced by their historical circumstance, life in a bipolar state, and as in this research, by the use of a new medical system which they have yet to understand, and in which they have yet to establish complete faith. That they are inept at interactions and understandings of the processes of the biomedical model of health care reflects that is a time of situational adjustment, amidst discordant understandings and contradiction.

Many Indo-Fijians women, and some Fijian women were afraid of childbirth. Attendance at the ante-natal clinics helped them to be less private about pregnancy and, as women attended, were examined together, saw each other semi-naked, they relaxed their attitudes. The Hospital Auxiliary pre-natal classes (discussed later) taught women how to breathe during labour, how to synchronize breathing and contractions. I saw with gratification (I had instituted the pre-natal classes) the first of the trainees put her pre-natal exercises to good use in the delivery room. With her mastery of the technique, fear lessened and she could take instruction from the nurse in the delivery room to bear down or to wait for the next contraction. This brought nurse and delivering mother into a closer interaction in which they were actively working together in the birthing, (with instruction and birthing talk).

Finally, in the discussion of the Women’s Ward I gave examples of how illnesses such as diabetes, and events such as suicide attempts were handled. The interactions and processes surrounding the diabetic patient and her daughter illustrate the facts that first, patient compliance and medical staff perceptions of it are often at variance. Once the busy nurses have a mind-set about a patient it takes active intervention to program re-evaluation and a changed treatment strategy. My intervention illustrated the problems and outcomes needed to bring about that change— it involved interacting with the patient and daughter, the nurses on the ward, the
Sister-in-Charge of the Hospital, the doctor in charge of the ward, the doctor she consulted (surgeon), and the dietician. The patient was re-evaluated and she went home the following week. She had waited in the hospital for one month with no change of her health status, except for a growing despondency about treatment and outcome. Unable to communicate effectively, she was not convincing in her arguments for evaluation of her state of health. She did however ask me and I did intervene on her behalf.

The suicide attempts point out many social problems in the changing social structure and organization of Indo-Fijian culture. Briefly, in summary, new familial composition, new life styles shaped by different employment opportunities for men, travel and an anomic-type of freedom from familial and social controls, result in changed mores. These in turn create havoc with the lives of women who are tied to the farms and families in rural areas. Some, as a consequence, feel they have no recourse to the wanderings of their husbands but to commit suicide. Interactions and processes during hospital treatment showed a remarkable empathy and cross-cultural understanding on the part of the Fijian nurses for Indian women. The two life crises, birthing and suicide, generated the same responses, a surprising well of sympathy and caring by medical staff (and other Fijians for their Indo-Fijian neighbours). And I was to see Indo-Fijian Nurses respond with the same gentleness and empathy.

At another level however staff respond to these situations afraid of litigation and they refer the case to the police as soon as possible. As I mentioned, Illich refers to litigation as an iatrogenic effect of medical care. I leave this discussion until the final chapter when it will be raised in more depth.

The interactions between patients and medical staff in this ward are not as tense as in OPD or the clinics. The staff have more time to interact with the patients. I believe that is why ethnicity does not have quite the same value as an important variable in interactions. But one thing is clear, that is that Indians and Fijians wherever possible keep socially separate. As
professional medical care staff, Fijians and Indo-Fijians minister to the patients of each ethnic group well within the ethical dimensions of health care delivery. Similarly the physicians from overseas, too, know and respect the fiduciary agreement which ethically binds the physician and the patient, regardless of the ethnicity, age, sex and other personal characteristics are concerned. As health care specialists, ideally, their motivations are first of all humanitarian. Nevertheless, ethnic differences between staff members are just below the surface most of the time. This is because social, economic and other differences (I include ethnicity) make an open moral relationship between unequal persons next to impossible. The inequality in Fiji arises out of historical and social circumstances which continue to have their reverberations in the society. Some of these are ethnicity, a colonial administration, a relatively new medical bureaucracy, a developing country without resources of its own, dependent on outside aid to develop its health care system.

Even medical staff have conflicting obligations which tend to make interactions and relationships ambiguous. People have to interact in multiple roles with each other. For instance two nurses, one a senior Indo-Fijian Sister and one Fijian nurse, from the men's ward and the Obstetrics ward will interact with each other as members of the same union, as members of separate ethnic groups, as opposed due to location in the hospital, as opposed due to geographical locations of residence, with a common interest with reference to outsiders from other hospitals. These are only a few of the factors involved.

In the same way, a Catholic nurse's interactions with an Indian patient who has procured an abortion will be ambiguous: the nurse will give medical care, but her own emotional commitment to her religious interest cannot be entirely suspended. I have already mentioned above, the treatment a young unmarried pregnant Fijian woman received at the hands of a number of nurses who represented a variety of ethnic groups, hierarchical positions in the hospital, age groups, etc. A classic case of divided loyalties. Should the nurses side with their
doctor against the girl, or should the Fijian nurses "rescue" the girl and risk giving the girl attention that conflicted with the doctor's, but would be more humane? Was the senior Sister observing the interactions of her whole staff, evaluating their behaviour for pay raises? Was the nurse from the Health Center, an Indo-Fijian married to a Muslim, observing the Muslim doctor with empathy or distaste? Was the doctor using the patient to get even with the handling of an Indo-Fijian by a Fijian? Why did the Fijian nurses not interfere, were they responding with the missionary attitude that the girl was immoral? All of these things were probably going on at the same time.

Finally, I was an interactant and I have reflected on my own behaviour. Clearly, the loyalties were divided. From the patient’s perspective, she was made speechless by the ambiguities she saw in the roles of the medical practitioners who were present: was a doctor acting in a role of someone who treats the ill; a minister who advises; a mother who is upset in the circumstance, but who does love her; a person of her gender; a friend who is concerned but non-judgemental; or a judge who punishes? What about the Fijian nurses who in a village situation, might interact with her differently? And finally, it was an older Fijian nurse who saw what she had to do in terms of ethics and loyalties. Although we do not know which determined her action—I would suggest ethnicity and cultural roles were the equally important factors. In the best of all personal worlds, medical staff and patient interactions are governed by humanitarian and altruistic interests, ethics and commitments to equity in delivering care. The world is not perfect however and the most that can be hoped for is that the moral ambiguities are not irresolvable.

In the hospital Patient/Patient interactions are minimal and only those of good manners and consideration, usually not of intimate friendships.

The interactions and processes in this chapter (and in Part III in general) show that some things cannot be easily changed by policy set by governments. Some aspects of health care
have evolved out of a historical development of transactions suited to the situational context. These transactional complexes generate their own rules and sanctions. I have shown this in the examples of the inter-ethnic interactions and processes, and in the interactions between people at various levels of the hierarchical organizations, as well as in the way patients and doctors negotiate diagnosis, therapy and compliance. Social life has its own momentum, as Moore (1978:80) states, "...the momentum of such an interlocking set of transactional complexes may not be entirely arrested by legislative alterations of parts of its formal organization". I have shown this in Part II with respect to the continuing use of traditional medical beliefs and practices. In Part III, the empirical data show that Moore's notion of processes of regularization, of situational adjustment, and the factors of indeterminacy are interlocking processes. Ideas and actions which have been "regularized" such as notions about pregnancy, undergo situational adjustment through indeterminate situations (the medicalization of pregnancy in the biomedical system, and new notions of anatomy) which are ambiguous, and which require negotiation.

The interactions and processes in these chapters show that social life is not static and that what is regularized at one point in time is changed at another and what is undergoing situational change may or may not be regularized and accepted as common practice. Still, people interpret new beliefs and practices in such a way that change is slow and minimal.

In this chapter I have described the interactions and processes in health care delivery to women who consult the biomedical system. As I stated in the prologue (Chapter 9) at the outset of Part III, chapters 10 through 13 are a descriptive analysis. Many themes have been drawn out, preparatory to the conclusions to be presented in Chapter 17. But before that, the next task (Chapter 14) is to present the public health care sector as it is carried out at the level of the District Nursing Stations in Fiji.
Footnotes:

1 Dr. Raghwa Narayan, Obstetrician at Lautoka Hospital kindly allowed me to copy his graduating paper: Commentaries for Diploma of Obstetrics and Gynaecology: Gynaecological Commentary – Ectopic Pregnancy; and Obstetric Commentary – Diet and Toxaemia in Fiji.

2 Brigitte Jordan (1983:123), whose work came to my attention as I write this, states, "I would suggest that women, where the system encourages active coparticipation, experience a physiological synchrony with the women in labour which allows them to co-experience the event in ways fundamentally different from men. I base this conjecture not only on my own experience but also on the accounts of other female birth participants, who have reported that they find themselves matching the woman’s breathing, pushing with her, and even experiencing uterine contractions, sometimes with the consequence of starting a menstrual period early”. She goes on to say that the co-labouring may have hormonal correlates in support persons. I have referred to this as “communitas” of a special type linked to gender.

In this research I know women who experienced this intensity of feeling with other women. For instance in an earlier chapter a woman healer (orijah) could not practice after taking a vow to refrain for three months, and on the occasions when she broke her vow she started her menstrual period early. In her case it was as a result of the empathy with women patients on the one hand, and the dissonance created by breaking the vow on the other.

3 During 1985 there were a total of 4,864 visits to the ante-natal clinic. Of these 442 were first visits and 4,422 return visits. [Fijian: 2369 visits, Indians 2470 visits, others: 25 visits]. Obstetric Ward, SDH, Unpublished annual report, 1985.

4 Dorland’s Pocket Medical Dictionary (21st ed. p. 24), defines secondary amenorrhea as “...cessation of menstruation after it has once been established at puberty.” Dysmenorrhea is defined as “...painful menstruation”; and various adjectives further define the cause.

5 See Michael C. Latham in Donald H. Merkin, *Pregnancy as a Disease: The Pill in Society,* (N.Y.: National University Press, 1976), p. xiii and xiv, for comments about the risk of macrocytic anemia in women in the U.K. and in the U.S. using birth control pills. He goes on to say that the risk is higher for women “in countries like India where anemia due to folic acid deficiency is already known to be quite high in women of childbearing age”. I suggest that many women in Fiji are probably anemic at the time of conception.

Latham also suggests that oral anovulants reduce breast milk quantities in lactating mothers.

6 See Appendix XXIV (b) of Parliamentary Paper No. 1 of 1986, p. 126, which is appended. In the same document see also page 42 re: STD as notifiable diseases and the rates of increase of incidence in ten years, i.e. syphilis increased from 69 cases in 1975 to 518 cases in 1984. While total cases of all STD’s has risen from 994 in 1975 to 2,196 in 1984. The annual report states: "The spread of the diseases are closely related to economic and cultural phenomena, such as declining and changing moral values, unemployment, alcohol consumption and promiscuity".
Dorland's Pocket Medical Dictionary (21st ed.) (1968:279), defines 'gravida' as 'pregnant'. Depending on the pregnancy, a woman is referred to as: g. I or gravida I as primigravida; gravida II as secundigravida; gravida III as tertigravida; etc.

The following table although it is from the Divisional Hospital in Lautoka, is representative of the family planning in the Western Division of Fiji where this fieldwork was conducted.

Table 13-2
1985 Acceptance Rate for Family Planning

<table>
<thead>
<tr>
<th>Method</th>
<th>Fijians</th>
<th>Indians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depo Provera</td>
<td>13</td>
<td>70</td>
</tr>
<tr>
<td>IUCD</td>
<td>53</td>
<td>192</td>
</tr>
<tr>
<td>B.C. Pills</td>
<td>51</td>
<td>80</td>
</tr>
<tr>
<td>Condoms</td>
<td>27</td>
<td>102</td>
</tr>
</tbody>
</table>

(Compiled From Annual Report, Obstetrics Ward, Lautoka Hospital, 1985)

Thomas S. Bodenheimer's paper "The Transnational Pharmaceutical Industry and the Health of the World's People IN John B. McKinlay, ed., Issues in the Political Economy of Health Care, N.Y.: Tavistock Publications in association with Methuen, Inc., 1984, pp.209, states that companies such as Upjohn pay immense bribes to government officials to encourage drug purchasing by their Ministries. "The Upjohn Company made payments totalling $2.7 million to employees of 22 foreign governers 'to obtain business overseas' between 1971 and 1975..."

Also, "Currently, the injectable contraceptive Depo-Provera, banned from use in the US for serious side effects, is widely sold by Upjohn in peripheral nations. Now the US FDA is considering its use in the US for special populations, that is, the poor and minorities. The drug apparently is being used already among American Indians. The racism involved in the marketing of this drug is highlighted by its use in South Africa: it is given widely to black women, but when a white woman asked her doctor for the shot, she was told, "Oh, I couldn't give you that, you'd bleed like a pig" (Talbot 1980)."

During this research newspapers in Fiji reported that Depo Provera was being tested in New Zealand on a select group of 50 white women. Unfortunately I did not keep the reference.

See: Ninth Development Plan, Nov.1985:144 Table 10.7: National Family Planning Protection Rates, 16.4% of Fijian women aged 15-44 years are protected while 33.3% of Indo-Fijian woman are protected. The crude birth rate per 1,000 for Fijians in 1984 was 32.6, and for Indo-Fijians it was 27.

The expected growth rate of population for 1986 is 2% [see Request for Expenditure, Ministry of Health, 1986 Budget provisions, p.24, unpublished document]

See Illich, Medical Nemesis, p.97-98. He says, "In other instances, however, the physician acts primarily as an actuary, and his diagnosis can defame the patient, and sometimes his children for life. By attaching irreversible degradation to a person's
identity, it brands him forever with a permanent stigma....The objective condition may have long since disappeared but the iatrogenic label sticks".

12 Personal communication, as suggested by Dr. M. Ames, Oct. 1987.

13 I felt privileged that the Ministry of Health had approved my research and that the doctors at SDH, had as much as possible, legitimated my presence in all areas of the hospital and most especially in these wards.

14 See titled footnote "Shadow Work", in Illich’s Gender, (1982:45-46). The discussion is about women’s unpaid but economically necessary and unreported work, of which there is more today than “woman’s gender-specific tasks in creating subsistence”, in the past. He takes it much further than this by relating it to “unpaid activities of women keeping a home for a married wage earner”.


16 Mohamed Aslam and Michael Healy, In Update, October 15, 1983, p. 1048, state: "...the fruit karela (Momordica charantia) is used for making curries but is also used medicinally by the Hakim to lower blood sugar. It is apparently effective in diabetes mellitus, having similar properties to the allopathic drug chlorpropamide (Diabinese). In at least one case a diabetic patient became comatose after taking both karela and chlorpropamide."


A survey of police and medical records in a province of Fiji indicated high rates of suicide for Indian women under 30 and for Indian men over that age, especially amongst families engaged in sugar-cane farming. Indian suicide rates were high during the indenture period (1879-1920), and are still higher amongst Indians than amongst native Fijians: almost 90% of all suicides are Indian though this group comprises only 50% of Fiji’s total population....The increasing use of toxic herbicides, especially paraquat, as a vehicle for suicide is discussed.

See also back copies of Fiji Medical Journal, articles by Dr. Parsu Ram on insecticides and unsuccessful attempts by doctors to have a ban on the product.
Chapter 14

THE DISTRICT NURSING STATION:

Public Health Care in Rural Areas.

In this chapter, I discuss the interactions and processes in the delivery of health care in the rural areas of my fieldwork. I will attempt to show that numerous factors, such as social organization and social structure, as well as social policy and its implementation, have important implications for both health care seeking and delivery.

The question this chapter addresses is the following. What interactions and processes are present when Indo-Fijians seek health care from the services provided by District Nursing Stations in rural areas? The Chapter begins first with general comments about the place of Nursing Stations in the organizational structure of health care in Fiji. After which I describe the work of the District Nurse at the District Nursing Station, and the outreach part of her work as she visits the settlements and villages in her area. Third, the role of the community health worker with relation to rural health care will be the focus. Finally, I draw some conclusions about the effectiveness and shortcomings of health care usage and delivery, and attempt to suggest how the problems can be overcome.
The chapter also uses and critically discusses the *Evaluation of Primary Health Care in Fiji*, Working Group of Ministry of Health and Social Welfare, Suva and Office of the World Health Organization, Representative and Programme Coordinator, Suva. (I refer to this report below as the EPHC.)

In the Nadroga/Navosa province of this fieldwork there are eight District Nursing Stations, which are included in the health care organization at the Area Level. (Table 3-1 (p.67) in Chapter 3 shows the organizational structure of health care at the Area Level.) The District Nurse, working in the District Nursing Station; and the Community Health Worker, selected and trained by the community in which she works, are at the grassroots level of health care. This is the level at which Public Health is delivered and where the effectiveness of Primary Health Care should be at its best.

The *Ministry of Health and Social Welfare*, Annual Report for the year 1984, Parliament of Fiji, Parliamentary Paper No.1 of 1966, states “nursing stations form the “front-line” of the country’s health system...provide “focal points” for primary health care, and are manned by district nurses who provide primary, preventative and limited curative services to the people” (p:20). In addition, the Ministry of Health has attempted to train and establish community health workers selected by the villages.

While the primary objective of the thesis is to explore and explain the health care beliefs and practices of the Indo-Fijians, the process cannot be separated from the life of the Fijian people in the midst of whom they live. In this chapter for example the District Nurse who serves both ethnic groups in the area is a Fijian woman (she has high status in the Fijian hierarchy). In the process of health care delivery, particularly when she makes her calls in the settlements and villages, she must structure her visits according to her knowledge of the social organization of the group in question.
At the beginning of this fieldwork I assumed there would be some transfer of knowledge so that each group would benefit from the practices of the other. For this reason, I gave weight to how the district nurse served the Fijian as well as the Indo-Fijian rural populations for which she was responsible. In what follows, I re-examine this assumption.

The District Nursing Station at Loma sits high on a knoll, overlooking a bend in the Sigatoka River; ironically, it is situated across the road from the tobacco factory. The building is of standard concrete block construction, built somewhat in an "H" formation. The first rectangular room is the waiting room, with the clinic in the center, joined on to the second rectangle which serves as the District Nurses' private residence. Behind this building is a small out-building, also concrete block, in which there are men's and women's restrooms. The restrooms have concrete floors and flush toilets.

Outside the main building there are several squat metal tanks which are used to store rain water collected and funneled from the corrugated iron roof for domestic use. There is a large area in lawn in the front of the Station. Shade from a mango tree growing in the center offers some respite to the hot traveller waiting to see the nurse. Between the building and the tree are several plots of garden in which the nurse grows Amaryllis and other flowers. On a level bench of land, above the bank facing the river, there are breadfruit trees in front of which the nurse has planted a garden. At the back of the station is a second garden. Cassava and other root crops flourish in the rich soil. Several orange trees are laden with fruit which is ripe and falling to the ground.

When I began this research, the District Nurse was a single Fijian woman of about 26 years of age. She lived alone and was on call 24 hours a day, all year around, until her yearly leave. In early 1986, she married a young Fijian man from a nearby village. Since then, they have built a small two-room house in the village where he spends most of his time attending to their gardens. She attends to her duties at the Nursing Station as before, but their evenings are
more companionable, as he frequently spends them at the Nursing Station. She also visits her home in the village as time permits.

Her medical practice area begins at the outskirts of the small town and follows along the "Valley Road", which itself traces the river banks into the interior. The Loma District Nursing Station is situated at a distance of about twenty-five miles from the town; and serves the health and welfare of people on both sides of the river.

The Loma Station Nurse who serves the area I selected for study, is responsible for a population of over 5,000 people. The Indo-Fijians live in dispersed settlements and the Fijians in villages. In the course of a month she visits every household in her area, inquires about public health related matters, (illnesses, prevention, family planning, nutritional practices, cooking facilities, etc.) and inspects the homes and compounds for sanitation practices (waste disposal, latrines, clean water supplies, etc.). All of these matters which are in keeping with the eight point declaration of the Alma Alta concept of Primary Health Care (PHC), are related to her work. Briefly the eight points relate to water and sanitation, control of communicable diseases and immunisation, mother and child health, health education, nutrition, supply of essential drugs, and curative care.

She keeps detailed records of every household. These serve as social indicators of the health status of the population for which she is responsible. Her statistics are compiled and become part of the total consolidated statistics which are sent to the Ministry of Health in Suva.

At the District Nursing Station she holds regular ante-natal, post-natal, and Mother and Well Baby clinics. The growth of each child is monitored for at least the first year and inoculations for immunities are given during that time. It is her duty to provide family planning advice, to stock and sell contraceptives (condoms, birth control pills, and injections of Depo Provera). She maintains detailed family planning, antenatal and post-natal records.
Every District Nurse also has a small dispensary of essential drugs, both those which affect disease and those which relieve symptoms; as well as supplies and contraceptives. (The dispensary list shows 37 such items. See Appendix 1). A small refrigerator is on the premises for the preservation of drugs and vaccines, etc. The nurse is responsible for reordering and for checking the expiration dates of her stock.

In the rural areas, the District Nurse watches over the general health of the villagers and settlement people, referring them to the hospital if necessary. She travels by foot, horseback, local bus, any available transport, and often has to ford wide but shallow rivers. In some cases, as at Loma (Vatulele and Keiasi, etc.), the nurse is lucky enough to have access to radio-telephone equipment of her own or that belonging to someone else, to contact the hospital. At Loma, the Nurse has the use of radio-telephone equipment at the tobacco factory across the road. Usually however, such contact is rare.

Highly respected, the District Nurse can requisition any carrier to take a message, a patient or herself to the town. The local buses drop off supplies and letters for her. As the health teams pass by the district nursing stations, they bring kerosene, drugs, vaccines, or other needed supplies. It is a simple task to ask the bus drivers or other rural project officers to take a message to the hospital or to the Health Sister at the Medical Health Centre in the town.

The Public Health Sister, who is in charge of the District Nursing Stations, liaises closely with the nurses under her supervision.

The nurse at the station in my fieldwork area was also in charge of supervising an extra-mural prisoner. This meant that he could live in his own settlement nearby and support his family, but had to be at the nursing station everyday. He maintained the gardens, the buildings and did other odd jobs. During this time the station was exceptionally well cared for and the government used it as a "model" station for display to overseas health care visitors and evaluators. (There is also a "model Community Health Worker" in a nearby village, I discuss
this below.) Later, after the extra-mural prisoner left, the station became overgrown and looked slightly unkempt.

After these few comments about the rural health situation, I return to the discussion of the District Nurse and the area under her care.

The Clinics

When women attend the clinics at the District Nursing Station, the morning "valley bus" stops at settlements and villages along the way to pick up sick patients, new mothers and babies, and those accompanying them.

On this particular day, I was also on that bus going up to the Loma District Nursing Station. The sight is pleasant; fifteen to twenty Fijian and Indo-Fijian mothers and infants all disembarking together to walk up the little incline to the station. As well as a curative and preventive health event, this is a social event as the Indo-Fijian women from different settlements visit and exchange information. Fijian women visit their friends and relatives. The women wait in the waiting room where the walls are covered with colourful health care posters.

The nurse sees each woman in the clinic room where she examines, weighs and completes the charts for each family. She gives babies and older children their inoculations and talks to mothers about any other medical problem. And she discusses family planning with some of them. She also attends to any other ailing person.

Since the women all arrive together on the same morning bus, and they must wait for the bus to return from the long trip up the valley to Keiasi, there is little concern about the order in which the nurse calls them for examination. I could discern no particular order except that two women friends and their babies might appear at the door of the clinic together in order to be examined one after the other. These women were often from different settlements and once examined they could go out and sit under the mango tree to talk until the bus came for them.
The women of the two ethnic groups are polite to each other, but each is eager for interaction with friends and relatives of her own group with little time for inter-ethnic communication. It is an interesting fact that socially the two groups do not mix but form little enclaves of their own even when in a situation such as the clinic. They are friendly with each other, but they do not have a great need to rely on inter-ethnic exchange in their social lives.

Cross-cultural exchanges and transactions do occur everyday in these rural areas where Fijian men and women work on Indian farms. This is when transfer of information mainly occurs, rather than through actively sought social encounters.

The District Nurse has an excellent knowledge of Fiji-Hindi (as well as her own Fijian language) so communicates well with both ethnic groups. She learned the Hindi language as she grew up with Indo-Fijian families nearby, and she has made it a point to improve her Hindi since becoming a public health nurse. She is rightly proud of her achievements. These days she is interested in improving acceptance of family planning, especially now that the Ministry of Health has released statistics about poor acceptance by the Fijian population in the Western Division of Fiji.

She tells me that she believes the “loop” is the best type of contraceptive, although Indian women use the condom very safely and better than the Fijian women do. Twelve of her “Indian” (few people in Fiji say Indo-Fijian) women are on Depo Provera and “they complain all of the time about it - that their menses have stopped and that the “bad blood” does not come out with the injection method, still, they use it”. Five Fijian women also use it but they do not complain about it.

As I watch her, she attends to patients with a number of different ailments. First, she talks to a diabetic patient and takes a urine sample, then tests it. All the while she talks to the woman about her diet. She calls all women “bha” (sister). Another woman is a ‘suspected’ anaemic so she takes a blood sample from her to test. A pregnant woman and her husband and
child are here just for the woman's routine visit. The nurse examines her and tells her that she is due any day now and that she should be prepared to go to the hospital early. "Don't leave it too late"! The woman and her husband smile at the nurse, she is well liked.

The District Nurses know most of their people by name and in most cases they have good recall of the medical histories of their patients. The people in these rural areas depend on the services provided at the Nursing station for primary health care (curative and preventive), they trust and respect the nurse. She will travel at night if needed to help in a delivery or if someone is sick, and she is always available.

Rural Villages and Settlements

When the District Nurse goes to the Fijian villages she meets all the women and children in one pre-arranged home where she acts as a consultant at the same time that she records children's weights, checks the health of the villagers, supplies contraceptives and attends to minor injuries and ailments. She uses these meetings as a time to educate the people in the Fijian villages.

On one occasion, we made plans to meet in the Fijian village of Naduri on the day that she was booked to hold a clinic there. I was accompanied by a Peace Corps volunteer. The turaga ni koro (an appointed administrative officer of the village) had arranged that the clinic would be held in one of the large modern cement block homes. When we arrived, the Fijian woman who greeted us, I assume the owner, had put fresh mats on the floor in preparation for the meetings. She asked me to sit at the front of the house, the place reserved as the place of honour for visitors. I felt honoured to do that, then told her that once the nurse started to examine the patients, my work was to be with her. The Fijian people, even in the smallest villages, observe their traditional protocol to honour visitors; it is gracious and refined. They are deferential to those whom they honour such as the District Nurse who is referred to as Adi, a term of respect for women from chiefly families.
The women from the village soon arrived with babies and young children. The nurse greeted them as she went around making her preparations. She put a scale up, hanging it from the rafters and attaching a cloth sling to weigh the young children. The women teased her saying they too wanted to be weighed. The Fijian children were all very quiet, even the youngest toddlers sat quietly in a row as they had been told to do by their elders, out of courtesy for the nurse and other visitors. One by one she attended to each baby and child, completing their charts as she went along. In all, about 15 children were seen before it was time for us to leave.

The general atmosphere when the nurse holds the village clinic is respectful, but also a time of good-natured laughing and joking. She held a short session on family planning and explained the use of Depo Provera to the women as well as the importance of spacing children both for the sake of the health of the mother and for that of the child. Her interaction with each woman is warm, the Fijian people keep up a good-natured bantering and teasing and everyone laughs with her, thus taking the edge off any embarrassment. A sense of privacy is not evident when the Fijian women talk to the nurse.

By contrast, when the District Nurse visits the Indo-Fijian settlements, she must visit each household separately. Indo-Fijians live in dispersed households, each of which looks after the individual concerns of its family members. Health matters are confidential and not readily shared with others. Her interaction is limited to a few people at a time rather than with a solidary group of people. As a consequence health education is not as effective as when it arises out of an interactive situation where a group of people are together.

There is no strong inter-household link in the settlements which can be used for health care delivery in the community context. Nor are there many Fiji-wide national associations with a formal normative structure which can be useful in channeling delivery of health care to Indo-Fijians. More important however is the fact that few non-governmental organizations are
mobilized for, or oriented to the necessity of providing volunteer aid in the health care field to Indo-Fijians.

Indo-Fijians, unlike Fijians do not have community buildings for meetings, etc. There are temples, but the building is usually only a small altar room (i.e. a sancto sanctorum) set in a large compound. For special occasions such as weddings or other yearly festivals, the people put up temporary structures with corrugated tin roofs (but no walls), under which people can sit on mats. These take concerted effort so are not often constructed. Most temple associations, apart from a oneness of religion, have very localized interests, although through history they have been the vehicle to bring people together for political purposes.\(^2\)

The social organization of Indo-Fijians traditionally weighs against women volunteers working in the health care field. This will probably continue until some role models are provided to overcome those barriers. (I demonstrate that it is not only possible to get Indo-Fijian women as volunteers, but that they are efficient and motivated to provide dependable aid once they start. Chapter 15 describes the development of an "intervention", a hospital auxiliary with both Indo-Fijian and Fijian women, which I proposed and conducted at SDH.)

These then are some of the general social processes with relation to the work of the District Nurse. Health care at the District Nursing Stations has more to do with prevention, with primary health care, rather than with continuing treatment or evaluation of pathological processes. Most of the interactions are between the nurse and the people she protects rather than treats. (Although she does of course 'treat' people as well, referring them if need be to a doctor).

**Interactions: Anthropologist and Nurse**

My interaction with the district nurse in the area was most satisfying. She had learned of my work in the settlements and the Fijian village about a week after I began. I had not yet introduced myself to her but she asked a woman in the settlement if she could travel with me.
(This was not possible because of her schedule; she visits Nasavu settlement once a month and then has duties elsewhere.) As it turned out it was also more practical for me to finish my initial geneologies in one settlement before contacting her.

I made an appointment soon after that to meet her at the District Nursing Station. On my arrival she showed me around and then asked me how she could help. We decided together that we would both benefit by going over our records and discussing every household one by one. It was a satisfactory exchange arrangement for us. She told me the medical histories and asked me to share my thoughts about each family with her. She was impressed with the geneological method and the amount and types of information generated by it.

As we discussed each household I explained the social reasons for certain Indian practices. One case in particular stands out as an example of the outcome of such sharing. R. is a middle-aged woman who lives with her husband and several teenage children on land she inherited from her father, in one of the settlements. They have built a general store on the property. She is quite well off, and also owns commercial property in the town. Her husband operates both retail outlets. Their problems arise out of some basic incompatibility, and from the fact that they live amongst her relatives rather than his (and perhaps from problems associated with her first marriage).

(Sh e was the only one to have made my work difficult for me, and this on the second day of my fieldwork.)

The women in the settlement refer to her as pagla or "mad"; they seemed to treat her like a spoiled girl. The district nurse told me that she too had difficulty understanding the woman, and that women in the settlement told her that the woman has marital problems. She described them to me in detail, as she had heard them from the settlement network. I told the nurse that when I was taking the family geneology my research showed that the woman comes from a very good family. As a very young woman she was married to a man who did not protect
her from very cruel treatment from his mother, and that he too was very unkind to her. She was frequently beaten; and her mental health was affected. She suffered the mistreatment for a considerable length of time before it became known to her parents who brought her back home to live; the marriage was dissolved. She never complained about her husband for whom she had a deep affection in spite of her troubles, but she did eventually talk about the suffering inflicted by her in-laws. At a later date she was quietly remarried.

When we had exchanged this information, the nurse was more understanding of the social context of the woman's behaviour. She could understand that what had previously seemed like bizarre behaviour was related to sad events in the woman's life. A new empathy for the woman emerged from our interaction. Interestingly, in later months, the nurse and I both found our interaction with this particular woman was decidedly improved.

As we went over the charts of each household in this way, we each augmented the information the other had. She told me that my sharing my knowledge of the cultural context of certain behaviours enlightened her previously biomedical perspective, and my geneologies filled in gaps in her data. Her information gave me an understanding of her health profile of the settlements and villages to enhance mine, in the district for which she was responsible and where I did my fieldwork.

**Primary Health Care - Its Implications at the Local Level**

The emphasis on prevention, and on Maternal and Well Baby care during the last Development Plan (DP8) is continuing into DP9. At the level of implementation of Primary Health Care however, the focus is very narrowly translated at the local grass roots levels. In the settlements where I worked, many older women into their late 60's and upwards in age, voiced their discontent with their chronic ailments and said the nurse does not attend to them but cares only about children and the tidyness of the compound. Old women are unable to secure
health treatment for themselves because of the distance to be travelled to the town or the District Nursing Station.

Families often do not listen to their complaints which are constant because of the chronicity of the pain they suffer. One young woman explained to me matter of factly that her mother's aches, pains and illness were due to her age. I replied that she need not be in pain, that perhaps it could be somewhat relieved after diagnosis and treatment from a doctor.

Many older women suffer from work-related ailments such as rheumatism caused by injuries during farm work, or from years of hard labour in the fields. I stayed at the home of one older woman who spent sleepless nights because of leg pains which she treated by putting hot water into an empty liquor bottle which she rolled back and forth over her sore legs.

At one home, as I was talking with two women, we decided that three or four of the older women in the settlement could hire a taxi to go to the OPD clinic at the hospital on the same day and share the costs since the bus trip was too onerous for them. Also in that way they could have some independence from their families in their decision-making about when they wanted to seek treatment.

The elderly do not want to attend the clinics at the District Nursing Station. Because of the emphasis of the last two development plans, most Indo-Fijians in settlements believe that only mothers and children are best treated there.

Although the Indo-Fijian women attend the ante-natal and post-natal clinics at the District Nursing Station, it was my impression from observing people in my fieldwork settlements that they do not go there when they are sick, but travel in the opposite direction to the hospital OPD, or to the Indo-Fijian private doctors in the town because they are closer. If the villagers and settlement people from the lower reaches of the valley were to travel to the District Nursing Station, they would be going in a direction which takes them further from the medical facilities in the town. Most rural people would rather go to town in the first place, than
risk first going to the DNS only to have the nurse refer them to the hospital Outpatient’s
Department. In that case they would have to travel double the distance.

Indo-Fijians choose between care options on the basis of long experience and
preferences based on them. In Fiji most Indo-Fijians have had a long association with all of
the medical options open to them and they have long distinguished which illnesses are best treated by
which healer. In the case of acute illness, they go first to their private doctor, or if they do not
have a doctor, to OPD at the hospital. My informants told me that medicine from the doctor heals
very quickly. If it does not, then they consider other etiologies, social, religious and
pathological; and which healers to consult next. I have noted in previous chapters that their
decisions are made in an ex post facto way.

The District Nurse is aware of the traditional healers in her area and she approves of
them. We discussed one Indo-Fijian orjah/vaid who she thinks of as “very intelligent, his
power is God given”. (Although she is a devout Christian she did not distinguish ‘which’ God even
though the healer is Indian and a Hindu.) She tells me that many people from all over the island
consult him. Another man, a Melanesian healer, “does not have the gift to heal – he is doing
witchcraft called daurairai or vakadraunika. He is living in an Indian settlement nearby. He
came from one of the other Islands in the South Pacific – so he can’t own village land. He rents
from the Indians.” She disparaged the use of his methods. Interestingly, she considers him an
“outsider” to the people of Fiji, Indo-Fijians and Fijians.

The nurse reports any illnesses which may become epidemics, to the Health Sister and
the SDMO. The SDMO is in charge of the public health care activities in his sub-divisional area.
Often he will ask his staff to notify the nurse of an illness reported in a rural family in her area
and will ask her to check the health status of the other family members. All of the District
Nurses in the area attend monthly meetings at the hospital at which time they raise any
problems and share their experiences.
Until the opening of the Health Centre across the river, the Nurse waded across the river at low tide to visit the families on the other side of the river. Now, there is an AMO stationed there with a staff of several nurses. That Health Centre is also used to train public health nurses, who live there for several months, for applied experience as part of their public health care practicum. For a portion of that time the trainees live with Indian or Fijian families in settlements or villages, and they conduct household and morbidity surveys.

The Health Centres in Fiji are the next larger health care facility to the District Nursing Station. Many of the health care professionals in the area asked why the Health Centre was built on the other side of the river, when the majority of the population is on the Loma side. One expatriate doctor (and a number of other people) told me that the Ministry felt that the Indians would cross the river if need be, to seek treatment, they are indulgent and go to pains to get medical treatment.

While this may be one reason, the other is that a massive agricultural development project is planned for that side of the Sigatoka River\(^4\) and the population will increase with it. There is also a large cattle scheme (Yalavou Cattle Scheme) in the mountains above the alluvial flat lands at Bemana, which is funded by the Government of Australia. Eventually, more than 100 families will be relocated to that project as well.

Interestingly, the Fijians who reside across the river would not cross from the other side of the river to Loma District Nursing Station, but rather, neglect seeking health care. This last statement needs elaboration at this point.

Throughout the year of this study, both health care professionals and the general public (Fijian and Indo-Fijian), have depicted the Fijian people to me as stoic, able to suffer pain and disease without flinching. I was told that unlike the Indo-Fijian, they are not indulgent in seeking health care. As I worked at the hospital and visited the Health Centres and District Nursing stations, it became apparent to me that Fijians are admired for not seeking health care.
often and for being stoical in bearing pain. But, usually it is unwise neglect of the individual's health. When Fijians finally seek treatment for the injury, disease or illness, it entails great expense, in terms of use of hospital facilities, care by professional staff who can be otherwise utilized, absenteeism from work, and more expensive medications. A few instances will illustrate this opinion:

V. is one of the senior public health nurses at the L. Health Centre. On the day I visited the station, she was the only one in the building, the other staff had gone out on their school visits. She was sitting applying poultices to her legs which had several large boils. She had been suffering from them for days. She told me the Peace Corp lady had told her to apply them. I told her she should get treatment at the hospital which she passes on the way home each evening. I told her she had to serve as a role model to the others and should get treatment immediately. She agreed and said she would stop by the hospital that very night. She did not do so. Several days later when I stopped at the station, she was absent and had been for several days. She later told me that she had not gone to the hospital for the injections and the boils had spread on the leg, becoming so painful that she could not work. The other nurses substituted for her at the center, for almost a week.

A second instance, occurred at the hospital:

A middle aged woman brought in a very young girl of about three years of age with a serious ear infection that had spread to the sides of her face and into her hair. The woman had pierced the child's ears and they became infected. She did not seek treatment for it and over the weeks the infection became much worse so that by the time the child was brought for consultation at OPD, she was feverish and ill. She was treated with antibiotics.

Another common example of neglect is that of the many Fijian men who come to hospital with sepsis of the feet. The soles of the feet are hard from going barefoot and at first the sores may not seem important so they are neglected. By the time treatment at the hospital is sought, the man must be admitted to the hospital and the wound must be cut away to remove the infected flesh and the person treated vigorously with antibiotics as well as surgical care and frequent bathing and dressing of the wound. What could have been a minor injury, develops through neglect to one that could mean amputation, and does often mean extended care.

These cases are only a few simple ones. Many others exist of serious disease which has advanced well past treatment and as a result of the neglect, the prognosis is not very good. There is urgent need to educate people to the differences between categories of illness when stoicism as an attitude is of value, or when it is a doubtful and expensive 'virtue'. Self-determination in
prevention and cure, and social responsibility for health care costs and benefits are all important considerations in an illness episode. I do not know the cultural reasons for the Fijian value of stoicism and self treatment but am reminded of Illich's (1976:140-160) examination of the topic. Unfortunately, because of time constraints, and because the Fijian culture was not the topic of this thesis, I was unable to explore the issue. I do not know if a stoic attitude was a traditional cultural response, or if it is an outcome of iatrogenic experiences during early contact in the colonial situation when thousands of Fijians died in dreadful epidemics.5

There is another District Nursing Station at Tuvu, further up "Valley Road" from Loma. Until recently, when a community health worker trained by the District Nurse at the Tuvu station began work at Bemana village, the Tuvu nurse served both sides of the river. This is the first time that one CHW has been trained by a District Nurse; previously a group of CHWs were trained together at the SDH.6 This is an innovative and enterprising way of training a CHW and at the same time providing the District Nurse with an assistant for the duration. Furthermore the trainee has on-going contact with her District Nurse, receiving moral support, advice and further training at the same time that she was doing hands-on work in the community in which she lives and will serve on completion of her training.

The graduation of this CHW was marked with a ceremony to which we were invited as guests. We travelled to the station by jeep, crossing the river in its shallows in the vehicle. Villagers from Tuvu fjorded the river as a group, the children shouting and playing as they crossed. The graduation was a formal vaoona ceremony with the CHW dressed in her traditional two-piece tapa dress, her hair dusted with powdered turmeric. The two nurses had taught the children a "health care skit" which they presented; and after the formal ceremony, hosts and guests danced the laraola. The celebration was concluded with a formal meal in the communal bure.
The District Nurse at Tuvu works in an interesting area of rural economic development and ecological change which has implications for improving the diet and social conditions of the villagers. New crops (watermelon) have recently been introduced with some success. The Yalavou Cattle Scheme is in the mountains which rise as backdrop to the village. Many of the villagers have already relocated from the village to the cattle scheme. The remaining community at Bemana have built a small wood and steel construction building for use as a health clinic. World Vision donated the large water collection tanks for the village.

A path winds from the village, skirting the mountains and goes up to the relocation site. Villagers are able to hail their relatives in the mountains by calling to them— their voices and the replies echo up and down the hillsides and through the valley.

And now the villagers also raise goats (it is unusual for Fijians to do so, although Indians usually raise goats for meat.) When I asked the nurse if the Fijians milked the goats, she was somewhat surprised and replied, "No the Fijians do not milk goats!" I suggested that in some other countries goat milk is a rich source of milk and cheese, both high in protein and calcium. She replied that perhaps they will have to first test the idea to see if the people will find some value in it. The goats are raised for sale, although Fijians now are also learning to use the meat as more and more they adopt the Indian diet. The government is trying to implement this change because of the poor nutritional status of most Fijians now (especially in urban areas). Nutritionists demonstrate the preparation of lentil and vegetable curries, and many Fijian women are able to make chapatis.

GENERAL COMMENTS AND OBSERVATIONS: Public Health Care

At the present time, the District Nurses in Fiji are the backbone of the public health service. If the CHW scheme is implemented with vigour, then they will provide the extension services so sadly lacking right now. As in many third world countries, the desperate need to
provide some service often means that attempts are made to implement schemes before the full implications of them have been conceptualized. For instance, the CHWs trained at SDH went to their respective villages, but there is no supportive network to continue their training, or to update their skills. These will come, but they are not in place now. Meanwhile many CHWs are more or less “out there”, but they are isolated and there is little regular feedback about their practices or problems. Without the support from the SDMO or the regional hospital or district nurse, the CHW will lose her motivation to stay on, especially if she is a volunteer.

Another area where rural public health care is uneven is that the government trains mainly Fijian CHWs who then serve the Fijian villages. I have already commented in a previous chapter that two groups of CHWs were trained at Sigatoka District Hospital (20 women) during this fieldwork (1985-86); there were no Indo-Fijians amongst them. The EPHC (Suva: 1984:22–23) states that in 1983, 34 village health workers were practicing in Rewa:

Most of the village health workers trained were for Fijian villages, but in Rewa the programme was extended to include 2 Indian settlements and a mixed community. Altogether about 60 village health workers have been trained by the end of 1983....In 1984, the term was changed ...to community health worker.

This Task Force carried out the evaluation mentioned above and collected data in 40 villages/settlements. They found only “four of the 22 Fijian villages, none of the 16 Indian settlements, and 1 of the 2 mixed communities had community health workers” (Ibid:23). By 1984 the Northern Division had increased its CHWs from 12 in mid-1983 to “...59 CHWs for 39 communities (including 1 male worker for an Indian settlement)” (Ibid:27). (I hold little hope for this service to be extended to Indo-Fijians in the near future, especially in the aftermath of the two coups in Fiji at the time of this writing.)

Training CHWs fits the traditional values and organization of the Fijian people and is easier to implement in the villages, which have their communal areas for meetings, as well as various administrative officers and health committees, networks of women’s clubs, etc. In the
dispersed Indian settlements it is more difficult to implement a CHW program because the needs of the people are different. In terms of health education in the Indian settlement, each household is separate and it is rare for any gathering to take place either as an informal situation or as a seminar.

As I mentioned above, a national infrastructure reaching to each "community" is not present in the settlements where most families assume responsibility for the health of their members, and no strong national vehicle for Indo-Fijian health organizations has yet emerged.

The EPHC states:

Experience in Indian settlements is too limited to evaluate, but there appears to be interest and a possible role in keeping with that culture. It is not clear whether the nature of duties and of community support should be the same as in Fijian villages (ibid:28).

Of course it will be necessary to have a slightly different type of health care delivery to the Indo-Fijian settlements. A number of cultural differences are immediately apparent, there are many others, which are structural and affect social organization. First, Indians do not usually allow their women to go out of their home and around the community to administer to the sick. There is no communal building in the settlements that can be used for health care. Notions of purity and pollution also may have a bearing on serving the sick, (although, as I demonstrate with the Hospital Auxiliary which we instituted at SDH, this problem was easily overcome). The primary drawback at present however is that the government has not attempted to research the Indo-Fijian health care needs, taking into account their values and beliefs; or to think of ways in which to implement such programs in the Indian settlements. Health care professionals at all levels interpret the fact that a community health infrastructure is not present and has not emerged as absence of need, rather than the presence of a type of social organization in which the needs are different and which thus requires not only different questions for evaluation but also a totally different conceptualization of how to mobilize CHWs and to best deliver health care.
The question of equality in health care delivery is very appropriately approached from the vantage point of the District Nursing Station. If we ask if there is equality in health care, a number of illuminating discoveries emerge. The first is that the care given in Indian settlements is not the same as that in Fijian villages. This is partly due to the different structural arrangements in the two areas, which I have mentioned above. The Fijian villages because they have a communal building where the nurse can go and hold mini-clinics, is served better.

The Fijian villages have had a long history of a "communal system" under the aegis of the Fijian Administration, which helps to set community projects in motion, and for which leaders then emerge. Spate (1959:31-39) provides a critical general and historical overview of its workings and shortcomings. He describes the Fijian administration as follows:

184. The Fijian Administration, which is to a large extent a state within a state, is the organisational expression, at all levels from the koro to the centre, of the communal system; each supports and is supported by the other. In the Fijian village, very little or nothing can be done in the way of social or economic activity - not even, in theory, the holding of a dance - without the support or at least the tacit approval of the Fijian Administration, except by those - the galala or independent farmers - who contract out of the village system.

And he later states:

186. In theory at least, a very large part of the daily activities of nearly all rural Fijians is controlled by Programmes of Work and other rules which are given legal sanction by Fijian Regulations. These regulations are made by the Fijian Affairs Board, which controls the local officials....

As well, there are strong national organizations with administrative support such as the Fijian women's club, the Soqosoqo Vakamara. This club with its wide ranging networks in the country is the ideal vehicle through which to raise aid funding to train CHWs, and to disseminate lectures, demonstrations on health care to the Fijian sector. And, it is so used, although with variable success.
By contrast the individualism of the Indo-Fijian settlements makes the work of the nurse more difficult and the educative aspect is dispersed and is not cumulative for the women she attends. Second, health care policy sets the goals for the duration of the Development Plan. The categories of persons it will direct its transfers to during DP9, are once more defined as people in their child bearing years (family planning) and mothers and children. Third, policy concern with Primary Health Care includes assumptions about areas and people between which unilateral transfers of health services will take place (i.e. urban or rural) as well as the type of health care (i.e. curative/ preventive health, etc.), and the personnel who will be involved (voluntary organizations, CHWs, District Nurses, etc.). The goals of policy are not always responsive to ends as people perceive them.

Self-determination (for some time now the concept has been used in the health care field) is an important feature of good health. Towards this end, the District Nursing Station and now the Community Health Workers, provide individuals in Fiji with that first step towards self-determination. The District Nurses assist the general public by their on-going assessment of the environmental, nutritional and social aspects of their life styles that, given adequate attention, will contribute to good health.

In parts of this thesis, and especially in this chapter concerned with the rural areas, I have drawn upon The Evaluation of Primary Health Care in Fiji, for its value in providing some data on the rural health situation. I also feel compelled to criticize it for its one-sided ethnic orientation. The findings of the report have not allowed for generalizations which would provide sufficient information to guide implementation of Primary Health Care for the entire nation. Its treatment of the health care situation of Indo-Fijians who make up almost 50% of the population is almost non-existent. The document also shows a lack of concern with the socio-cultural differences between the cultures. Recommendations thus are drawn from an analysis of the Fijian condition, but are presented as applicable to the whole of Fiji as if it is a single culturally
homogenous entity. There is no discussion of the differences in the social organizations of each ethnic group. These are shortcomings which can have deep reverberations into later planning and implementation of policy in the health care field, and in planning health care delivery and education.

Clearly the EPHC report did not fulfill all of its objectives, and other on-going evaluations are to be recommended in the context of rapid social change in a developing country. The first report can be assessed as to its limitations and its successes. Other evaluations, perhaps of significant portions of, rather than all the topics covered in the first document could be initiated but with a strong cross-cultural focus. Ideally, such evaluations should be made by a team not connected to the Ministry of Health or to W.H.O. For obvious reasons, the W.H.O. is constrained to present evaluations which reflect the ideology of the Ministry of Health and government, and is conservative in any evaluation.

If universal health care is to be implemented, and the goal is Health For All by the year 2000, then a first step must be to know a) the current health status of all sectors (ethnic and rural/urban) of a multi-cultural country, b) to understand the social, economic and geographic barriers to the implementation of a universal health program. The question might be posed, What are the key components of the medical system that is employed at the present time by each ethnic group? And second, How are the two systems, that of the Indo-Fijians and that of the Fijians, different or similar? What existing organizations can be employed in enhancing health care delivery more evenly to both groups? What new organizational form could simply and efficiently transcend the ethnic variance, and allow for better health education? How can the people of Fiji be educated to accept their individual responsibility in the wise use of the many alternative health care systems which are in place?

This thesis answers the first question with regard to Indo-Fijians., and provides some suggestive points as a beginning for the remaining questions.
An in-depth evaluation of Indo-Fijian health care needs, within their cultural context, is long overdue. As a first step, separate evaluations of each culture, with the concept of equity in health care delivery as it applies in a multi-cultural country as the basic premise, and an overall objective of providing universal health care, will help to gain understanding of the nation's needs. And within the context of universal health care in Fiji, attention to inequalities in risk may help to provide better care and to reduce the risk factors to both Fijians and Indo-Fijians; for those sections of the total population that are the most susceptible, or whose ailments do not lend themselves to simple curative methods.

As Warham (19:127) states:

as a point from which empirical research into the equalising effects of social services may start, is that no social policy, and no social service, can be considered as promoting 'equality' or maintaining 'inequality', but only as promoting equalities, or maintaining or modifying inequalities, of particular kinds, as between particular categories of persons. In so far as 'equality' is considered to be an important social principle, the establishment of qualifications of equality, and of categorisations of persons between which unilateral transfers of a variety of kinds are to be effected, constitutes an essential component of social policy formulation, implementation, and evaluation, both within particular services, and as between one service and another. (My emphasis.)

In this chapter, I have discussed the interactions and processes in the delivery of health care in the rural areas of my fieldwork area. I have tried to show that factors such as ethnicity, social organization and social structure have important implications for health care seeking by the people of Fiji and for health care delivery by the outlying stations which deliver Primary Health Care as public health professionals.

The question stated at the outset of the chapter, directed the answer. Very simply, differences in social organization in the two cultural groups ramify into how health care is delivered in the rural areas. At the nursing station, the two ethnic groups receive similar health care. But, during the important outreach section of the work of the District Nurse, each group receives quite different care due to extremely different social organizations and structures.
which affect how the nurse interacts within each context (i.e. a communal setting as opposed to individualistic consultations.) As well, I have shown that due to proximity to the more sophisticated services of the hospital and private doctors, Indo-Fijians show a marked preference for consultations with them for illness. Another determining factor in their strategies for seeking therapy is the way that health policy sets the goals and thus type of interaction which the District Nursing Station can effectively dispense. And because curative procedures for acute illness (the type of ailment for which they readily seek therapy in the biomedical sector), are not very highly refined there, Indo-Fijians seek them elsewhere.

In discussing the District Nursing station and the interactions and processes which occur there, I have continued in my endeavour to discuss the totality of a therapy system as a semi-autonomous social field (Moore, 1978:55ff), one that "...can generate rules and customs and symbols internally, but that it is also vulnerable to rules and decisions and other forces emanating from the larger world by which it is surrounded". This is a processual characteristic which is especially apparent when participant-observation is carried out in a situational complex such as the District Nursing Station and the forces which impinge on it. People have here certain inducements to comply or conform and out of this situational adjustment new values and norms emerge. In this chapter I have also shown how legislated change or "policy" affects and is affected by existing social arrangements. The success or failure of implementation of policy often depends on understanding these existing social arrangements which encode the way values and beliefs are transacted based on decisions and choices of individuals in the social context. These transactions illuminate the factors of indeterminacy as people perceive them.

The following Chapter documents my attempt to set up a hospital auxiliary with an outreach section in which Indo-Fijian women were invited as volunteers. Further generalizations, problems, successes or failures will be stated at the end of Chapter 15 which discusses the establishment of a Hospital Auxiliary.
Footnotes:

1 The government of Fiji has a National Drug Bulk Purchasing scheme which was instituted to keep drug prices low and in order to have a "free drug policy". For a time, patients who went to the Outpatients' Department at the hospital received free drugs. This practice however was abandoned as too costly and now only the district nursing stations provide some free medications. In Fiji there are infinite problems with maintaining drug stocks in the various health facilities, and in keeping quantity and quality controls. During this fieldwork I found that drugs with expired dates were still being dispensed. Many drugs, and supplies such as bandages and contraceptives were often out of stock. Although cost was a factor in availability, often due to inefficient inventory procedures the stock was dispensed long before new orders went in, or reorders were not filled for one reason or another. Quality was affected by heat and some items which required refrigeration were difficult to store, or to transport.

In the document Evaluation of Primary Health Care in Fiji, (November, 1984:59-64), the Task Force discusses the availability of essential drugs in district nursing stations. It states District Nursing stations have 15 more drugs than the WHO model list for Primary Health Care, which has 22 items. Yet seven of the WHO drugs have no equivalent in Fijian lists. Of these the document notes the absence of mebendazole, paracetamol, activated charcoal and ipecac, stating:

"...it is suggested that the principles of what drugs are essential at primary health care level need more adequate consideration. On the other side, there are a number of possibly less essential drugs included in the Fiji nursing station list, which could result in savings if a thorough consideration recommended their deletions" (Ibid:60)

These then are some of the problems which exist related to supplies of medication and other first aid supplies. My limited experience at the Nursing Stations, based partly on observation and in part on comments from Nursing and Peace Corps Staff supports the EPHC report on the topic of essential drugs.

2 Please see Gillion (1977) for accounts of various Hindu associations such as The Indian Cane Growers Association as early as 1919; and later in 1937, the Kisan Sangh or Farmer's Association, as well as the beginning of trade unionism with such organizations as Fiji Bharatiya Mazdur Sangh (Indian Labour Union of Fiji -1930), the Suva Motor Drivers' Union and the Indian Motor Drivers' Union (1934). Also, the formation of the Chini Mazdur Sangh (Sugar Workers' Union - 1944) and the Indian Association of Fiji.
There are and have been many Indian organizations concerned with social welfare and politics. But, to date no major organization is based in the grass roots or takes most Indo-Fijians into its membership as does the network of the Fijian Administration.

Following the second coup this year, 1987, the plight of the Indo-Fijian may see the formation once again of stronger cross-country networks.

I have not included a more extensive treatment of the concept of pagla in this thesis because except for one instance in the hospital where an Indo-Fijian woman was admitted, I met very few people who were referred to as pagla in the sense of insane. The term is used very often in the settlements in the same way as we use the slang expression, "Oh! you're crazy". Siblings often call each other pagla. The woman I am discussing is called pagla on the basis of her behavioural peculiarities. She contravenes ordinary expected behaviour in small ways, which over the years people have come to expect of her and which I think now go almost unnoticed unless a newcomer (such as an anthropologist) visits the settlement. Then, since I noticed her rudeness, and her relatives felt compelled to apologize for it, they called her pagla. As a point of interest, Fiji-Hindi has lost the gender-relatedness of language. In Punjabi, when referring to a woman, we use the word (f) pagli.

Before the two coups of 1987, the Fiji government had planned to invest $10 million to develop 2100 hectares of land in the Sigatoka Valley. The study was funded by the Asia Development Bank, and conducted by Hawaiian Agronomics International, Inc. I would expect that two military coups of 1987 and the resulting destabilization which introduced the weakening of the currency, and other problems, will defer the beginning of this project which was to be completed by 1990/91. (The project was cited in newspapers in Fiji and in other popular journals during my fieldwork year. I was unable to get a copy of the two-volume report.)

See Timothy J. Macnaught (1982:13-14), The Fijian Colonial Experience: A study of the neotraditional order under British colonial rule prior to World War II. Pacific Research Monograph Number Seven, The Australian National University, Canberra, 1982. He states: "The decrease in population had been a worry to the government for over twenty years. The measles epidemic of 1875 had carried off about one-fifth of the pre-Cession population of perhaps 140,000. Subsequent epidemics of whooping cough, dengue fever, dysentery and influenza took several thousand more lives". He states the census of 1901 population of Fijians as 94,397.

The latter method of training is expensive thus the hospital must await funding from some source in order to train the next lot of women. When the funding ceases as it did this year, then no CHWs can be trained.
There is a vast literature on the concept of equality as a social objective. Joyce Warham's paper "The Concept of Equality in Social Policy", Vancouver: Department of Health Care and Epidemiology, University of British Columbia, 1974, Mimeo., discusses it as a philosophical concept, and then relates it to social policy. A useful perspective.
Chapter 15

THE HOSPITAL AUXILIARY:

An Extended Case Study of an Intervention Process

I have described the Western Biomedical System in Part III above without showing the effects of an intervention, the implementation of a hospital auxiliary at SDH. In this section I present an extended case study of the process of development of a Hospital Auxiliary, an idea which I had thought might work, in a local subdivisional hospital. The conceptualization of that model will emerge slowly, as it did on site.

The chapter records the interactions between people in many roles, their conflicts and changes in their situations during the process of instituting a new social form. My interest is to show the ways in which changing individual choice and how people negotiate or refuse to negotiate in the same situation can be factors in the continuity or in the indeterminacy of the social form. I have introduced the work of Moore (1978) in Chapter 1. Her work is especially appropriate in this chapter for she succinctly states a universal characteristic of culture:

"...that it is useful to conceive of an underlying theoretically absolute cultural and social indeterminacy, which is only partially done away with by culture and organized social life, the patterned aspects of which are temporary, incomplete, and contain elements of inconsistency, ambiguity, discontinuity, contradiction, paradox,
and conflict. It is therefore suggested that even within the social and cultural order there is a pervasive quality of partial indeterminacy. (my emphasis)

The Hospital Auxiliary - A Study in Intervention

The interactions and processes in setting up a hospital auxiliary show how people make choices and decisions as they negotiate (or transact) the best amongst the available alternatives, to gain the maximum value. As they transact or make their strategic choices, they manipulate situations in the face of ambiguity. Thus far I have shown this to be as true in seeking therapy in the traditional medical sector as in the biomedical. Now we consider how people vie for position, power and authority when setting up a hospital auxiliary.

What I was interested in at the outset of the "intervention", can be stated as questions to direct this chapter: First, how would the health care community, in this case the health staff at the hospital and the Health Center, go about instituting a hospital auxiliary to help in the very overcrowded ante-natal, and post-natal clinics, and in the Obstetrics wards? Second, how would health care staff structure their priorities, i.e. to help patients, or to relieve their own work loads. Three, how would potential members be recruited, who would be recruited and by whom? Finally, what incentives and constraints to joining the auxiliary were present?

I did not think at the beginning that people who joined volunteer organizations had other interests and priorities and not just altruism as motivating factors for joining. The reasons became clear as the Auxiliary developed.

The idea first occurred to me while working with Dr. B., in the ante-natal, post-natal and other clinics at Sigatoka District Hospital. I came to believe that there was a need for help in the clinics. At the same time it seemed to me that the situation provided an opportunity in which women, who had to wait for hours to be examined, could be given education about pregnancy, breastfeeding, nutrition, and pre- and post-natal exercises. Auxiliary members I thought, could also show pregnant women the labour and delivery rooms, and in general relieve anxieties
about the space and the technology employed. In the wards there was work such as repairing
curtains, sewing cot covers, etc., which women could do. I thought of fund-raising too as an
aspect of the work of an auxiliary, for clearly the organization would need some economic means,
however small at first.

According to the model that emerged in my mind, those of us who were working in some
aspect of health care could recruit volunteers from the various settlements and villages, who
could be trained to give education in each of the five areas mentioned above. After learning and
applying their skills at the hospital for a sufficient time to become proficient, they would be
health educators at the hospital and they would become the Out-reach section of an hospital
auxiliary. In other words they would become "Hospital Auxiliaries".

At the outset I did not have a clear idea or definition of what I am referring to as a
hospital auxiliary. The immediate impetus to the beginning of the idea was the fact that as many
as 50 pregnant women waited hours in the heat and crowdedness of the hospital to be examined in
a situation which I felt stripped them of their dignity as well as their clothes. It seemed cruel
that their nude bodies, large with babies they were carrying, were then covered by three very
dirty hospital gowns which they all had to share. The gowns landed on the floor, over chairs, and
were sometimes not available at all. The staff were very over-worked. The clinic facilities
were poor and under supplied. The first thought I had about getting volunteer help was in terms
of providing better service for patients, at the same time assisting the physician and clinic
nurses.

As I worked in the settlements I thought that many of the young unmarried women could
quite possibly volunteer four hours a week of their time to learn some practical health care
oriented tasks, and a) assist the hospital staff in the clinics, and if time permitted, in other
areas of the hospital, and, b) once trained, assist in the public health area by assisting that
staff, as well as quite possibly holding educational health care sessions for the public.
Once trained, the volunteers would be hospital-based, they would come to the hospital to work thus always refreshing their own skills and learning new ones. And they would go to the District Nursing Station closest to their own village or settlement to assist the District Nurse for four hours on another day. Thus the District Nurse would have a woman volunteer from each settlement or village who would be knowledgeable about, and who could serve the needs of, her own community.

The auxiliary worker’s function would be to teach the subjects learned in the hospital to the women at the District Nursing Station. Thus, the women patients who returned to the rural areas after discharge from the hospital could still be taught post-natal exercises and other subjects which they missed after they left the urban area. In total each volunteer would give up two-four hour periods on two separate days each week.

The volunteers who worked as the out-reach section could also help the District Nurse by holding seminars in the villages and settlement on cooking, nutrition, sanitation, etc. They would form a cadre of health educators.

That, at any rate, was my idea. Would it work out in practice?

Dr. B. and I, and the two surgical nurses (one male and one female) shared tea time every morning, in the office space between the operating theatre, and the labour and delivery wards. During our tea break one morning, I introduced to them the idea of recruiting women volunteers from the communities to help in the hospital. The male nurse (E.) was especially interested in the idea of an auxiliary group for education in public health. Dr. B., E. and the surgical nurse and I decided how to begin the training for the women in the ante-natal clinic and we outlined a preliminary curriculum.

I knew that before we progressed very far with the idea, we would first need permission from the S.D.M.O. to see if he would allow a voluntary organization to work at the hospital. I told
him only about the hospital portion of the model because if I told him the purpose was more than that, I was afraid he would feel it was too ambitious and refuse.

I approached him privately, explained the rationale and how we would proceed, assuring him that it would only come about if first, there was consensus about its need; and second, if the staff approved of the idea in principle. By this time I knew there would be no real opposition to the idea. I had discussed the idea with the Sister-in-Charge, who was not opposed. When I proposed our plan to the S.D.M.O., he asked a few questions then agreed that it was appropriate and we could begin. His one reservation was that we could not use the nursing staff of the hospital. This of course ruled out E. who had wanted to conduct the orientation tours though the labour, delivery and obstetrics clinics. Thus we lost one member before we began, although E. retained his interest in the auxiliary.

Over the next several weeks I presented the idea to the nutritionist and again to the Sister-in-Charge of the hospital; as well as to the clinic nurse and the family planning nurse from the Health Centre. The latter two women stood to gain the most in help from volunteers, since their clinics were busy, understaffed and awkwardly managed. The family planning nurse who was on loan from the Health Center, was hoping that she could be relieved of the one day per week which she spent in the hospital clinic. The clinic nurse had observed my work and I think she was encouraged to want a more permanent "helper".

At the same time I talked to the Peace Corps worker and the nurses at the Public Health Center in town. From these preliminary discussions I was able to discover the skills and interests of the nurses and health educators who were available to the potential auxiliary. I also discovered that some people including the Peace Corps Health educator were opposed to the idea. I was to learn later that a few of the staff nurses thought volunteers would perform their tasks and their jobs would then be obsolete. Nevertheless, Dr. B. and I and a number of others who
were interested had enough support to be encouraged and we decided to have a meeting to see if we could locate people in the community who would volunteer.

By this time, it seemed to me that enough interest had been generated to take the idea to another level, that of trying to see if we could get volunteers from the community. Each of the first seven people with whom I had discussed the idea and who had shown interest in the idea, was asked to bring one person whom they knew, and who they thought would come to work, learn and to teach general health care.

In the next several weeks most of the people I had talked to thus far appeared to be interested, up to the point of actively trying to bring in volunteers from the community, the settlements and the villages.

Recall that in an earlier chapter I have mentioned the negative image the health care professionals have about Indo-Fijians volunteering to work in the medical area. For my part, I wanted to show that young single Indo-Fijian women would be interested in volunteer work and would be permitted to join. I had already talked to the women in the main pandit family in the settlement; knew that if they approved of the project then I could get the consent of others. During my talk with them I asked them to suggest those women from the settlement whom they would approve of for the work, although I had several women in mind. They approved of the women I had wanted.

About a week later, I went to my fieldwork settlement and stopped at the home of the pandits to ask one of the women in the household to accompany me to talk to the families of the two young Indo-Fijian women, Anju and Sita. My purpose was to ask each woman if she would like to be a volunteer and to ask the family if they would permit her to do so.

Anju is from a pandit family, and was waiting at home for her marriage to be arranged. When I described the auxiliary to her and her mother, they were both convinced that it was a very good thing for Anju. She would do seva (service) for the community, thereby using her
high school education, and at the same time learn health care herself. They knew that I would be at the hospital and that the Anju would work with me. I told them that I was going to ask Sita, a young married woman in the area, to join. The two young women would work together.

Anju's parents were not concerned about transportation because her father would provide that, at least part of the time. I had assured them that their daughter would be chaperoned at all times and that I would be responsible for her in the hospital.

Mother and daughter asked me to wait until they discussed the work with the young woman's father that evening, and they said that if he agreed, Anju would attend the meeting at the hospital the following week. Anju's mother is seriously disabled with diabetes, but she became so interested in the work that she said were it not for her poor health, she would also volunteer.

I approached Sita's family next, and they agreed at once that she could be relieved of her household chores one morning a week to accompany Anju from the settlement. I asked Sita to liaise with Anju and to accompany her (if her father approved), to the meeting.

I also told them that two young Fijian women from N. village would probably be volunteering. In order to get permission for these two women I had discussed the project with the District Nurse and she agreed to accompany me to their village. The District Nurse was my spokesperson as I presented yaqona to the chief in the village to get his permission, and the advice of the villagers about which two girls would be allowed to volunteer. Again we were successful in getting the approval of the senior generation. They assured us that two young Fijian women would attend the organizational meeting.

The next step was to find the women who would be the health educators for the volunteers. In order to begin the exercise portion of the training, I called the woman from Holland who was implementing the mobile physiotherapy project in Lautoka, and asked her if she could attend our organizational meeting and help to set up a training in ante-natal and post-natal exercises, and breathing techniques, for our volunteers. The volunteers once trained would then
teach the women who attend the clinics. Happily, she agreed and also offered to come to the first few training sessions.

There was one rather awkward situation which resolved itself because of the level-headedness of a Fijian Red Cross worker. The SDMO had informed me that this woman, a mother of five children, had worked at the hospital for a number of years in a lowly paid job for the Red Cross, that she was not entirely a volunteer. He asked that this be kept confidential, but that our work should not overlap her paid work. If it did, she would be unemployed. I realized the sensitivity of her position. She received acclaim at the hospital and in the community, for her "volunteer" work in the hospital. (In actual fact the woman does more work than she is ever paid for.) It was important not to displace her. When I asked her to join the auxiliary, I told her I knew about her work, and also asked her if she felt a conflict. After our talk she appeared relieved and said she not only felt it was appropriate to have an auxiliary, but she also offered to join and thus give the hospital an extra few hours a week, and more importantly the benefit of her years of Red Cross experience and training. (At a later time she also told everyone she was paid by the Red Cross.)

Because she is well known in the community, and is a member of many voluntary organizations, it was important that she not be offended or inconvenienced in any way. When I had first mentioned a volunteer organization to her, she had appeared cool to the idea, but not against it. Her manner is quiet and non-confrontational, but I later realized that she had worried about her job.

One other person was important to our organization and that was a European woman (Mrs. J.), who was born and raised in Fiji, but who had just returned after living in Hawaii for twenty years. When I met her at a social gathering at the home of a Canadian woman, she told me that she had been a very active member of the Hospital Auxiliary in Hawaii. I invited her to join us.
Our first meeting was held in the Labour room of the hospital. On the day of the meeting, the four young women from my fieldwork area arrived as we had planned. Dr. B., the Family Planning Nurse, the Nutritionist, Sister-in-Charge, the Health Sister, the Red Cross Volunteer, the Peace Corp Health Educator, the Physiotherapist, Mrs. J. from Hawaii and two friends of hers (L. and M.), arrived. Two of these latter three women were white and one oriental. They were all "expatriates". Dr. B. and I both attended with Dr. B. acting as spokesperson.

We briefly discussed the fact that the volunteer group would have a formal organization. Mrs. J. said she could obtain a copy of the constitution of the auxiliary to which she had belonged in Hawaii. She also mentioned that we would have to be incorporated as a society. This would in effect mean that the auxiliary would become a more semi-autonomous social field. The rules of the organization would set the interactional style and the transactions between role holders. For the time being the interactions and transactions within the loosely organized group were based on the ordinary, everyday relationships which arise spontaneously and from self-regulation in small groups, and out of the social life of the people (Moore, 1978:80-81).

I explained my role to the women as one in which I would volunteer to assist in everyway, but I would not hold office. Even by this time, the first meeting, I sensed that the potential auxiliary was becoming divided along the lines of staff and non-staff; and other cliques were emerging. Certainly, the more senior members present who were medical staff were relieved that they would in actual fact probably control the activities of the Auxiliary. For the time being at least I saw no problem with that. They would be training the volunteers.

We explained the work that we hoped to undertake to the women who attended the first meeting. I attempted whenever possible, to explain that the decisions of the auxiliary would be made by all of the members together as the auxiliary evolved (interactively and generatively). In retrospect I realize that the women did not have any idea what this meant; they did not have the experience that belonging to organized clubs gives to its members. Within the next two
months or more, I discovered that not only did we have meetings to decide on the work to be performed next, but concurrently, we had to teach the members how to run an orderly meeting, how to vote, etc. In this my former experience in club memberships was of immense help. (At this first meeting, which was an informal gathering, only two of us knew anything about Roberts Rules of Order).

As I understand the structures of hospital auxiliaries, there are two models. The first is one where the members are a completely separate semi-autonomous body responsible through an elected representative only to the hospital board. The second type is that where a doctor from the hospital sits on the auxiliary board and where the activities of the auxiliary are more dependent on the approval of the hospital physicians. The latter model usually is not as effective as the first, but for several reasons, it was the one which the volunteers at SDH had to use. First, because the structure of the biomedical system is authoritarian and hierarchically arranged, any organization working within it had to somehow fit into the existing organization of the system. Second, we were relying on the goodwill of the Obstetrician and other medical personnel from the hospital and the Public Health Center for access to the work situations. Because we would be assisting in the Obstetrician's areas of responsibility, she was interested in helping to initiate the programme of work right from the first organizational meeting. Under the circumstances it was quite appropriate for her to do so. The problem with it was the degree of absolute control which she sought. (What will come out in the following description is a struggle between opposing units in an evolving organization; between reaching decisions through transactions and negotiations or through the authoritative decisions of one individual or clique.)

Prior to the meeting, I had impressed on the medical care personnel that if each person brought one potential volunteer to the meeting, we would soon have our foundation group. My intent was to see if the Indo-Fijian staff members would bring either daughters, nieces or other young women as volunteers.
By this time we had an Indo-Fijian (Muslim) Obstetrician, the Indo-Fijian (South Indian) Sister-in-Charge of the hospital; an Indo-Fijian (Christian) nutritionist; a European woman of Fiji-birth (second generation and a Christian); a European woman who had worked in community work in Australia, with her friend who works at a resort; a part-Fijian Red Cross worker; the male surgical nurse, a Fijian; the Public Health Sister from the Medical Centre, and several nurses from SDH, all interested in the volunteer group.

Meanwhile, I typed a page of notes which came out of discussions with Dr. B, the male surgical nurse (E.), and myself. It was a rough outline of The Hospital Orientation, a short one page tentative 'curriculum' which was to include a tour through the ante-natal ward (if it was available) where the routine examination and preparation is done. The labour area was to be the next stop and women would be told that there are three stages of progression in this ward: a) onset of contractions; b) onset of strong contractions to delivery; c) expulsion of placenta. The final area to be visited was the post-natal or obstetrics ward, and nursery.

After the orientation tour the women waiting for the ante-natal clinics would have short 5-10 minute talks on 1) Nutrition, 2) Family Planning, 3) Breast Feeding, 4) Physiotherapy (ante and post-natal exercises), 5) Dental care during pregnancy, 6) General Health during pregnancy. We assigned one of these topics to each of the senior professional volunteers so that they would then train the lay women.

By the day of the meeting, in addition to the group of women mentioned above, several Indo-Fijian women and two Fijian women attended. When the group began to introduce themselves, I held my breath—the experience of all of the expatriate women (including me) was intimidating for the self-effacing Fijians and the shy Indo-Fijians, neither of which group knew anything about formal meetings. The "expats" had all worked for large auxiliaries, or as community leaders, in formal organizations in overseas countries. They had their exceptionally good skills, their boredom and a need for self expression in common, as well as genuinely
altruistic interests. On the one hand we could derive a lot of work from them and thereby learn from their skills. But they wanted personal satisfaction through control of the auxiliary as well. "Development" was not in their repertoire. The reason they became volunteers was at least partially to satisfy their own needs.

I felt that Mrs. J. would be a great asset since she was born in Fiji and understood both ethnic groups and had a commitment to the development of the poor Fijian. I had already discussed my commitment with her, that of helping the auxiliary develop by assisting the volunteers to find their own way. With a little help their own leaders would emerge and they could identify their own needs. She understood and agreed. When three expatriates joined, with whom I had not discussed this, I feared that the auxiliary would break up into separate divisions. It was not yet strong enough to have developed goals which might provide solidarity, and already the Fiji people were intimidated. The meeting was nevertheless vigorous with the expatriates, the doctors, and the nurses all helping in the planning. The Indo-Fijian and Fijian women volunteers, new to the situation, looked interested but detached by virtue of their ignorance of the work involved.

During the earlier planning stage talks we had decided that each person who brought a volunteer would have her to train in their own area of expertise. I was disappointed to find that none of the hospital health care workers brought anyone although several weeks had gone by since our talk. It was doubly disappointing in the case of the Indo-Fijian people because a lack of volunteers could be taken as confirmation of what health care professionals had been telling me all along, that Indo-Fijians will not volunteer or allow their women folk to do such work away from home. I was trying to show that breaking that stereotype was easy and potentially beneficial both for the Indo-Fijians and also for the medical care system of Fiji. I had successfully got two young Indo-Fijian women to join the auxiliary.
The Fijian nurses did not do any better—they did not bring even one woman volunteer from the many nearby villages. The only Fijian volunteers to attend were those I brought. (But Mrs. J., whom I had invited, later brought two Fijian volunteers—she understood how recruitment worked from her involvement in the overseas auxiliary to which she had belonged.) In spite of my disappointment in this aspect, I was happy to see we had enough members to make a beginning—there were already fifteen of us.

When the time came to allocate the work, and a volunteer to each of the professional people, the nutritionist and the Indo-Fijian nurse were the first to ask if they could have the two Indo-Fijian women I had brought from the settlements to assist them. My annoyance was apparent to everyone but not the true reason. My intention had been to train all of “my volunteers” in all aspects as quickly as possible and to have them become the core of the outreach portion of “my conceptual model” and to get them working at their District Nursing Station and settlement. In effect, I was trying to test the complete model. (Of course I still had not presented anyone with the whole abstract model, or of my intention, for fear it would intimidate people into inactivity, and others into hostility.) Most people assumed that I did not want to let anyone have my volunteers. (It was interesting to see that the Indo-Fijian women volunteers were very anxious to be able to associate with these professional people, and wanted to be “attached” to them for training. They were not thinking in terms of separate loyalties at all. I felt proud of them. It boded well for getting other young women into our organization.) I realized then, that I was attempting to implement the whole model too soon. Consequently, one woman was assigned to the nutritionist, and the other to the ante-natal clinic. We decided to begin our training session on the following Tuesday, the day of the next ante-natal clinic.

There were some problems to take care of first. The first was to find space for the exercises for which women would need some seclusion. We decided to use the men’s waiting room which was curtained. We put a medical screen across the entrance. The mattresses from the
children's ward (usually used by mothers who roomed-in) were perfect for the exercises. The breast-feeding instruction would be held in one part of the laundry which the Peace Corps health educator and the Public Health Sister decided to clean for that purpose. I was impressed with their innovative problem-solving. The other sessions were to be held out-of-doors, where we put long benches for seating.

Usually, the "mothers" had no beverages readily available during the long wait (sometimes four hours) for the ante-natal clinic. Our volunteers decided to donate plastic glasses and a powdered orange drink which could be easily mixed with water and placed on a table in the shade for all who wanted it. We were ready for our first trial run. At the same time I emphasized that we would need more volunteers.

The first meeting adjourned with a sense of accomplishment. At the end of the meeting, I wrote a memorandum to the SDMO (as well as for our files), briefly telling him what we had accomplished. In it I credited the surgical nurse for suggesting a portion of the proposed "curriculum". I felt strongly that people who came up with suggestions should be credited with them. I placed the memorandum on his desk and later showed it to Dr. B.

Dr. B. looked annoyed about the memo (I guessed) because she had wanted to tell the SDMO of the success of it herself. I quickly assured her that in future it would be the job of the Auxiliary secretary to keep the records and to keep the hospital and auxiliary members informed about the on-going affairs, and achievements of the group. I was interested in keeping power out of the hands of any of the hospital staff.

I did not feel that I needed permission to type it or distribute it since I had largely been instrumental in initiating the project and had already obtained his permission to try it. Furthermore, he treated me as a colleague, I was invited to attend the weekly doctor's seminars in the hospital, and in other ways, was accepted and treated as a Ph.D. level person. Dr. B. on the other hand had started to tell her friends that I was "only a student and not a doctor." This was
true in itself, but I then sensed what the purpose and effect of such a statement could be. It placed our interaction into one of competition and ordered us hierarchically. This was for me a potentially dangerous situation since I depended on goodwill in order to have the freedom to continue my work. Soon after the first meeting, I stopped actually working in the clinics, to allow the volunteers to learn and to help. I also made it clear that my role was that of a researcher, but with an interest in the auxiliary which I was "documenting as a development project". This legitimized my role in the auxiliary, in observing and participating in its growth, and in directing it to some degree. It also had the effect (I hoped) of some social control of the situation, and a reminder that I was there with legitimate permissions.

I was in a strange position inasmuch as I had no 'scarce resources' which could be used in my transactions with others, which could be used to generate compliance or binding rules. My strength or power was in my official capacity as a researcher, in being sufficiently independent of the hospital and its staff and in being organized and knowing my rights. I imagine now that from the viewpoint of others, my power lay in the potential I had to mobilize coercive force from the top.

The other question which began to arise, as soon as it started to be known in the community that I had made it possible for Indo-Fijian girls to work at the hospital and to learn, was that of "who started the auxiliary"? I did not want to give myself credit for it, although the idea was mine. Also, I definitely did not want to outline the model which I had conceptualized, because I wanted it to be generative, as I learned about medical care delivery in Fiji, and to allow myself and the volunteers to be innovative. As much as possible, I wanted the volunteers (the settlement and village people most of all) to mold the organization according to their felt needs as members of the communities they would serve, and in accordance with the social values of their own ethnic groups. From my new and growing perspective, the model was supposed to be an emergent one.
The question of who started the immediately successful venture was apparently an important one. I learned that medical staff could use the success of the auxiliary for personal gain in relation to immediate superiors, and to the Ministry. In a country where staff shortages were serious, the auxiliary was one way to get help. I still had not told anyone about the outreach potential, nor did anyone think of that. People in the immediacy of dispensing health care were not always successful in seeing the broader potential or of conceptualizing abstract models, nor was it their work to do so, for that matter.

The question of attribution of responsibility for initiating the project was the first inkling I had of the competition and imminent cooptation of the project. I also realized again the extent to which the doctors on staff were competitive and envious of each other. I was told about Dr. B.'s attempt to discredit me by another doctor. The doctors had watched the growth of the auxiliary and knew that I had initiated the idea. I knew the potential of such petty arguments could be to disrupt the new organization. I decided I had to be careful of my research and told them it was immaterial to me who started the organization, it was now developing out of the interaction of all of the women who were volunteers. Furthermore, it was Dr. B. who gave us the opportunity to work in the clinics and wards which were her responsibility.

In the settlement, the families I had talked to were proud that I had "given the Indian girls a chance" and they eventually showed their regard by honouring me. They invited me to raise the flag for the foundation of the settlement temple and of the youth organization.

The week following our first meeting I brought two more volunteers, a single Indo-Fijian pre-school teacher, and a newly married Muslim Gujerati from New Zealand. The nurses did not bring any volunteers. Two reasons are apparent. First they might have been constrained by the fact that since they were employed, they could not easily ask women to come as volunteers. A second reason is that they were continuing their initial disapproval of the
volunteer group in a more subtle way. Dr. B. some time later brought two young Gujerati women from the town as volunteers.

Although the auxiliary volunteers very much wanted to begin work almost immediately, we had to meet a few organizational problems. Benches promised by someone in the community did not materialize so we had to arrange for other seating. Many women said they knew how we could get benches or the lumber for them. Neither the supplies nor the benches materialized however. Several of the members amongst the "Expats" were angry with each other over it almost immediately, but kept it under control. Several weeks intervened as we tried to sort out some of the problems. Then the members in the meeting made the decision to begin with what we had available rather than to lose the momentum of the volunteers.

Mrs. J. and I also discussed fund-raising, something we felt we would have to do to get the money needed for cot covers, shower curtains, books, etc., and to help with small equipment purchases. We discussed this when we met with the SDMO. His response was that we might first need the permission of the Hospital Board of Visitors. We decided that we would not ask for permission but we would ask if one of our members could sit on the Board of Visitors and ask the Board to assign a member to attend our meetings. We both strongly felt the auxiliary should be a separate and independent entity, working within certain guidelines, but not constrained by being governed by the hospital or the Board of Visitors.

Several other issues remained to be sorted out. The Sister-in-Charge felt that volunteers should not write on the ante-natal charts or take blood pressure, etc. We were already committed to teaching ethics to the volunteers and to making sure that in no way was the privacy or health of the patient to be jeopardized. This became an issue because the women who became members of the auxiliary, in all cases had much more education than did the Community Health Workers who were trained at the hospital and who worked in all areas of it (including admittance to observe surgical procedures) for the six week training course. We resolved it by
agreeing that the volunteers would jot down the blood pressure reading (BP) on a sheet of paper for the nurse to transfer to the charts; volunteers would not write on the charts. Right from the inception of the auxiliary, we attempted to make the nurses feel they were a part of the auxiliary, that they were participating in starting something good by allowing it.

Another nurse told me that the union rules might be infringed by the volunteers. This was a rather important concern so I made sure to tell the nurses at a meeting that the volunteers would not be paid, nor would they be doing the work of the nurses. We emphasized that the curtains were all falling down in the wards, and that the uniforms, gowns and other things, needed mending and sewing. The volunteers, in fact had started to mend the curtains already. Most nurses agreed that the auxiliary was indeed helping them so the problem was set aside (temporarily as we found out later). My growing unease is apparent from my notes, “It was my impression that there was some opposition to the volunteer group getting started but that they (nursing staff) did not see how not to allow us to participate. It will be interesting to see what transpires.”

I continued to work with Dr. B. and to carry out my research as usual in the hospital during the week. It was to her credit that our interaction during the auxiliary (when it was poor and competitive) rarely carried over into my research with her during the week. When it did, it was only a slight aloofness, and not a withholding of information or a refusal to interact. This was something I had carefully cultivated over the months, by soliciting her ideas about ethics, about whether doctors could work together in spite of fundamental differences in personalities, ethnicity and moralities. Now this had to be proven, as of course it was.

As I now reflect on these issues, I am convinced that by the very fact of being an anthropologist, and by participant observation we do much more. We are very much social engineers, even when the exercise is one which I feel is manipulative and can even be degrading. People feel manipulated by our questions, especially those professional people who are
introspective and reflective. Those who knew that I was documenting all of the activity in the
hospital felt constrained to prove by their actions, and that what they said was the case. Many did
not know exactly what I was studying. When they asked me I told them that I observed and
recorded everyday behaviour related to health care. I think this sometimes structured the
actions of some people at least part of the time. For doctors especially, the whole question of
ethics is a crucial one. To have their interactions under scrutiny everyday must have added to
the daily stresses and I regret that aspect of this type of research.

For my part, I was continually assuring myself continued access to the resources I
needed, and with as wide a range as possible. I began to see the auxiliary with its many emerging
problems, the jealousies and the factionalism or divisions, as a threat to my work. Sometimes, I
resolved to leave the auxiliary to its own devices as soon as I could and focus on my work. At
other times, and usually, I saw it as my work to see how the model would function. At still other
times, my anger and frustration with staff and volunteers made me forget that I was here for a
short time and would be leaving the whole thing behind me, that it was not wise to become
personally so involved. At these times, I withdrew from the hospital for a few days and worked
in the settlements, thus regaining my perspective, and after my absence I usually returned to a
better situation.

On the Tuesday when we were scheduled to begin, each group carried out its
responsibility. Each took a number of women and talked to them about a topic for ten to fifteen
minutes. The exercise group surprised us the most. Contrary to our expectations the women got
down on the mattresses on the floor, whether in dresses, saris or sulus, tucked their clothing
in such a way that they could do the exercises, Fijians and Indo-Fijians all together sharing the
learning experience. The breathing exercises were explained very carefully. The
physiotherapist told them that when they came into labour and it was time to deliver the baby,
the exercises would help them to know how to breathe to push the baby out. They would not feel
as much pain and they would not tire out so easily. The women wanted the exercises written down so they could practice at home. Since the hospital does not have a copying machine, I used carbon paper and quickly drew multiple copies of "stick" pictures of each exercise. We handed them out to each woman as she left. They folded the bit of paper so carefully that I knew it was going to be used. We had made the break-through and been accepted by the women.

The nutrition educator had prepared her session with posters and other pictorial aides so it went very well. The breast feeding educators had set their course up in the laundry room which they had cleaned. They too used illustrations as well as assisting each woman to learn how to breast feed. They had the private space here to do so. The "Red Cross Lady" taught family planning. We had arranged that all the volunteers would meet after the clinic to evaluate the first session. There was general agreement and satisfaction that we were doing good work and it was being improved as we went along.

The officers of the auxiliary were chosen with care. In our early conversations, Mrs. J and I had wanted the president to be a Fijian or Indo-Fijian. During one of the early meetings, the Fijian Red Cross lady was elected President, with an expatriate woman (H.), as secretary. We decided, after Dr. B. and the secretary suggested it, that Dr.B.'s husband be selected Treasurer since he was an accountant at one of the banks in the town. We had no one with training to fulfill that role and I had no time to personally train someone. The slate was decided upon. The members also decided to have three trustees, an idea proposed by Mrs. J.. The SDMO was chosen. Then Mrs. J. proposed the name of her aunt, a prominent elderly woman in the community. I found myself playing a gatekeeper role since my other volunteers did not know that their auxiliary was becoming top-heavy with the elite in the town and with expatriates. Several Fijian women professionals knew what was happening, but suffered in silence until I suggested it should be someone prominent from each of the main ethnic groups. I did not know many people, and I found it inappropriate as a Sikh woman a to suggest another Indian, so I
suggested the *Roko Tui* for Nadroga/Navosa. Mrs. J. then suggested the woman Chieftain from Cuvu, who was the aunt of the Prime Minister of Fiji, and an excellent choice for an organization of women. We agreed that she be invited.

Our first fundraising was held to attempt to get some money for small recurrent expenses of the auxiliary and for items needed in the hospital. However it came to my attention, after others had informally decided it, that the auxiliary would also attempt to raise funds to build a structure of its own, to serve as an obstetrical clinic on the hospital grounds. This transpired at a time when I was working in the settlements. (Once the auxiliary was formed, many of the women were consulting Dr. B. alone and decisions were being made without ratification in meetings.) No amount of convincing would make Dr. B. and “her following” (by now it was becoming that) see that we would need not only the permission of the Board of Visitors but also the Ministry of Health in Suva to put up any structure on government property. During this time there were all sorts of schemes, mainly from the expatriate women about which agency would fund the structure: the army, the Pine Commission, the Peace Corps, etc. Everyone professed to have “networks” to some funding source. I had also started to develop some networks in Suva. A woman from a prestigious women’s organization told me that through their office, it would be possible to obtain funding from Australian sources if we could provide the building plans and the permission from the Ministry of Health. An interesting development was the way the auxiliary was dividing up into groups.

After the meeting adjourned, we began our fund-raising drive. We had divided up into groups of four or five. The objective was to go to every store or commercial establishment in the town and ask for donations of material goods or for cash, whatever the shopkeepers could donate to us. We were given small amounts of cash, as well as fabric for baby shirts, many *sulus*, and other small goods. The fund-raising showed us how little available cash there was in Fiji. The expected number of tourists had not come to Fiji because of the strength of the Fijian dollar.
compared to Australian and New Zealand currency. The shopkeepers were suffering
economically and could not afford to give more than two to three dollars. Some offered to
contribute services, such as the labour for the wiring of our building when it is built, or goods
such as lumber, etc. They were willing to help but had so few resources. We thanked them and
noted the donation in our receipt books. The shopkeepers are often “hit” by many clubs with the
same requests for donations, and they do not refuse, but give what they can. There are at least
twenty service clubs in Fiji, such as temple organizations, Rotary, Apex, (not counting the
sporting organizations) etc. all of which rely on the Indian merchant for donations.

The Auxiliary volunteers soon knew their work and they performed it reasonably well.
It was remarkable that the two Fijian women from the village I had gone to, did not come back
after the second session. I believe it was because the Fijian nurses had not attempted to help
them to fit in. I did not know why they did not feel a part of the group, nor did we get other
Fijian women from other villages as auxiliary members. The two Indo-Fijian women came
without fail, thoroughly committing themselves to their volunteer work, in fact, in the case of
one, to the extent that her son was left more and more to the care of her mother and sister. I
spoke to her about it, telling her that twice a week was enough for she had a child to attend to at
home. These two women were our best volunteers of the settlement women. The two Gujerati
women and the Muslim Gujerati woman were also committed helpers for the time they attended.
They were townspeople, from very well off families in contrast to the poor settlement women.

The auxiliary had planned to pay the bus fare for the two women from the settlement,
but it soon became apparent that we could not afford to do so. During the fund-raising we saw
that if we received only one or two dollars from merchants, we would not have the funds to pay
two dollars a week for bus fare. I attempted to get two free passes for the volunteers but after
repeated attempts I finally gave up on the bus company which was an unwilling donor. For six to
eight months the volunteers from the settlement paid their own bus fare, twice a week. It
amounted to 49 cents each way into town and an additional 15 cents from town to the hospital, or $1.30 a day. This was quite a strain on an agriculturalist’s income.

The fund-raising effort went on for several weeks and the money raised was substantial although I do not know the actual amount now. The secretary who by now was trying to get some power herself, aligned herself to Dr. B., and became a constant companion both at the hospital and a friend, privately. We soon found that the auxiliary decisions were being made by them without consulting anyone else. To make matters worse, Mrs. J. went to Hawaii for medical reasons, and I was going to be away, off and on for several weeks.

When I first began to think about the auxiliary, I had talked to the Sister-in-Charge about the potential good it would do for the volunteers. It would give the young women a legitimate place where they would learn something of value for the rest of their lives. Also, many of them might later decide to go into training for nursing. Those who had less schooling would be a greater asset to their families and to their communities once they had learned about health care. Furthermore, even if they left the auxiliary, the chances were that sometime in the future they would return. Mainly, I wanted to know from her if there was any way that women with less schooling than high school graduation could get training as nurses aides or at some other level of health care in Fiji. She did not think they could, but she was interested in recruiting those girls who were unmarried and did have the training to go into nursing after volunteering. She felt the training we had outlined for them was valuable to the hospital. She had overcome her initial pessimism in the light of the work the auxiliary had already performed. The wards were cleaner, and the halls had fresh flowers. All the curtains between the beds were put on hangers instead of hanging all askew as they had done. In general in the areas where we worked (the Labour, Delivery, Obstetrics and Gynaec. wards), the wards looked
better, and it affected the morale of the nurses who took on a more professional demeanour so that even their uniforms showed their pride in the improvements. It was the result we had hoped for.

I asked the Sister-in-Charge of the hospital if there were any tasks which she knew of that the auxiliary members could perform. She gave me several suggestions. First, she wanted to have one woman, someone who would respect the condition of confidentiality of hospital records, to set up a visit card for people admitted to the hospital and who attended OPD. Second, she said the volunteers could cut and prepare dressings for OPD. I was relieved after my talk with her, for she showed that she supported the auxiliary, and she trusted us to select someone appropriate for a sensitive task.

The person working with records would be under the direction of the hospital clerk. I expected that work to open up a position from which we could train women to be receptionists and to learn the switchboard. In most third world countries such training is difficult to obtain and it is expensive. Ideally, it could have been used to train a single parent or a young widow. I asked Dr. B. if I could present the decision of the Sister-in-Charge for approval by the volunteers, at the next meeting. She refused permission for us to do the work saying if any supplies went missing she would be responsible. My disappointment was evident. For her part, Dr. B. was making sure that we did not extend the work of the auxiliary to areas of the hospital outside of her control. As the key person informally in charge of allocating our work, she was in effect restricting the opportunity of the auxiliary.

Subsequently, I was away from the hospital for several weeks, and when I returned, a number of upsetting changes had occurred. (Dr. B. was also away at the time.) I met the two volunteers from the settlements in town. They were wearing red and white gingham uniforms which they had made. When I arrived at the hospital, the clinic nurse asked me if I liked the uniforms the girls were wearing? I asked how it came about. When I saw the secretary of the
auxiliary, I asked her if all members of the auxiliary were going to wear uniforms and I wanted
to know how the decision had been made for Anju and Sita to do so. She replied that the uniform
would be worn by just the settlement women—and that they had made them.

When I asked Anju and Sita, they told me that they were told to make them and wear
them. I was angry too, when I heard that the girls had gone home and told their parents that they
would be paid seventy dollars a month by the hospital. When next I went to the settlement,
people there asked me if it was true that the girls would get money for the work. I was very
surprised, so I went to the home of one volunteer and asked her in her mother’s presence what
had happened, and if in fact they had been told they were going to be paid. She looked sheepish
and replied Oh! no! they were not, that the other woman may have said so but they were not
being paid. When I returned to the hospital, I asked the Sister-in-Charge if she had intimated to
them that they would be employed at the hospital. She said no, but that she had asked the women
if they would like to become nurses. The whole thing arose out of a misunderstanding, the girls
(at least one of them), thinking that they would be sent for training and that they were being
selected for work. She unfortunately honestly thought so and told people in the town. I corrected
the misunderstandings as best I could, very quickly, because as far as their parents were
concerned, I was responsible for them. They did not wear the dresses to the hospital again. The
clinic nurse, and the secretary of the Auxiliary had taken it upon themselves to allow them to
make and wear them as uniforms.

The other problem that arose was that Dr. B. and H. had decided on their own the
direction the auxiliary would take. They did not want the settlement women in the clinic, but
preferred to have the women from town who had more prestige and schooling. (Their parents
were wealthy merchants and Dr. B. received acclaim for having them in the hospital). This
preference was thwarted however, when other circumstances intervened and the two women
from town could no longer come as volunteers as regularly as they had thought they could.
There was another factor that was important in the decision about who worked in the clinic. I believe it had to do with restricting access to me about the role and function of the auxiliary. The women from the settlements were closer to me than to Dr. B. and H.

I had a heated discussion with H. about the changes they were making on an ad hoc basis, without a formal meeting to ratify the decisions. At the last meeting before my absence I had mentioned that I had the permission of the Public Health Sister to take the two settlement women up to the District Nursing Station one day a week. Since they wanted to work more than the hours we needed them at the hospital and since it was close to their homes, I could see no objection. This aspect of the work of the auxiliary was the last phase of my model, the Outreach section extending the educational component to the District Nursing Station and then to the settlements.

On my return, I planned on a trip to the District Nursing Station. H., the secretary, asked if she could accompany me. We caught the valley bus at the station. When we arrived at our destination we talked to the District nurse and asked her if she needed the two volunteers and asked how she would use them. She was delighted and said they could help with the clinic and with teaching ante-natal exercises.

While H. and I waited for the return bus, she told me that while I was away she and Dr. B. had decided to dissolve the auxiliary and to start again, because it was not getting proper direction under the president. Dr. B. wanted H. to be President, in place of the Fijian woman. They also planned to remove Mrs. J. from the position of vice-President (a position which she did not hold!), because she had not yet returned from her medical trip to Hawaii. I was taken aback and told her that they could not dissolve it without the support of the membership and furthermore I would object strenuously to the displacement of the current president. I advised her to take more responsibility if she wanted it, and perhaps even create and take another office (i.e. program officer), to augment what they felt were the shortcomings of the president, rather
than embarrass the Fijian people and the woman by ousting her. She agreed to my suggestion, saying she understood what I pointed out as the implications of that action, that it would do the Auxiliary irreparable harm if they were to oust a Fijian person.

I was not convinced of her (H.'s) competence. During the time she was secretary, minutes of the meetings had not been kept. The hours worked by the volunteers were not registered, and there was no accounting of the monies earned during the fundraising, or expended subsequently. She had in effect kept no records. In spite of repeated discussion and requests about it, the auxiliary had not yet been registered as a non-profit organization. I felt this was crucial since we were fund-raising. Nor was I able to comprehend the reluctance she had to fulfilling her role as secretary of the auxiliary. She was the center of a clique, with Dr. B., and some of the wealthy expatriate women from the exclusive resort area. They saw their roles not in terms of assisting in the development of the rural women, but by their actions and in interaction with the rural settlement women, made the latter feel inferior. The auxiliary was becoming a vehicle for the self fulfillment of a few women—-it made them feel, and showed their friends, that they had altruistic interests.

I could see there was a problem in the friendship of the president of the auxiliary and the doctor from the hospital. Clearly the two interests could not be kept separate. Dr. B. wanted control of the auxiliary and was not interested in it being incorporated as an entity separate from the hospital. She insisted that we needed the approval of the Ministry of Health before we could incorporate, and H. believed that to be the case. I argued that they were confusing status and practical function. It was the latter for which we required approval, and we had that from the SDMO, who was in charge of the hospital.

Before the next meeting she and Dr. B. apparently had discussed disbanding the auxiliary again and H. had changed her mind--she again wanted to be the president. The meeting began after the clinic. The volunteers who had finished their work came into tea in the women's
lounge, and before everyone was there, especially the President, Dr. B. and the secretary attempted to start the meeting and to dissolve the auxiliary. I told them they could not do so. As long as the president was still working, we should hold off starting the meeting. (It would only be five minutes or so) meanwhile we could finish having tea. They waited. When the president arrived they said they wanted to disband and start again. The president asked to be heard. She told us that she was willing to step down, but she wanted to tell us that no one had heeded what she had to say, that under the circumstances she preferred to take directions from someone else. Then, she stepped down. In the light of her decision, I had no alternative but to suggest to the secretary that she too step down and that would clear the slate. We then had to vote in a new slate. Mrs. J., whose presence could have prevented disbanding, was absent. The other members were too uninformed about the process to support me if I attempted to stop it. When I asked H. when Mrs. J. would be returning she denied any knowledge of her return (even though she was marrying into the family). When Mrs. J. returned she was furious, saying H. knew of the date of her return, and also could easily have phoned Mr. J. to find out.)

The secretary, H., became president, and a friend of hers, an oriental woman midwife from overseas, became education chairman; the Muslim Gujerati woman from New Zealand took the role of secretary. The Auxiliary was loaded with expatriates, all siding with Dr. B. on every issue. Dr. B. and I were voted in as Honorary Members.

The topic of incorporating the auxiliary was raised formally in the meeting. I had already discussed with H. that in order to do so we had to have a set of objectives or goals of the society. I had told her informally that we should keep to a very broad set of objectives in our formal statement. This would give us the most leeway about our functions and roles vis-à-vis the hospital and community in future years. For now, I emphasized we were working in the Obstetrics clinics and wards, but later, if and when Dr. B. was posted to another place it might
be difficult to continue there. In other words since no one questioned our working in almost all areas of the hospital, I felt it unnecessary to impose undue restrictions on the auxiliary.

At the meeting however, Dr. B. and H. presented their new set of objectives (which they called "aims"), which were specific about the areas the hospital auxiliary would work in, the Obstetrics clinics and related wards. I asked for discussion of the objectives and after presenting my argument, asked that I be allowed to present it as a motion and the membership be asked to vote on the objectives. When we did, the membership decided to vote for taking the widest possible mandate as I had asked.

At the end of the meeting Dr. B. and H., the new president, told me that they were invited to the council chambers in the town to a meeting of the Coral Coast Festival. (I later learned that the invitation to attend the meeting included me.) I finally learned another reason for why the auxiliary was disbanded. It was because the auxiliary was already being given attention by the township and the office holders received acclaim and prestige. As well it gave them an opportunity to use the auxiliary and its members as a vehicle for planning a community festival. Dr. B. later told me that the festival would be raising funds for the auxiliary as well as for many other organizations in the town. I knew it could not, and also knew that the energy of the newly formed group would be dissipated. The learning by the members of the auxiliary would be halted in the interest of a community (town) project. I had the feeling that Dr. B. and H. were being used to do organizational work which the men who belonged to the many clubs in the community did not want to do. When I was asked to assist, I thanked them and asked to be kept informed of their progress since I could not attend the meetings.

The demands of the Hospital auxiliary and the Coral Coast Festival organization soon involved much more time than the Obstetrician had. It was curious that she allowed the Hospital auxiliary which was intended to reduce her burden of work, to multiply it immensely. At the
same time her personal life became very complicated. And to add to the stresses, the SDMO was transferred and replaced by a younger man with strongly pro-Fijian interests and an interest in Primary Health Care in the rural sector. He thought the auxiliary was an excellent organization, he had seen my memos to the former SDMO in the files. He asked me to talk to the next meeting of the nurses about it. I told him that I would but that we had a President who should be asked. He invited me, as a senior person in the hospital to address them. After the meeting, he told me of his plans for the auxiliary, he wanted to use it to link with the CHWs who had no network. I told him that they could in fact become non-voting members of the auxiliary; non-voting because the auxiliary was to be hospital-based with an outreach section for education. Again there was the potential of it being co-opted for other reasons than those for which it was started. I agreed with him that there was a role for it in connection with CHWs and we agreed to talk about it further. I felt that we could negotiate a successful network with the CHWs when the time came. For now there was little contact with the CHWs. He invited the auxiliary to the next meeting of the Hospital Board of Visitors, to be held in several weeks.

In the meantime, my interaction with both Dr. B. and H. became tense. H. began doing “hands on work” in the hospital, although she had no permissions to do so and had only a “visitor’s permit” in the country. I felt that she was being irresponsible to do so and to take positions which required her to sign legal documents for the auxiliary when she would have to leave the country very soon in order to get permission to re-enter as a resident. She was unconcerned about it so I did not mention it. Dr. B. did not know about her status in the country. We struggled on for two weeks. The auxiliary members came and their experience was gratifying, they were of immense help, they began to educate the ‘patients’, and their pride in themselves was apparent. I was especially moved by the settlement women, the Indo-Fijians who gave so generously of their time. By this time they were working in the Obstetrics clinic
and giving talks about health related topics, and teaching pre-natal and post-natal exercises. Their settlement community was also impressed with them.

During my absence Dr. B., H., and the midwife, had instituted formal lectures (a set of ten or more) to be given by the midwife, to the volunteers during their tea-time and prior to their going home. The lectures were very well prepared but they were too lengthy and well above the comprehension level of the women from the settlements, as well as of other volunteers. Occurring at the end of the volunteers' day, the lectures were too long and the volunteers could not interact with each other about the day's activities. The members decided to discontinue them after about three such sessions, much to the disappointment of Dr. B. and her supporters.

The auxiliary in the meantime was being rendered more and more ineffective by the cliques in the group. We lost several members due to the infighting. Several quit to go to employment opportunities. I was devoting less and less time to the hospital since I had decided to add research work in one more settlement to my data. I could not let the auxiliary experiment affect my main research.

H. was personally devoting more and more time in the hospital and ingratiating herself to Dr. B. and the SDMO. She was driving the doctor to and from the hospital, and on errands in town. The intensity of their interaction was creating problems in the auxiliary, as other members saw it as a kind of preferential treatment of one volunteer.

Then Mrs. J. returned and the storm broke loose. She arrived at the hospital one morning when I was there, to help. Before talking to me she heard from someone that H. was president. She immediately went up to her and told her "Oh! No! you are not!" Mrs. J. was born in Fiji and has a strong commitment to the betterment of its people both Indo-Fijian and Fijian. Her father was one of the first principals of the schools in the Western Division and her family have deep roots in Fiji. She abhorred the insult to the gentle Fijian woman who was
thrown out of office. I arrived at just that moment and when she asked me later, I told her what had transpired in her absence. She was furious and demanded a meeting, that morning after the volunteer work was finished. H. had already told me that there would be no meeting that day.

Meanwhile I went to the surgeon and asked if the volunteers could work in his wards, especially the children's ward over which he had authority. I knew that Mrs. J., a paediatric nurse, would be happy to have an area in the hospital away from the authority of Dr. B. They were hardly acknowledging each other's presence. The surgeon happily agreed saying that it needed attention and that we could begin by talking to the women about nutrition, though in a non-judgemental way. He said he felt that the mothers of undernourished children needed understanding and support with their problems, not the additional burden of condemnation and guilt from the hospital staff. I felt that by extending the auxiliary to other sections of the hospital we could ease the burden felt by some people in the auxiliary of Dr. B.'s authoritarian control over our activities. It also showed the members of the auxiliary that we were supported not only by Dr. B. as she wanted us to believe, but generally in the hospital.

H. who was normally intimidated by Mrs. J., and B., had also decided that the Auxiliary would meet only once a month. After that day's work, at tea time, the storm came to a head. We decided we wanted a meeting then and there to clear the air. H. and Dr. B. said we were not having a meeting. Mrs. J. outspoken and loud, said Oh! Yes! we were, we could call a meeting if we liked, as long as there were enough members present who agreed to call one. I reminded H. that if there was a show of no confidence in the President, we could also again disband. The meeting was called to order and the grievances voiced. The minutes of past meetings were requested, as well as the treasurer's report and H. agreed to provide them within a stipulated time.

At the same time, I told the Auxiliary members that the Rotary Club had invited me to write a proposal to their international, for an extension of the hospital. The total funds
potentially available were $100,000.00. We recommended a small extension and a rearrangement of the existing facilities which I had suggested to a Rotary member. I also told the meeting that the Rotary Club had also invited me to give a lecture at their club outlining the activities of the Auxiliary. It was "Guest Night" and quite a few people from overseas (Australia and Canada) were present, at the meeting. The response from the club members and the overseas guests was positive.

At the end of this very tense meeting of the Auxiliary, I told them that I was willing to write the proposal (with someone from the Auxiliary) for Rotary with the auxiliary being the potential beneficiary. The grant application stated "payment cannot be made to a Rotarian, the relative or dependent of a Rotarian, or to any Rotary Club or district". If the proposal was accepted, Rotary would appoint a local bank to be the custodian of the monies which would be for the benefit of the Auxiliary. Rotary would actively participate in the implementation of the project if the grant was approved. The members of the hospital auxiliary agreed that it was appropriate for me to write the proposal. I could sense that both H. and Dr. B were upset that I had been approached to write the proposal.

The bad feelings in the meeting were the culmination of weeks of divisiveness, cliques, and infighting for control of the auxiliary. At the meeting Dr. B. and I finally voiced our disagreement about the outreach portion of the auxiliary – she refused to be part of the educational public health component of the group. Furthermore, she specified that if the women from the settlements were going to work in the District Nursing Station, they would be going as individuals not as members of the auxiliary. She said she could not take responsibility for them off the hospital premises. But that was not the question. That was the authority of the Public Health Sister, also a member of the auxiliary, who had already accepted the responsibility, and had allowed the District Nurse to utilize the volunteers. Still Dr. B. persisted, to her later embarrassment. We adjourned finally, after much argumentative debate and an attempt to
institute some order. Mrs. J. and I tried to have the meetings follow formal procedures of Roberts Rules of Order so that the fighting and waste of time could be reduced. We asked that suggestions be introduced as motions on which the Auxiliary members could vote. Within the limitations of understanding of the volunteers who were unaccustomed to such processes, and the unwillingness of Dr. B. and H. who wanted to retain their autonomy and arbitrary decision making, we eventually succeeded in instituting some formal order to the meetings.

One other circumstance occurred about this time to make my interaction and my friendship with Dr. B. very brittle. While working with her in the OPD one day, she complained that the infighting and her work in the auxiliary were creating serious problems for her with the new SDMO, her supervisor. The inference was that the disharmony in the meetings, and my role in it were the cause. I immediately told her that it would be best for the auxiliary, and for her professionally, if she were not a part of the auxiliary, (and I wanted to end the sentence with...but kept at arms length from it, as the other doctors were doing). She did not allow me to finish but took umbrage at the unfinished statement. She closed the door to OPD for about 30 minutes as she berated me loudly for wanting her out of the auxiliary—it was difficult to defend myself or to tell her that most auxiliaries value their independence from the doctors, at the same time that they welcome their permission to work on their wards. She was intractible in her anger, and she refused to see my reasoning even after I was allowed to finish the sentence. The patients in OPD waited and they listened. The other staff, doctors, nurses and technical staff did the same. This episode was unfortunate and I perhaps should have responded differently. When she asked my opinion at other times, I was always very open and frank with her—a quality she valued. Also we knew one another very well by now, personally and at work. A "conspiracy of politeness" has its value, and I had forgotten that for that moment, thinking only of the developmental project.
During this time a young Indo-Fijian doctor worked at the hospital as a researcher for several weeks. He was working on a degree program in Australia and he was on-leave from his position as an SDMO in Fiji. He asked me to explain the auxiliary to him and how it began. He then also advised me that it would be inadvisable in terms of my research to claim responsibility for its initiation, but at the end of my research, I should write up the "history of the beginnings of it" for the SDMO before I left for Canada. (I did not have time to do so.)

During the meeting of the Hospital Board of Visitors, to which the auxiliary members and the visiting doctor were invited, the SDMO called on me to explain the auxiliary's work, which I did. I had not been told beforehand that I would be asked; consequently I gave an extemporaneous talk and finally took the opportunity to outline the complete model of the auxiliary and its out-reach section. The visiting doctor stood up and spoke up for the educational component, the outreach portion of our future activities. He said it was a model which showed promise for the health care goals of the country, those of public health, and Primary Health Care. He commended the hospital for using the expertise of visiting researchers and especially sociologists and anthropologists. Dr. B. at the end of his talk, jumped to her feet and introduced H. as the President of the Auxiliary. The implication was that H. had been slighted by the SDMO calling on me. He invited her to say a few words. The visiting doctor's comments had praised the very section of the auxiliary which Dr. B. had taken a strong stand against. After that, I thought there was hope for it, but realized that it would be imprudent to raise the general issue again for some time.

Meanwhile the two women from the settlement were coming to the hospital as volunteers one day a week and going to the District Nursing Station the other day. Furthermore, the seminar in the village, in the home of one of the settlement families which I had proposed months before, was also held with the two auxiliary volunteers functioning as health educators in their own settlement, with the District Nurse in charge. From my perspective, the model I had
conceptualized had now been completely "tested" and it worked. I had learned something about the interactive and social constraints which would affect the implementation of volunteer organization as I had thought of it.

One more brief "skirmish" occurred prior to my leaving Fiji. We had pressured Dr. B. and H. to formalize the legal position of the auxiliary as we had agreed in the meetings. It was becoming more and more urgent that the Auxiliary be registered as a non-profit organization since we had been successful in raising about $1200.00 through various fund-raising activities. Once again our insistence on structural formality cause a further rift - I could not understand the reason for the hesitancy which was presented to us. Dr. B. insisted that we needed the permission of the Ministry of Health in Fiji before we could register as a non-profit organization. My argument was that we did not, we could register as a non-profit organization and all we needed was the permission of the local SDMO to work in this hospital. Once again, her concern (very realistic) that the work on the auxiliary could affect advancement in her career was interfering with the functioning of the organization. She did not want to apply to the Ministry of Health where her position was tenuous because of other matters, but could not give up the mistaken belief that we had to apply to them for permission to incorporate.

Sometime after this meeting, while I was away working in the settlements, H. and Dr. B. arranged to make a formal representation to the woman chieftain to be a sponsor of the Auxiliary. It was not voted on and no one in the auxiliary was advised that Dr. B., and H., and several women from the town would make the formal visit. As it happened, I arrived at the hospital on that day and someone told me of the plans. When I went into the surgical theatre, Dr. B., after a short time finally told me and invited me to accompany them. I asked them who was going, fully expecting that Mrs. J. who had proposed the woman chieftain's name, would be accompanying them. But no one had informed her, and it now was too late to do so, since the
cars were ready to go. I hesitated and then thought it would be better to go than to have someone think I was showing resentment.

I do not know the details, but the person who was to make the formal presentation of the yaqona sent word that he would not be able to do so. Suddenly, they had to get permission for the Fijian cleaning man from the hospital to make the presentation. There was a flurry of activity among the Fijian people, but I could not discern the reason for it. Another Fijian woman also declined to go. The rest of us drove out to the village. Here, a messenger was sent to the chieftainship that we had arrived. Someone from her home came out and invited us to her house, we were not taken into the ceremonial bure. The woman chief of the village is a most noble looking woman; she is from Prime Minister Sir Kamisese Mara's chiefly group. She greeted us at the door with dignity and regal bearing, and invited us into the house. (The house incidently, had many pictures of the British Royal family on the walls). She invited us to be seated, then she went out into her rooms for a few minutes. H., Dr. B., and I, sat down on the sofas, and several other people stood in the front room. When she returned she too sat down on the sofa so the Fijian people and I all promptly sat down on the mats on the floor, in order to keep our heads lower than hers, according to Fijian protocol. She was so obviously impressed with my having done so, that she maintained eye contact with me all during our meeting and during tea, her people were especially attentive to me. Neither Dr. B. or H. moved, they sat on the sofas looking uncomfortable. I was unsure if it was deliberate or an oversight on the part of Dr. B., but think it was an inopportune oversight about the custom. The Chieftainess agreed to be a sponsor of the auxiliary. Later, the women in her family served tea. We left her home within about an hour of arriving. Later, when the auxiliary members found out about the ceremony, there was some resentment. Mrs. J. was understandably angry, she had proposed the name of the woman chief in the first place.
In the days that followed, I wrote the proposal to the Rotary Foundation, with the aid of Mrs. J. and her husband. I was able to obtain blueprints of the hospital from a member of Rotary who is a graphic artist. He kindly made drawings showing the proposed revisions. Mrs. J.'s husband and I drew the sketches attached to the proposal. (See Appendix 5.) He agreed with what I wrote, changing very little, but checking it for accuracy and producing the typed copy. He was generous with his time and drafted and retyped the copies on his computer as we needed them.

It was at this time that Dr. B. and H. requested a meeting with the SDMO to inform him of the auxiliary's operation. The auxiliary had successfully raised quite a bit of money towards the building they wanted to erect and now they had the plans for it. Because I arrived at the hospital Dr. B. and H. invited me to go along to attend the meeting with him. I was not informed beforehand of the subjects to be discussed, so I planned to tell him of Rotary's suggestion that we write a proposal for the extension and rearrangement of the existing building. I had a draft copy of the proposal for him, which I had planned to deliver in any case. During the meeting, Dr. B. and the President presented the work of the auxiliary to him as I listened. Then they tried to quickly adjourn the meeting. He asked however, to see the proposal Rotary had asked us to participate in. After a short discussion, he said he would take the copy with him to the Ministry of Health in order to get the approval of the Minister for Health. And he agreed to give support to the proposal. (Later he told us he had been unable to meet with the Minister on the day he went to Suva, but he said he would take it to the next appointment.) Meanwhile we had his approval for the project as proposed. This was important since we required his signature on the document.

I consulted with the Rotary members, delivering the final copy to them on the day that I left Fiji for Canada. One copy was provided for the hospital as well. Our understanding was that the Rotary Club would keep the Auxiliary and I (in Canada) informed about the outcome. I have not heard from them.
Intervention Examined

At the beginning of my fieldwork, I was deeply concerned about, and committed to, the idea of non-interventionist roles for anthropologists during fieldwork. In my undergraduate years, I had read Turnbull and others, and was convinced that intervention would distort and contaminate the data. For several months I tried not to intervene, and in the settlements it was not too difficult to hold closely to these ideals for there I was a participant-observer who worked on the terms of my informants and those of the settlement people in general.

As I have described in Chapters 11 and 12, my resolve ended in the hospital situation where another type of ethics came into play; where I felt non-intervention was unethical. In a hospital, where life and death are in the balance, or an injured child, or a sick adult came into the hospital there was no time to contemplate such things. When I was asked to assist the first time in the hospital, I knew that I would of course help. Research in such settings is "hands on" work.

I have a different view now of intervention with regard to work in the medical anthropological field. I was also interested in the role of applied work in anthropology, and now distinguish between research which one initiates and applied work in which one is invited to participate. This research has pointed out many of the problems which would be involved in doing actual (usually referred to as activist work, advocacy work, project development, etc.) work in the real world of power, politics and bureaucratic institutions.

Intervention in an existing social form (the hospital) by attempting to introduce a new structure (a volunteer auxiliary) within it, and then waiting as the "middleman" or "interpreter" of the interactions in the process, smacks in hindsight of manipulation although that was not the intent. The terms come from Whisson (1986:136–137):

Bailey describes 'middlemen' as 'roles which come into existence to bridge a gap in communications between the larger and the smaller structures' (1969:167). Monica Wilson called them interpreters. 'I use interpreter for the man between,
whose primary function is communication, and secondary function negotiation. Now interpreters, just because they are men between, are commonly distrusted. Where the groups between whom they interpret are in conflict they are likely to be distrusted by both sides because they are negotiators between opponents' (1972:20).

The 'pure' anthropologist will limit himself to Wilson's primary function, the 'applied' anthropologist will be no less concerned with the secondary.

Even in a small intervention project, where one injects the ideas in the appropriate places so that others will institute them if they want to, one is on potentially troublesome ground. I wanted to interpret communication and to negotiate the ongoing development of a conceptual model of volunteerism which I thought might work, but which I did not want to impose. For a time my role was that of the traditional anthropologist, collecting data for ethnography.

To be an applied anthropologist, one must be wholly committed to the task in all of the everyday problem solving aspects that arise. Documentation and data gathering are not given the same priority that purely academic research requires. Not only that but the work, because it is political, can jeopardize pure field research. For this reason I had to be very cautious in juggling my roles of academic interest and activist and in negotiating the structure and function of the developing auxiliary. The factions developed immediately, (I have documented these above) and a number of interest groups emerged which were unintended consequences of the process. The effects were often unintended, although they arose out of the interpretations that others placed on suggestions and roles. My conceptual model which was an emergent one by intent, since I knew so little about the interactants, took bizarre turns. So too, did my moods and those of others in the auxiliary. Few people conceptualized the whole hospital auxiliary in the abstract. Many had a personal interest in the direction it took and fought for control. This chapter has also had implications for our interpretations of ethics and principles in the fieldwork situation relating to applied anthropology. They emerged from the exercise.

About committedness, Whisson (1986:136) states it must be
"beyond the constant display of academic virginity demanded by the AAA principles, and be ready to go into the real world of politics, power and persuasion. Martin Luther King urged his congregations to be 'wise as serpents and harmless as doves' (Matthew 10.16), which he glossed as combining 'a tough mind and a tender heart', the former characterized by 'incisive thinking, realistic appraisal, and decisive judgement' (King 1969).

Applied anthropologists could do worse than to start from that point, drawing the essential distinctions between intentions and effects, as well as between their possibly conflicting roles as advocates, brokers or collaborators (the tough minded element) whilst remaining sensitive to the needs of their subjects as their subjects themselves experience them (the tender hearted element).

CONCLUSION

The questions posed at the beginning of the chapter can now be answered. The first question was to see how staff would prioritize the work of the auxiliary members. I wanted to know if they would think in terms of the volunteers as individuals involved in "community participation" in self-help health care, or if the staff would be more interested in getting help with bureaucratic and other chores in the clinics.

The answer to this is not clear-cut. My interest affected their judgement; my first concern was to somehow make the clinics more humane, and to make the waiting women more comfortable, to assist the doctor and the nurses. Consequently, Dr. B. and I immediately assigned volunteers to help in the clinics. We had to fulfill those aspects of work for which we requested permission to recruit and train volunteers. My eagerness to have the volunteers assist in the clinic structured that expectation. In another instance, much later, when I suggested that in place of the dirty gowns (of which there were only three), the 'patients' wear the sulus which we obtained by fund-raising (this made examination easier, provided women with a garment that covered them, and the sulus were easily washed) I structured the situation before the staff or volunteers had a chance to conceptualize it in another way. As I later reflected on the situation, I wondered how the auxiliary might have evolved with someone in another role rather than as an anthropologist.
The second question was related to recruitment. In this, in spite of "gentle persuasiveness" or personal leaning towards the rural poor, my co-workers recruited volunteers from their own socio-economic status groups. Most of those volunteers were women from the town's upper class, expatriates and townspeople. (My meaning of expatriates in this context is ambiguous. I am referring to one woman who was born and raised in Fiji and is a permanent resident. The other "expatriate" women in the auxiliary were in Fiji with 'visitors' status and were not allowed to work.) I recruited 2 Indo-Fijian women, 2 Fijian women, 1 Fiji-born expatriate (Mrs. J.), an Indian expatriate from New Zealand, 1 European physiotherapist. Mrs. J. brought three expatriate European women (one a resident and two visitors), and one Fijian woman. One of her volunteers later brought a visiting expatriate (Chinese) midwife. Dr. B. recruited 2 Gujerati women from the town. The Red Cross volunteer also joined. In addition several nurses were usually present - the nutritionist and the Sister-in-Charge. The Public Health Sister and the Peace Corps health educator from the Health Center in town came regularly. The latter assisted in spite of her initial reluctance, and primarily because the Public Health Sister, in charge of the Health Center, asked for her help. One Indo-Fijian woman from a settlement came, but she did not join; she was under the impression that this was paid work, or would lead to it. The hospital staff did not recruit any volunteers for the auxiliary. Few people recruited women from the rural settlements or villages. One woman told me it was too expensive for most rural women to pay the bus fare (about $1.00 return fare to rural settlements). Although it is difficult to recruit people as volunteers when one is employed, that is often how volunteerism is initiated, by people working on-site. Nevertheless, the nurses who lived in town and had daughters in their late teens, did not bring them to the auxiliary. Nor did they bring friends. They did not perceive the auxiliary as an opportunity for those girls who were finished high school but had not yet married. The settlement people were less reluctant.
When I learned of the CHW training program that had taken place at the hospital, I assumed that health care professionals would be interested in recruiting volunteers from the grass-roots level who could be used in public health education. My reason? Prior to the fieldwork, I had read the literature on WHO’s Primary Health Care (PHC) and Health for All by the Year 2000 (HFA/2000). Obviously I had not taken into account factors such as whether the socio-political orientation of the doctors, nurses, or volunteers was atuned to the implications of an auxiliary aimed at making health care more accessible to the people by their own efforts.

de Kadt’s (1982:749) work which came to my attention as I wrote this, is relevant to this analysis and clarifies some of the issues I overlooked. First, he says:

Community participation as a concept is particularly bedevilled by confused usage, and as a policy it is especially prone to ideological affirmations.....Taking two extremes, organisations related to a government which is leaving existing socio-economic inequalities and power relations untouched, are likely to have a conception of participation different from those operating in a context where the government is committed to increase social justice and the power of the under-privileged--be it by a radical transformation of the social system, or by a process of reform.

..... Community participation may be defined by outsiders, and be predominantly an expression of compliance with existing norms (e.g. those related to class or professional dominance). Alternatively, community participation can be seen as demanding definition essentially by those directly concerned, and be regarded above all as an expression of creative challenge to dominant norms and meanings.

It is quite apparent in hindsight that there were several components missing in the initiation of the auxiliary. First, there was no radicalized commitment to changing the circumstances of the people. Second, I did not guide the auxiliary in the way that a project leader with a broad mandate to start a community project would have done. (That is, if the project had been conceived of and funded by an outside organization as a development project.) My primary effort was going into keeping my interaction with the doctor, the staff and the volunteers from disrupting my fieldwork, while at the same time attempting to inject enough direction to make the auxiliary a success. It became more and more difficult as a power struggle
developed between several factions in the organization, and I found I could no longer effectively walk the tightrope of Wilson’s (quoted above from: Whisson 1986, 136–37) person “between”. I had started to side with one group more and more. If I was going to direct the form the auxiliary was to take, I could no longer negotiate between the groups, or communicate to both groups, neither of whom entirely trusted me, the broad direction it should take. This was especially the case since Dr. B. had herself declared advisor of the auxiliary, at the meeting when the first President was ousted. This was the situation at the end of the fieldwork. If nothing else the volunteers perhaps learned something about political process and its manipulation. They did learn from me that according to Robert’s Rules of Order and formal parliamentary procedure, it is the right of the minority to be heard even though the right of the majority prevails. This represents a cultural innovation in a country with a strong communal social order in which power is held by a small chiefly group. They learned to challenge decisions they thought were wrong, and that they could influence the political process. It’s enough, for now a beginning.

A third question asked above was, What motivated people to join? For some, the most common interest was that of prestige that was accruing to members of the auxiliary from the community, as it learned of the organization. Also, some members perceived that they would be helped professionally by being recognized as initiating the group which showed a successful beginning in recruitment of voluntary personnel from both ethnic groups. After all this is what the government’s Development Plans advocated but had not yet implemented.

Recognition from the community was immediate--invitations to help organize the Coral Coast Festival meant that the members of the auxiliary would be interacting with key people from the upper classes in the town. There were also invitations to participate in the meetings of the Hospital Board of Visitors. In a small town, these privileges are rarely extended and are valued and sought after. The faction which aligned itself with Dr. B. was clearly at an advantage
in this interactional arena. Her position as a respected member of the elite, whose husband was one of the bright young business professionals, brought this group immediately into the "limelight". From the perspective of the other groups, its members were perceived as capitalizing on the organization. The ethics of top-loading the auxiliary so that the power was held by the group supporting hospital control of the auxiliary was anathema indeed.

The young rural women were motivated to join the auxiliary for a number of reasons. First, they were able to leave the monotony of settlement life to interact with professionals in an ambience where they were respected by the public they met. They were also attracted because of the Indo-Fijian concept of *seva* (community service). Second, and important to them was that the situation was a "learning situation" which appealed to them for its intrinsic interest, but also because they thought it could eventually lead to avenues to training in the health care field and later to paid employment.

Altruism seemed to be sadly lacking as a primary motivating factor, although it was the ostensible reason every woman had for joining.

Self-fulfillment was also a motivation for most women, but most especially for those who had health care training and wished to use it. For instance the women who were nurses or midwives, but were in Fiji without work permits, found the auxiliary an excellent vehicle for their skills in teaching and assisting at the hospital. Their contribution was immense and they gave unflaggingly of their expertise.

Others, such as the Red Cross worker, the Peace Corps volunteer and the physiotherapist, had a number of reasons for joining. First, they were contributing to their chosen field and as consultants which added to their prestige. For some, the work was also sometimes in the form of an assignment from a superior but performed in good grace.

I have also asked above what constraints to joining the auxiliary were present for potential volunteers. First, the obvious contraints were economic. Women from rural area
could not afford the cost of the bus fare, and we were not able to convince bus companies to allow us passes for three to four volunteers. Nor, as it turned out could the auxiliary afford to pay the fares out of monies raised. Other constraints were related to family values. Some Indo-Fijian people did not believe in volunteerism, and others held caste-related notions that hospital work was polluting. And some families were still reluctant to allow a young woman to go out unchaperoned by a member of the family.

Many Fijian people were shy about working in the hospital ambience, and still others could not afford the fare every week.

Later as the auxiliary was in full swing with twenty members and interactional problems were emerging, the gossip networks carried the problems through the town. A private doctor, a woman, told me that the problems at the hospital were preventing many women from joining the auxiliary. They perceived it as something which could create problems for them, thus avoided joining. Indo-Fijians are conscious of and are avoiding membership in organizations in which factionalism is rife, thus some women were told by a relative not to join (i.e. by a husband, mother-in-law or a mother).

If I ask the question, In what respects was the auxiliary not a success? I must point to the bureaucratic form it took. Several factors stand out as intervening obstacles to its lack of success in emerging as a "creative challenge" to existing structural forms. I give an example.

The form it took was pre-ordained by the fact that it was not a developmental project which had outside funding. The auxiliary had to generate its own funds. As a consequence it was bound by the rules and regulations of the umbrella organization (the hospital), itself a bureaucratic organization. For instance, according to the SDMO and the Hospital Board, we could not fund-raise unless we were first registered with the government as a non-profit charitable organization. In order to do that we were forced to register or prepare to do so. This required us
to have a slate of officers (a treasurer to account for funds) and a bank account number. The
bank in turn suggested two signators for the account.

If I wanted to submit a proposal to the Rotary Club (or any other agency) for funding, the
Auxiliary had to show it was a registered society, which had made some attempt to raise some
of the required funds by its own efforts. This required confirmation from the bank that we did
indeed have funds. Before Rotary Club could accept the proposal it required permission of the
Ministry of Health to erect the building we were attempting to fund on its property (or to make
changes to the existing structure). The Ministry had to approve the blueprints. It would not do
so for an ad hoc group. The more we attempted creative responses to situations, the more we
found we were bound by existing bureaucracies from which the only way of having some degree
of autonomy was through private funding sources. It was, to be brief, a circular problem, one
with no foreseeable end during this fieldwork. (I did dream of what a privately funded
development project could have done to begin the type of Hospital auxiliary I conceptualized.)
Given these circumstances, I was unable to consider appropriateness. (And retrospectively, I
am amazed that it was a success. At last word (prior to the coup of May, 1987), two of the
volunteers Mrs. J. and the expatriate midwife, had cleaned and covered sixty mattresses with
covers they made. Not a bad achievement.)

These then were some of the incentives and constraints with which people were
confronted with relation to the hospital auxiliary.

To write about interactions and processes in the context of a small local group, embedded
within the institutional structure of the hospital reveals the roles of its members and their
strategies as they negotiated outcomes within social constraints, to form an auxiliary.

I now wish to use Moore's (1978:45-46) framework for studying social process, and to
structure this conclusion, I will quote from her work. Then it will be used to analyze my role,
and those of others, vis-à-vis the hospital auxiliary, and to show the implications in terms of Moore’s framework.

After analyzing the work of Firth, Nadel and Barth, Moore states:

They seem to divide roughly between the study of regular repetitive events having to do with the circulation of persons, power, goods, and information, and the study of events specifically having to do with processes of changing social and cultural regularities. In abbreviated outline:

A. The movement of individuals through roles and positions. Repetitive or cyclic events that nevertheless imply shifts and changes of relations between or among particular persons:
   (a) temporarily occupied roles.
   (b) Shifts and adjustments connected with conflict, competition, exchange, communication, and the exercise of power.

B. Changes of norms and of social/cultural regularities. Events that imply shifting and changing social/cultural frameworks and symbols; the generation of social forms:
   (a) from indeterminacy to determinacy or vice versa (i.e., the generation of social forms where they did not exist before, or the degeneration of social forms into indeterminacy).
   (b) the replacement of existing rules or forms with new rules or forms (i.e., the change from one kind of determinate arrangement to another).

What is immediately evident is that A and B are not and cannot be exclusive categories (Moore, 1978:45-46).

The Roles

In the preceding chapters I have given suggestions about my roles during this fieldwork. They can be most clearly distinguished according to the places where I worked. In the settlements the people knew that I was conducting research, the role was quite clearly defined, and it was the rare occasion when I took any other role. Even though people knew that I had many other roles at home, this was the one role they knew best. Towards the latter half of the fieldwork, as I began to talk about leaving Fiji, people began to communicate other roles and statuses which they ascribed to me, such as ‘friend’ to most people, a ‘daughter’ to the old women, someone to honour at a temple ceremony. Most importantly they referred to me as a member of Nasavu settlement, identifying me as one of their own at ceremonies.
In the hospital in the course of everyday work my role was that of a Ph.D. student; perhaps because I accompanied medical doctors and assisted them, some people thought of my role as similar to that of an intern. Out of my hearing, and in the town, many people referred to me as ‘the doctor’ from Canada. In both places, my role was one which I was occupying temporarily, in the movement from one to the other my interactions and the social processes involved different types of relationships (transactions or exchanges) and events in a complex society.

Throughout this chapter with reference to A in Moore’s model, I have depicted my role (a) as central in terms of part (b). In starting the auxiliary, from my perspective I had started something by a simple injection of ideas, which had gone almost out of control, and also on which I could not spend more than a limited time even though it needed some strong guidance. I found I was frustrated by my lack of ability to communicate the abstract issues involved to Dr. B. who formerly had been a confidante. For most of the time we worked together in the hospital in a shifting relationship of mutual support and encouragement with open communication in our roles as doctor and student; and marked by competition, asymmetrical power and conflict as co-founders of the auxiliary. In the latter case, we were soon in different factions; she held most of the power, but did not have the time, nor did we share the same kinds of organizational knowledge and ability.

In retrospect, I see that I had the ability to control meetings whenever I decided to invoke the order for running meetings. Whenever I did this, logic prevailed and I was able to achieve what I intended. The cost, however was the anger of Dr. B. and the possibility that she might be less co-operative in my research. This managed to keep me from invoking too often this “power” which we had as the “other” faction, made up of several of the expatriates, the Red Cross worker, and the volunteers which I had recruited. Keeping the reins on this power made me feel
as though I was manipulating the situation and was maternalistic (i.e. in the sense of paternalism). In retrospect, I think the knowledge I had about how to conduct meetings seemed to intimidate people and that in itself became an instrument of power.

For a time my role was that of the traditional anthropologist, collecting data for ethnography. Then as I have mentioned above, I had two definite roles in the hospital (one in conflict with the other), which were cyclical, changing and evolving through "...shifts and adjustments connected with conflict, competition, exchange, communication, and the exercise of power" (Moore, 1978:46).

Although both my roles emerged interactively with others, it was in the case of Dr. B. that both our role sets were most apparent. The doctor's role was one which oscillated between an authoritarian figure at the beginning, to one which was more and more indeterminate, as the auxiliary attempted to form its own norms (Robert's Rules of Order), and struggled for semi-autonomy while embedded within an authoritarian and hierarchically ordered medical care system.

In the description of the setting up the hospital auxiliary Part A of Moore's framework is appropriate; and its application can be shown very clearly with respect to the movement of the Red Cross woman from her role as volunteer/employee to volunteer. Similarly, each woman who joined the auxiliary moved from her roles and statuses outside of the auxiliary to A(a) a new role in it, and was involved in A(b). Although it applies to all the members of the auxiliary, Section B. of Moore's model, that of changing of norms and of social/cultural regularities fits clearly with the movement of Indo-Fijian women from their traditional place in their culture to take on new roles B(b). Thus norms governing their roles were changed in the process. It also shows the movement of the nursing or medical staff, from the norms and regularities of their positions in the determinate medical system to an indeterminate social form (the auxiliary structure) which was attempting to move to determinacy ("the generation of
social forms where they did not exist before...”). Furthermore, for each group the process involved B (b).

Section B. of Moore’s framework analyzes “changes of norms and of social/cultural regularities”. The auxiliary was an indeterminate form moving to regularity or determinate form. It was generative and new norms were being formulated and implemented. I have documented the struggle of the auxiliary to keep from being submerged in the authoritarian normative rules of the medical system. The struggle involved in the introduction of Robert’s Rules of Order, to replace the autonomy of powerful individuals, was a move in that direction. The attempts to incorporate the auxiliary as a non-profit society, the side-stepping of the issue of obtaining the permissions from the Hospital Board of Visitors, while inviting them to send a member to our meetings, and refusing to have a narrow mandate for the objectives of the auxiliary, are obvious examples of sections (a) and (b) of part B. of Moore’s framework.

The use of norms to guide decision-making and choice are illustrated in Dr. B.’s reluctance to allow incorporation of the auxiliary. She invoked the rules of the Ministry of Health to block the achievement of semi-autonomy of the emerging institution. She could have decided, with the authority she had, to make any number of other choices and decisions (i.e. to not intervene at all, to disengage herself from comment on incorporation, or even to approve it as if she had the authority to do so).

As Moore (1978:211) states about judges, people in the position of power and authority “...have very wide opportunities to make choices in deciding cases. Yet they almost invariably explain their decisions as if there were no choice, as if the decisions followed inevitably from the very existence of the norms cited”.

Two people in positions of authority and power in this extended case study utilized the same normative structures of the Health Care System in entirely different ways. The SDMOs both allowed the auxiliary almost complete freedom to work as a semi-autonomous social form
trusting the women who were leaders in the volunteer organization to set the appropriate boundaries. They seldom intervened. Dr. B. interpreted the same norms as a way to impose restrictions on the emerging auxiliary, to control it.

A multitude of processes are apparent in this extended case study; I have chosen to point out a select few. Like Moore, I view structure and process as mutable, and social reality as indeterminable although transformable into determinable form for a time, through processes of regularization. The Sigatoka District Hospital Auxiliary is illustrative.

Armchair Reflections of an Anthropologist (post-fieldwork)

Fieldwork came to an end in May, 1986. Two weeks prior to that I disengaged myself completely from the hospital work in order to do archival research in Suva and to prepare to return home. I had left the auxiliary work with some reluctance, a little earlier, disengaging slowly by not attending the clinics, and by telling people my work was finished. The women in the auxiliary had a tea for me and presented me with several gift souvenirs. There were several other teas and friends arranged dinner parties for my farewell.

Initiating the SDH Auxiliary (for which I am still nervous about claiming credit), has been one of the worthwhile, but frustrating experiences of my fieldwork. Interpersonally it gained me friends, and I think, made some people very angry at me. Overall, it was successful at that time. At the very least, it broadened the lives of a number of women volunteers, as well as touching those of the women whom they attempted to help. I say attempted to because for the most part, I did not measure the success from the perspective of the patient. I do know that the clinics were a much more kindly place. In the Delivery room several women delivered their babies without fear, using the breathing techniques we taught during the exercises. They were pleased with their own success. The nurses expressed satisfaction because they could communicate better with the delivering mother, telling her when to push and when not to.
I know that the District Nurse and the volunteers from "my" rural settlement continued as volunteers until Anju was to be married in the fall of 1986. She wrote to me to tell me she had had to leave the auxiliary sometime prior to her marriage to make all the preparations. The other young woman from the settlement stopped as a volunteer because she and her husband and child moved from the area. The young Muslim Gujerati woman from New Zealand and her husband left the auxiliary to move to Ba.

The expatriate oriental midwife (L.) came to visit me in Canada in March. She is vivacious and full of energy. She and H. have had their differences and are less friendly now. She and Mrs. J. are good friends and together have covered sixty mattresses in the hospital, after first cleaning them and airing them. Not a small achievement for two women. H. has quit the auxiliary, the members of the auxiliary were angry with her for not providing up-to-date treasurer's reports which were asked of her. (She has subsequently married the man she was engaged to in Fiji and is now a resident.) As L. has told me, at the moment the auxiliary is at its lowest ebb. And the final blow might be when L. leaves in April - her husband, an employee in the tourist business, has once more been transferred. The Rotary club has not notified me of the state of the proposal for which I had such high hopes. L. does not know its current status. Still, when L. was in Canada, she told me that SDH has received monies from a charitable organization in Australia (The Good Samaritans), who had been approached by the Surgeon at SDH.

Dr. B.'s husband has also been transferred to another town and she will in all probability be moved to the Divisional Hospital where her exceptional medical expertise will be utilized more fully. Her medical competence and dedication to the field is probably unrivalled in the country. As a woman gynaecologist and obstetrician she is perhaps amongst the best in Fiji. As a woman specialist she is consulted by many women who otherwise may not want to be examined by a male doctor. She is usually a great help and kindly shares her medical experience.
This "intervention" and the interactional and processual description of a small group and its struggles shows her as a person who is a skilled, dedicated professional woman who uses many strategies in her interactions with others. She is an admirable woman in a Third World country where access to the professions is even more difficult for women to achieve than in the West, and the personal costs greater. I hold her in high regard as a woman, as a professional person.

L. told me that the Coral Coast Festival to which she gave so much effort, returned about two thousand dollars (not a small achievement, and what I expected) of the expected 50 or 60 thousand the men had expected to earn (which was unrealistic).
Footnotes:

1 This area is used by the doctors as their 'space' - there is a desk with a phone, and several chairs. It has a small room with a bed, lockers and a wash basin off it, which is used by the doctor on call who often stays overnight. (A door opens off this office space to allow entry into either of these areas.)

2 I could only surmise that the reason why she had a negative view of the volunteer group was because she had not been able to successfully work within the organizational structure of the hospital, and had left it to work with the public health nurses in the Medical Center.

3 This woman and her husband (an man with a degree in Agriculture) have become permanent residents of Fiji and have begun a developmental agricultural project with some Fijian villagers.

4 Roko Tui is defined by Dr. C.S. Belshaw, in Under the Ivi Tree, (1964:21) as: "The head of administration [of a Fijian Province] is an official of Fijian birth, the Roko, who is sometimes advised ...by a European District Officer, who is responsible for the supervision of the whole population of the area." He states that the Fijian province has "... no administrative responsibility for Indians or Europeans."

Macnaught (1982:xiv) defines the term as "...government title of heads of provinces - in some areas also a hereditary title". Writing about the problems of development, Macnaught states the Rokos had lost much of their traditional power by the post-war period (1950's), "...at provincial level with a siphoning of power from the Rokos and District Officers to powerful District Commissioners responsible for four or five provinces, so that, for instance there was little the Roko Tui of Nadroga and Navosa could do without reference to the District Commissioner Western at Lautoka".

Macnaught identifies the work of Belshaw (1964, 1965), and Spate (1959) as amongst "the most influential publications of 'the development writers' " (Ibid:189).
Chapter 16

PROCESSES AND INTERACTIONS:

The Western Biomedical System

Part III presents the descriptive analyses of processes and interactions in organizations representing the Western Biomedical Model.

In this chapter I draw some general conclusions arrived at from Chapters 10 through 15. This is perhaps most clearly approached by writing about various themes (or variables) that emerged as I presented the data.

But prior to that, there is an important and fundamental change in the interactions and processes observed in the work written about in Part III. Whereas in Part II, ethnic relations of importance were those within the category "Indo-Fijian"; in Part III, (a) they are between Indo-Fijians, (b) between Indo-Fijians and Fijians, and (c) between Indo-Fijians, Fijians, and "others". Thus, ethnicity took on added importance in this part of the research.

Throughout Part III, the recurrent themes which run through the whole presentation of processes and interactions are those of communication and knowledge, prior experience (socialization, familial influence, education) expressed as values, ethnicity, power
relationships; social and economic incentives and constraints. The processes and interactions observed here are those between lay persons seeking health care (the patient role and the therapy management unit), and the practitioners who diagnose and dispense care (doctors and nurses). These illuminate cultural aspects of interactions and processes in which patients must learn the appropriate way to negotiate their way through an illness and to respond to therapeutic interventions suggested by physicians and nurses.

In order to draw conclusions from a vast amount of data, I ask the reader to recall Moore's explanatory framework, used in the last chapter. There, I discussed my role as an anthropologist with respect to the formation of the hospital auxiliary. Now I pick up that thread in this one and write about two primary roles, those of Indo-Fijian patients and doctors (or nurses), as they interact during diagnosis and therapy in the biomedical health care system. In doing so, I treat the roles as ideal-types in order to rise above the empirical level and to be able to generalize from the five chapters above, which are entitled The Biomedical System.

The following structure will be helpful in organizing the data. I will discuss the relevant roles and factors which influence their formation. Then, the values present in the roles and their origin will be discussed. If I ask How does communication take place? in each context, that will allow for a discussion of interactions and processes in terms of the transactions and exchanges which take place. By doing this I can also account for the variations on the many themes which can be drawn out. Finally, the general and interpretive implications drawn from this analysis will be presented.

Illness is an event which is regular and recurring and because it circulates among the people in a population in a cyclical fashion; the role a sick person takes in most cases is but one aspect of a person's statuses in the culture. Becoming sick and "a patient" is one of the most anxiety producing and disruptive of roles so people have a repertoire of behavior patterns, or modes of relationships, with which to confront the changes induced by the sickness event. Within
the total sickness event, the other role of import is that of the healer, in the biomedical sector, the doctor whom the patient (sometimes accompanied by the therapy management unit) consults to alleviate the distress.

In general people try to return the situation to its former state, or if that is not possible, to encapsulate the change (the new status) and make it part of the new life structure. In essence then I argue that this process illustrates Moore's "processes of regularization" and "processes of situational adjustment", and illness is the factor which makes life indeterminate.

In the following, I discuss the roles first of the doctors and then those of the patients, and the factors or variables which directly affect interactions and processes involved in the treatment of patients.

The interactions of medical personnel with each other are hierarchically ordered within the SDH, as well as between various levels of doctors (the role holders) within the three levels of biomedical institutions depicted in the organizational charts (Table 3.1 in Chapter 3, and Tables 11.1 and 11.2 in Chapter 11). Thus, there is competition within the medical profession for tenure, scholarships, and to secure information with respect to advancements.

I have mentioned above that a system of patronage exists between the upper echelons of the medical system, i.e. at the level of Ministry of Health and specialists, and the younger doctors low in the hierarchy. This situation produced long term asymmetries; the transactions showed how prestige (the younger doctors look up to and ask advice and aid from those higher in the system) is exchanged for assistance in advancements and for crucial knowledge. I showed the relevance of Gellner's arguments (Chapter 11, pp. 243-245) to these observations.

Ethnicity (religion, language and other cultural differences such as diet, costume), and residential status in Fiji, are two other factors which operate in the interactions and processes between doctors mentioned above (Chapter 11, p. 247, and Chapter 12, pp. 271, 274, 294). These processes are more apparent in the work milieu, in the everyday interactions at the area
level hospitals, with which this thesis is most concerned. There, while Indo-Fijians and Fijians compete with each other for positions, they both compete with and resent to some degree the expatriate specialists who receive the more prestigious jobs and salaries, as well as the benefit of superior accommodation and other privileges which accrue to those with higher status.

Time management is structured by the hospital administration and directly impinges upon the interactions of doctors and patients. Nurses vie for certain shifts of work or for time off, and doctors are scheduled for work within such constraints of time that they often must be in two places at once. The shortage of staff, both doctors and nurses, makes it difficult for them to give the type of care they would wish. Time management compels them to engage in a type of interaction with patients in which they are rushed, to say nothing of working under stress. This can lead to two effects. First, most doctors in Fiji during the time of this fieldwork (1985-86) were suddenly concerned about litigation. Prior to this, litigation had not occurred with any frequency, and doctors did not fear the outcome of a poorly handled case. Such litigation arises mostly out of iatrogenic effects of treatments in the biomedical sector. Second, there is another type of iatrogenesis which is also an effect of biomedical treatment seeking, and which leaves long-lasting social labels. I have discussed this (Chapter 11, p. 69) with respect to a doctor who felt compelled to secure police protection, against future litigation for non-treatment, or malpractice (Illich, 1976).

In Chapter 11, I have attempted to show that the roles of practitioner and patient are extremely asymmetrical. The physician is an authoritarian figure and the patient is submissive and dependent. The degree to which this asymmetry operates depends, first, on social factors such as ethnicity, sex, class, educational level and language of the interactants. Its behavioural manifestation is the "social distancing" that a physician maintains from the patient, that is, beyond that of the detached concern that physicians are socialized to learn in the treatment of patients. During the socialization of a doctor a certain "attitude", that of detached concern,
focuses his or her attention to the pathology (the voice of medicine), and away from the situational social contexts of illness and the "voice of the life world" (Mishler, 1984:14). Second, it depends on the structural constraints in the institutional setting. Factors such as large numbers of patients in OPD and the clinics mean that physicians cannot spend more than a few minutes with each patient. In those few minutes they must communicate with each other sufficiently to enable the doctor to diagnose and treat the patient's discomfort. In Fiji, there are barriers to communication and understanding not only of languages, but of dialects within language groups, as well as the cultural barriers created by having different conceptions of bodily anatomy and causation of ill health and disease.

I have shown that the role of the doctor is fashioned through education in the biomedical scientific tradition, and in terms of its value structures. This gives doctors a power through their specialized education which the lay person does not have, a factor which conditions interpersonal relationships; interactions between doctor and patient therefore are in a dominant/subordinate form.

In general, within the biomedical system, power is held by the physicians because of their status and ethnicity as well as by their knowledge of medicine. Patients by contrast do not have power, but are stripped of their power with their clothing. Their naked bodies, and custodialism in the hospital, emphasize the powerlessness of the patient. And this is even more marked in the case of the socially disadvantaged patients, the poor and elderly as well as those classed as "social problem cases". In the latter cases, the role of the doctor is ambiguous for most doctors do not want to deal with the social context of a patient's life.

Within the biomedical system, the nurses face most of the same problems with which doctors contend, competition, and a hierarchical system which leads to patronage for privileges, although recently unionization has helped to regularize the bureaucratic system, so that patronage is less evident. Nevertheless, in a bipolar state such as Fiji, there is immense
pressure applied within the same ethnic group, upon those who control the access to resources for advancement, and there is a system of patronage. At the area level, nurses work under the direction of doctors and they often concretize the differences between doctors, by helping to keep the differences alive. Thus the hospital has numerous factions. I have shown how staff are torn by divided loyalties, how for each type of issue or problem, there is a new alignment of people (see Chapter 12). People join forces perhaps on ethnic lines, or on the basis of unions, geographical divisions, as well as many other types of variables which polarize and help groups to emerge.

In the thesis, I elected to focus research on how Indo-Fijians use the facilities of the Sigatoka District Hospital. Indo-Fijians also consult private physicians in the town. I was unable in the time I had for fieldwork (exactly one year), to add research among privately practising Indo-Fijian doctors. My permission from the Ministry of Health did not include private practice, and to get permission from each doctor, and to have added that dimension, would have taken an inordinate amount of time. As a consequence the thesis lacks that aspect of the biomedical system. The data I have obtained would have been impoverished to the extent that extra travel and the logistics of making other research arrangements would have entailed (and for uncertain returns), had I added private practice.

The Role of the Patient

The formation of the role of the patient begins when the patient whose illness is legitimized by the therapy management group seeks therapy in the biomedical sector.

The illnesses for which Indo-Fijians seek biomedical therapy are primarily those with a "natural" causation, and which are acute rather than chronic (although some of the latter type are also presented at the hospital of course). In previous chapters, and especially in Part II, the decisions and choices Indo-Fijians make about the locus of seeking therapy have been discussed;
thus here I write only about how patients interact, and the process of treatment after the biomedical sphere has been chosen.

The role of patient as described in the OPD (Chapter 12) shows there was little time allowed for interaction with the doctor. Barriers to communication such as language differences, and lack of knowledge about physiology meant that a patient could not explain symptoms in a way that made sense to a doctor. Diagnosis was carried out most effectively if the patient exhibited empirical symptoms, pain, coughs, fever, rashes, boils, lacerations, etc. When patients presented chronic ailments, they often did not receive the treatment they usually expected. Most often they were given analgesics to relieve symptoms, and not the cures they anticipated. Thus from the perspective of the patient, the doctor did not comply with the expectation of the patient.

The role of "hospital patient" implies many values, all discussed many times in the chapters above. Here they will be given brief mention only. First, Indo-Fijians do not relinquish custody to the institution; the patient is accompanied during trips to the hospital by an "escort", a member of the family, or a friend. Once admitted, the patient can be sure that a member of the family or a friend will not be very far away; rarely is a patient left alone for any extent of time. During visiting hours, it is Indo-Fijian custom to show solidarity and caring by attending at the bedside of the sick person. This process affects the functioning of the hospital organization, and doctors, nurses and staff make accommodations to incorporate the style of interaction Indo-Fijians carry out.

Other than in OPD, most of the patients I observed were women, some who were pregnant or who had just given birth, others in gynaecological clinics, or Women's ward. Research focusing on male patients was more limited.

The Indo-Fijian woman who is having a child or who is sick often lacks knowledge about the physiological types of knowledge and explanation in the biomedical sector. Consequently, she is disadvantaged in understanding the language of doctors and nurses, and in the ability to
communicate her symptoms, bodily states, and her concerns. Due to hospital time management practices she is not always able to elicit the type of interaction with doctors or nurses which would most effectively help her. (In this respect, the formation of the hospital auxiliary was helpful. It provided education for women about birthing and exercise as well as nutrition, breast-feeding and other processes.)

It seemed to me that because of the fact that pregnancy is treated as an illness in the biomedical system, contrary to Indo-Fijian beliefs, it does become transformed into a medical condition through the process.

The patienthood of Indo-Fijian women is completed through vaginal examinations, pap smears, folic acid and iron tablets, blood tests and other technical procedures—women start to feel like patients through this process. It continues through the family planning clinic, where medical procedures are needed to insert I.U.C.D.s and for TLs or for injections of Depo Provera. The technological procedures are vastly different from the warm oil massage, touch and verbalizations of the traditional dais (discussed in Part II). A woman's self is restructured through the hospital context, to patient status.

The patient role in the labour and delivery rooms and the interactions and processes showed a greater empathy and caring from biomedical staff than in many other aspects of hospital care. (See Chapter 13, p. 30 ff) Here, the interactions and the process was warmer and nurturing. The pregnant woman had usually been to see the same doctor and staff for a few months and they were able to at least recognize and interact with each other more easily. When the woman went into labour and was admitted to the hospital, she was part of a solidary group of women who were there to accomplish the birth together. The pregnant woman relied on the staff to get her carefully through a risky procedure without harm. There was genuine caring through touch, eye contact and verbally. Even if she transferred from another hospital at the end of the
pregnancy, to deliver at SDH, the staff were kindly. From attending ante-natal clinics the woman already had some idea of the process that would be followed.

The greater ease with which pregnant women took the patient role was partially situational, because women were helping women in a process where communitas was possible. (Chapter 13) I have remarked above on the types of interactions such as eye contact, birthing talk, instruction, holding hands and rubbing or patting of the pregnant woman's stomach by the nurses and the doctor to encourage and to show empathy, which occurred. The caring shown in the Obstetrics ward when the nurses and the doctor taught the new mother how to breast feed her infant, or alleviated the concern of a young mother with an infant in the incubator all point to the other side of biomedical practitioners, their more humane side. Nurses, and the obstetrician, working in the Labour, Delivery, and Obstetrics wards were more concerned with the situational side of a new mother's life. The doctor refused to allow a new mother to go home if her good health or that of the child was the least in doubt (Chapter 13). Frequently, a baby with a rash was kept for the extra day and the mother shown how to take better care of herself and her baby.

The patient role in the Obstetrics ward was also one in which women received the most instruction, usually all together since the ward was a small one, and the interactions with the doctor heard by all. Thus each 'patient' learned about family planning, and the circumstances when one type was better than another.

The exchanges or transactions with the doctor were often less asymmetrical, as she told of her own pregnancy and shared with the women, her own experience. So that some pregnant women moved easily through the role of patient to that of a mother, a new status from the one prior to the event.
General comments

The interactions and processes in the biomedical system in Part III, revealed that each ethnic group has a different level of tolerance for pain and a different response to the onset of illness. Indo-Fijians have a low pain threshold and want analgesics and injections for relief from pain as soon as possible. When ill they diagnose illness within the home and they seek treatment that is illness-specific. For acute illness, they invariably go to the physician, whether in private practice or in the hospital for treatment. This does not mean that they do not go concurrently to other sources of therapy as well, for they often do seek treatment for different aspects of one illness from a variety of healers, both in the traditional sphere and the biomedical. Some patients go to both the private physician and the hospital, for treatment in the biomedical system alone, as well as to the orjah for treatment of psychological unease caused by illness. Thus, healing is both illness-specific and at the same time, multiple therapy systems are in use for some aspects of the same illness. (Example 9 on page 268-69 is an example of this usage.) This example also shows how the socialization process of doctors leads to the decontextualization of illness. A psychosocial approach to healing, which is being advocated more and more in professional medical schools, will allow a greater depth of understanding of cases such as these.

Doctors do not know or appreciate the alternative therapies which their patients use. If they gave more attention to the beneficial effects of such therapy, and elicited comment from patients about the reasons for its use, they would learn that patients feel these therapies are a necessary adjunct which relieve some types of problems which the patient cannot present to the doctor, but which are sometimes somatized and presented as physical ailments. Patients know they cannot tell the doctors about alternative therapies. Many seek therapy from more than one doctor, and obtain prescription drugs from each, as well as using home remedies. Doctors prescribing medicines to such patients do not usually know if they are already taking other
drugs which may be contra-indicated. A particularly telling example was provided in the instance of the abortion in Chapter 13, p. 327-329. Research in other countries shows that some home remedies are also reactive with pharmaceutical products. I have mentioned this in Chapter 13, p.368, footnote 16, with regard to diabetes.

Inter-ethnic interaction between physicians and patients frequently reverberates with ethnic undertones which although submerged show that each of the two groups has a negative stereotype of the other. Physicians and nurses of each ethnic group sometimes play off these stereotypes in their interactions with each other. How much that affects their interactions with patients of the 'other' group can only be suggested here as notes for further research.

Communication is sometimes a problem, in spite of the fact that all doctors speak a little of the other language. Intra-ethnically, language can be used to invoke social distance. To speak Hindi to a patient who speaks only the vernacular is one way to show superior status and to keep patients from becoming too familiar or dependent, as well as to limit the time a patient takes interacting with a physician.

Communication is hampered too, because patients lack knowledge of bodily processes and anatomy as conceptualized in the biomedical system. Patients cannot always understand the cause of the illness as a doctor describes it, and they cannot describe their symptoms in a way that doctors can understand the condition. Oftentimes, for lack of time and because the patient does not understand the biomedical conceptual framework, doctors do not tell the patient the diagnosis, but tell the patient what to do to treat the unwell state, prescribing medication. Patients do not understand that medicines cannot be combined and some will visit a second practitioner, get a second prescription and take both medications at the same time.

Those women with social problems are the extreme case because they are also further stigmatized as society's misfits who are contacted by the police in the interests of the protection of the social order. It is quite apparent to these women that the doctors and staff do not
appreciate the forms they have to fill for the police or their interaction with them. And in actual fact, their degradation becomes public property through the institutional means of their physical "protection" (Chapter 13). As I have discussed, Illich calls this social iatrogenesis.

Part III, the Western Biomedical System has been treated here as a separate medical system. But the division of the health care system of the Indo-Fijians into the traditional and the biomedical is a heuristic device; I do not think Indo-Fijians conceptualize seeking health care in this way. And I never heard them talk about different systems of health care. They seek care from the totality of health care alternatives about which they know—which makes up their health care system.

Landy defines a society's medicine and its medical system (1977:131):

A society's medicine consists in those cultural practices, methods, techniques, and substances, embedded in a matrix of values, traditions, beliefs and patterns of ecological adaptation, that provide the means for maintaining health and preventing or ameliorating disease and injury in its members.

In Part II, I have partially provided this matrix for the Indo-Fijians. Part III augments those data with my observations of the usage of the biomedical system by the Indo-Fijians. In it I have described the hierarchical structure of the biomedical institutions, and the personnel in them, utilized by the Indo-Fijians as they use various strategies to seek cures for illness. These two sub-systems make up the medical system of Indo-Fijians. According to Landy (Ibid:131) a medical system is:

...the total organization of its social structures, technologies, and personnel that enable it to practice and maintain its medicine (as defined), and to change its medicine in response to varying intracultural and extracultural challenges.

In all of this (the medical system) "...we observe the close ties that bind these medical systems to other aspects of the cultures and social systems of which they are elements" (Ibid:132).
I was told of at least three cases of litigation due to malpractice. One in the Divisional Hospital in Lautoka involving an evacuation procedure, one in SDH about which I could not find out anything. Another, in SDH, which staff were talking about at the end of my fieldwork, was about to go to the courts. During tea time Doctors often talked about various cases of litigation in other hospitals which involved doctors whom they knew. In addition, the SDMO discussed it at one of the staff meetings.
PART IV
Chapter 17

THE CONCLUSION

INTERACTIONS AND PROCESSES BETWEEN

ALL MEDICAL CARE DOMAINS

Preliminaries:

The task of this research has been to address the question posed in Chapter 1 which is the following. What are the interactions and processes with regard to the phenomena of illness, disease and therapy within and between, a) the Traditional Medical System, and b) the Western Biomedical System, in the lives of Indo-Fijians in contemporary Fiji? The question was posed in order to understand and explain the dynamics of the plural medical systems which make up the medical system of the Indo-Fijians in Fiji.

In this concluding chapter this question forms the basis for the review of the interactions and processes in the two medical care systems postulated in the research question by focusing on:

a) processes of communication and knowledge (i.e. transactions, exchanges, cooperation, competition, power relations, consensus and conflict, etc.)
b) processes of patient diagnoses, (i.e. decision-making, choices, where does the knowledge to evaluate come from and how is it used?), and

c) the therapeutic process (i.e. are the decisions based on consensus or do other factors [structural relations] enter into the decision-making? On what values are the decisions and choices made? How is the decision-making process transacted? Routine decisions? Emergency decisions? Consensual decisions? Decisions out of conflict and debate? What are the incentives and constraints [normative rules, resources, costs, incentives, rewards for compliance, pragmatic consequences] on seeking health care? What processes are involved in the patient's handling of advice and medical directives?

The key questions which flow logically from the research question are the following:

1. What recurring social processes are revealed? What conditioned them? What roles?

2. With whom does the person experiencing symptoms of illness first interact to communicate about it?

3. Who diagnoses and legitimates the sick role, and by what process?

4. Who interacts to decide on therapy and how do people arrive at their decisions and choices?

5. What are the alternative strategies and procedures that exist in seeking health care? What qualifying conditions help to establish alternate goals?

6. What factors external to and/or internal to the therapy managing group, not mentioned in the above questions, condition the influence the choice of healing system utilized?

7. How does the settlement (community) influence the strategies and choices? (political issues).

These questions are congruent with the analytic framework abstracted by Moore (1978:46) from the work of Nadel, Firth and Barth suggesting "...certain gross classifications of processual studies". Recall that in the portion of that framework, (presented in Chapter
15:444), Part A involved events, repetitive or cyclical, implying "...shifts and changes of relations between or among particular persons:

a) temporarily occupied roles.

b) shifts and adjustments connected with conflict, competition, exchange, communication, and the exercise of power".

The research began with the assumption that there were two main medical systems, the Traditional system of the Indo-Fijians, and the Western Biomedical system introduced during the colonial period by Europeans. I hypothesized that the Traditional medical system of the Indo-Fijians would consist of some aspects of the professional medical systems of India such as Ayurveda, Yunani or Siddi, with elements of folk traditions such as home remedies and recourse to secular, religious and magico-religious healing. A related assumption was that during the long period of contact with the Fijian tradition in herbology and massage, there would be some syncretism of elements from it apparent in the medical system of the Indo-Fijians. Finally, there would be a strong reliance on the governmental health care system of the country, the Western Biomedical system. I have hypothesized that the health care system as utilized by the Indo-Fijians is the result of processes of social interaction and historical development. We will see below how these assumptions fit my findings.

In Chapter 1, the concept of values was explained as fundamental to how people make decisions and choices, based on cost factors (including time and other material and non-material elements), to achieve certain valued ends or goals. That discussion too, informs the analysis presented in this concluding chapter. Before that however the following paragraphs provide the main concepts and fundamental ideas relevant to health care of Indo-Fijians.

To recapitulate, in Part II I showed that Indo-Fijians classify their medical world into bimar or "illness", the experiential or individual and the "societal reaction to disease"; and bimari or disease which "denotes a malfunctioning in or maladaptation of biological and/or
psychological processes" (Kleinman, 1978:85). Bimari is also used in the sense of “sickness” in Frankenburg’s model (Chapter 1), “to apply to the total social process in which disease is inserted”. (The Hindi concept of rog or disease, and rogi which means literally “the diseased one” or patient, were not used in everyday language by the Indo-Fijians of this study.) Thus the Indo-Fijian concept of bimari, or illness is used in the sense of both physical and societal disruptions which affect tundroosti. Recall that tundroosti is cognized as good health encompassing the Indian world-view, religious practices, and a holistic concern with the psychological and physical well being.

Indo-Fijians refer to healing as ilage, without regard to the arena in which one seeks it. The word is also used to mean “cure” or “remedy”, such as when one asks, “Is there a cure?” or “Is there a remedy?” When used with the verb form karo (to do), the meaning becomes “to do a cure”, or “to do healing”. These three words, bimar, bimari, and ilage can be glossed by the words: sick, disease; and cure (therapy), remedy or “to cure”. Interestingly, therapy is referred to as the kum or work (occupation) of certain healers, and some illnesses are healer specific. I think this conceptualization which links occupation strongly with certain roles is also related to ideas about caste-linked occupations (i.e. the dei role was always one of a particular lower sub-caste in the Indian hierarchy and had specific functions such as washing away the pollution of childbirth, as well as the work of assisting in the birthing itself.)

In the chapters on Traditional medical care practices I discussed wellness (tundroosti), minor illnesses treated within the home, barrenness, menstruation, pregnancy and birthing, and the possession types of illnesses with supernatural causation. Tundroosti was discussed at length because it codifies Indian ideals (norms and values), and the social action necessary given these beliefs, to maintain good health. We discovered that Indo-Fijians treat an extensive list of minor illnesses within the home, and utilize many home remedies (ghar dawai) for them.
An important aspect of healing, and of showing nurturance is tactile and oral. Touching, massage, preparing special medicinal preparations, preparation of foods for dietetic and ritual purposes, and preparation of oils, threads and amulets, as well as bathing and aromatic heat treatments are also therapeutic. Foods used in religious healing ritual are offered to deities and consumed as sacraments, communally by the social network of an individual. Verbalization is also an important way in communicating caring to the patient. The sick individual hears the family consulting one another about aspects of the illness and suffering, and from their evaluation, learns whether taking the sick role is appropriate. The patient feels his family care, that they are actively engaged in alleviating the disease. In the process of diagnosis a network of kinsmen (in the case of married women, both patrilineal and affinal) and friends come together, often resolving their personal differences to seek therapy and to restore the sick individual to the normal role in the social group. Although consensus about causation and healing are important, at times the therapeutic process will proceed along divergent paths, as affinal and lineal kinsmen of a woman take separate action which they think is appropriate given their diagnosis. Thus, there may be simultaneous use of several types of healers for an illness episode.

Indo-Fijians think of menstruation as polluting because of its association with the discharge of blood, and they think of it as bimari (illness). Even though there are very few home remedies for relief of menstrual problems and discomfort, Indo-Fijian women seek some treatment from the dai in the Traditional Medical sector.

In the Traditional Medical system pregnancy is not considered bimari, as a consequence within the Indo-Fijian household the sick role is rarely legitimated for the pregnant woman and she continues her normal work functions. But the role is accompanied by many proscriptions and prescriptions (ideals) for maintaining good health. Indo-Fijians believe the process of birthing is polluting and the end result of it is weakness, which if it is not treated with proper
rest and diet, will result in illness. As a consequence Indo-Fijians give women a great deal of post-partum care such as special diet, heat treatments, massage; and general nurturing care for mother and child.

As with Indians in general, Indo-Fijians consider barrenness as misfortune rather than an illness. But they believe a woman may be barren as a result of the efforts or effects of supernatural or human agents through envy, sorcery, magical practices or because of Karmic influences, or living in inauspicious places. Indo-Fijians treat barrenness by consultation with healers, thus by implication it is bimari, although the person does not take the sick role. Generally, barrenness is so disruptive of social processes that people seek remedy through recourse to all avenues of treatment. Continuing inability to fulfill the reproductive role and societal expectations often leads to psycho-social maladjustment; and women are blamed if they do not conceive. Thus barrenness is discussed here under the rubric of health care seeking behaviour.

In Part III, The Western Biomedical System, I discussed the processes and interactions in the Outpatients' Department, Labour and Obstetrics Wards, Women's Wards, in a number of hospital clinics, and in the District Nursing Stations. In addition, I examined an 'intervention' in the formation of a voluntary organization, a hospital auxiliary.

Paradoxically, I found that barrenness, pregnancy and birthing are treated as illness in the Western Biomedical System, with tests (urine, blood and blood pressure, scans, etc.), clinical appointments (at set intervals depending on the gestation period or problem), treatments (folic acid and iron tablets, etc.). While menstruation is not treated as an illness in the Western Biomedical system, Indo-Fijian women seek treatment for menstrual disorders in far greater numbers than any other group in Fiji. This is congruent with their traditional view that menstruation is illness. I also discussed social problems such as battered wives, cases of attempted suicide, and accidents.
Now, after a short explanation of the use of some terms, I go on to draw the conclusions from the data based on the specific processes of interest and using the framework of key questions listed above.

In this discussion when talking about social interaction, I mean role relationships and consequently the influence that individuals and groups exert on each other as they attempt to achieve certain goals. This striving behaviour is disclosed or revealed empirically by its influence upon roles, positions (statuses), and moral norms.

Any social situation or context reveals a multitude of processes, and any social interaction can be identified with more than one process and goal. In this part of the thesis I keep at the forefront those social processes and social interactions which allow the abstraction of generalizations about health related behaviour and systems. Throughout, however, other processes will perhaps be mentioned which take place in the social milieu but which relate to the primary processes of interest (i.e. process of transaction, negotiation or exchange). Now, I proceed to answer the questions posed at the beginning of the chapter.

1. What recurring social processes are revealed? What conditioned them? What roles are present?

In answer to the first of the key questions above, the influences or interactions revealed are those which are clearly related to health care: illness, disease and therapy; and are apparent in the social processes of communication, diagnoses, and therapy.

I conclude that the process of communication is inextricably involved in the exchange of mediated information about events; it is both factual and evaluational; and encodes social control and power. Paine (1976:65) explores the meaning of transactions as communicative events, and states that value is "contextually perceived" so that in a transaction a message is transacted between senders (i.e. patients) and receivers (i.e. healers), and is often mediated by third parties (i.e. therapy management group). This relates to the fact that any communication is a
codification of information and can be an instrument of social control. An important aspect of such exchanges is how power is balanced in such transactions. Paine states: "...when engaging in exchanges persons are concerned to render them intelligible". In exploring his premise, two analytic connections have been paramount: (1) between exchange and communication—how a person renders his own exchanges intelligible; and (2) between these and power—how another person imposes "intelligibility" upon one's exchanges" (Ibid:81). The implications throughout this study of the notion of communication encoding exchanges, transactions, and mediation is summed in the notion of interaction.

The roles (positions or statuses) and interactions (role relationships) of interest are those of and between, patients, diagnosticians (parents, siblings, spouses, affinal and lineal relatives, and unrelated social networks; and importantly doctors and nurses in the Western Biomedical system), and healers (in the Traditional and Western Biomedical health care systems). Roles are discussed more fully in a later section of this chapter.

Broadly, I have shown that the processes and interactions are conditioned by goal-seeking behaviour related to illness, disease and therapy and constraints and incentives derived from a) Indo-Fijian values, and norms (the ideological component); and b) the reality of the social, economic and political, or situational context.

Indo-Fijian values and norms are codifications in Hindi concepts such as tundroosti. I conclude that although the professionalized systems of medical care from the Indian continent such as Ayurveda, Siddi and Yunani, do not exist in Fiji, still the beliefs and practices represented in the concept of tundroosti (wellness) encode ancient ideas, some of which are from Ayurveda and are pan-Indian (including Overseas Indians).

That these ideas are fundamental to an Indian world view is suggested by Kakar (1982:220):
Reading the Ayurvedic texts, I cannot help but marvel at the process which has transformed instructions from ancient doctors on the grooming and care of the body, dietary prescriptions for different seasons and times of the day, on proper exercise and conduct, as unquestioned and unquestionable articles of faith for countless generations of men and women who were born, grew-up and died in the fold of Indian culture.

Furthermore, he states:

Since Ayurveda has dominated the medical traditions of all South Asia and, to a lesser extent, Southeast Asia, Ganath Obesekere has suggested that this unity may extend beyond the geographical boundaries of India."

I ideas about tundroosti codify many of the Ayurvedic beliefs and values in the lives of Indo-Fijians. At the expense of seeming repetitive, primary among these are notions about purity and pollution; dietary ideas about the hot and cold idiom relating to foods and bodily states; and emotional and affective states such as a calmness, peacefulness, and maintaining harmonious interpersonal relationships. A state of unwellness (illness, or disease) is viewed as due to a departure from the prescriptions and proscriptions encoded for a state of wellness. Diagnosis, decisions and choices about necessary therapeutics are made to correct the imbalanced state. I discovered that Indo-Fijians treat an extensive list of minor ailments within the home, and utilize many home remedies for them.

Recall that ideas about purity and pollution have a powerful influence on the social and religious lives of Indians. And the hot and cold idiom is linked to the health care beliefs of Indo-Fijians. The latter has to do not only with foods, but also with states of the body, weather and emotions.

The traditional medical system of Indo-Fijians consists of the following beliefs. First, that physical, mystical and social and economic factors are interdependent and the occurrence of illness and misfortune may be indicative of disruptions or tensions in social relationships involving moral integrity, well being and harmonious living. Second, man's relationships and actions in past lives and in the present one, influence outcomes and goals in everyday life and rebirth in future ones (the Karmic beliefs). Many of the factors contributing to the anxieties
and stresses which lead to states of unwellness, and exacerbate illness, are those found in this belief system (the ideological component) and its practices and are expressed in disjunctions in Indo-Fijian social structure and social organization. I have mentioned them in the relevant chapters above, and will bring them up more specifically with relation to each key question to which they apply in this conclusion.

Other factors are those found in the social conditions (the reality) in the life of the Indo-Fijians. First those which are political in nature emerge out of their interaction with the Fijian people and the asymmetrical power relations in the structure of an ethnically bipolar state. In day to day life the reality of this situation is submerged in what appears at first glance to be a symbiotic relationship, where Indo-Fijian and Fijian cooperate. The Indian leasing land from the Fijian, in turn hires him as labourer and relies on his work to run the market vegetable farms. The Indo-Fijian teaches the Fijian farming and other skills and gives him extended credit and loans against future work. It seems ideal until we ask the Fijian who is tied to his communal system, envies the individual enterprise and achievement of the Indian. The Indian feels the land and its improvements and his labour requirements are constantly at risk.

Inequity in land tenure leads to insecurity and anxiety over an inability to plan a secure future. I have mentioned problems of land tenure with regard to Nasavu settlement above. Unemployment and education are other sources of unease and tension. Within the Indo-Fijian group disruptions also arise out of their interactions with each other as communal groups with different origins in India: North and South Indian, Nepalese, and Muslim. These conflicts emerge in economic enterprise, religious beliefs (Hindu/Muslim), intermarriages, political and educational structures, etc.

These then, are some of the factors which condition the recurring processes and interactions with regard to the phenomena of illness, disease and healing in Indo-Fijian life.
2. With whom does the person experiencing symptoms of illness first interact to communicate about it?

Once the patient is conscious that something is wrong and is experiencing illness, the "making social of disease" (Frankenburg, 1979:199), is the first phase of the illness, disease and therapy syndrome or process. Among Indo-Fijians the sick person communicates the symptoms and onset of the illness to members of the immediate family, usually a parent (mother), spouse, sibling or other responsible adult in whom the patient has faith (confidence and trust).

In the process of making disease social the individual is subjugating his or her individuality, and making himself or herself dependent on the sociocentric group, the family, for advice, nurturance and healing. As in the settlement areas of this research, dependency on others is a valued state in sociocentric societies such as the Indo-Fijian; the social group is more important than the individual. An illness creates disjunctions in role relationships if the role holder cannot fulfill the obligations inherent in them, necessitating the group to fulfill them. The Indo-Fijian society values decisions made by interactions with family members to reduce risk: and to take advantage of the knowledge and experience of the widest number of kinsmen. Children are socialized to share, to make decisions and choices interactively and they are encouraged to remain integrated within the familial group. Dependency on others in the extended family is viewed positively, and is more highly valued than individual effort, privacy and struggle. In urban areas, and among the more educated younger Indo-Fijians, these ideas do not have the force they once had, but where there still are older family members in the household, the norms are still enforced.

Now, we turn to how illness is made social, through the processes of communication (verbal, symbolic, behavioural) and knowledge. In the following pages more attention is given to the section on the process of communication for it explicates exchanges, transactions and
interactions at the same time that it encompasses aspects of the processes of seeking diagnosis and therapy. I discuss the Traditional Medical system and the Biomedical concurrently throughout.

Mothers recognize illness in infants and young children by symptoms such as irritable and unusual behavior that is out of character for the child, crying in pain, fevers and rashes. They try to recall if there was a sudden onset of symptoms or if they developed over a few days. A young mother will communicate about the illness to her spouse and her mother-in-law right away, and later they may decide to tell others in the household. Usually remedial action is taken in the household by holding the child to comfort it, as well as by soothing through verbal means, massage, feeding, and by encouraging the child to sleep.

Older children and adolescents communicate pain and illness or disease to parents, siblings, grandparents or other responsible adults in the household. Or they may tell a relative (uncle or aunt) in an adjoining compound. Most illnesses are self-limiting and are treated within the household first with home remedies. Any illness which becomes acute or lasts for days becomes the concern of the whole community and relatives and lay persons interact to ascertain the cause, and to decide on therapy.

Communication between the afflicted family and the community may take symbolic form such as when a mother puts smudge marks on the face of her child to prevent a recurrence of nazar and she may put a black spot on her child's forehead so that he or she does not attract attention and an envious 'gaze' from others. These marks are the outward or explicit sign that someone is guilty of envy and that the family is taking precautions against it. The guilty person or persons are made conscious of societal norms that each child is to be treated as an equal within the family; and of the potential of conflict in households where favouritism is shown for one.
The symbolism induces guilt and is thus a form of social control. I have quoted Barth in the Introduction as referring to signs (such as the black spots placed on children (mentioned above) as "...symbols of a communicative code...", and Young (1976:12), who states that sickness episodes have an ontological status. They are a useful way of communicating and legitimizing changes in how social relationships are distributed within a country; and they affirm the society's value system by forcing people to reflect and act on aspects of their social order.

Adult Indo-Fijian women, if young and unmarried, usually communicate illness to their mother or to a female sibling, or to the wife of a male sibling (sister-in-law), or to other responsible adult females in the family. The extent to which disease is communicated in the community, depends on the perceived seriousness of the illness and its potential to affect the marriage chances of a woman. Illness, especially if it is stigmatizing (possession, cancer, T.B., etc.) is sometimes not disclosed beyond the confines of the immediate household.

When a young married women is ill, she usually tells her spouse who communicates the information to his mother, or a woman may tell both her spouse and her mother-in-law. They may tell other adults within the extended family compound. If the illness is serious (acute) or it is incapacitating for more than a short time, the woman's parents are notified and they are consulted about diagnosis and therapy. When sorcery or possession is suspected a woman's affines are reluctant to undertake therapy for her and they usually send her to her parental home for treatment as soon as possible in order to escape blame for her condition. Although they may still be blamed, at the very least, they will have taken the initiative in enabling her family to secure treatment for her. A woman's parents could accuse an affinal group of sorcery if the woman has not conceived or in the case of a woman who has interpersonal problems among her affines and becomes possessed.
A married woman who has children and heavy familial responsibilities cannot usually take on the sick role unless she is acutely ill. Some women may feign illness. I believe that is what happens in the case of illness that is somatized, and which appears to be chronic, rather than acute. Then, treatment is sought from traditional healers. A woman communicates illness to her spouse and to other older female relatives (mother-in-law, sisters-in-law, older daughters). It is rare for an older woman to return to her parental home when ill. By this time in the life cycle her own parents are probably cared for by her brothers and she has sons and daughters at home on whom she can rely. If the illness continues however, and is serious, her parents and siblings are informed, and they can visit, help to diagnose the illness or legitimate the diagnosis and therapy undertaken.

Where an affinal group and a lineal group interact to communicate about an illness, there is always the potential for conflict when the sick role and the decisions and choices about therapy are transacted. Therapeutic action depends upon whether consensus about diagnosis and therapy is reached or not. Where it is not, conflict can ensue unless the two groups negotiate alternative forms of therapy and the order in which it is undertaken.

Older women communicate illness to a spouse, other women in the family (unmarried daughters), or the eldest son and daughter-in-law. The latter are often responsible for the health care of the parental generation. They communicate with anyone in the women's own lineage to whom she is close such as her siblings in other places, other sons and their wives, other older women (sisters-in-law) in the household or relatives and neighbours in adjoining compounds. A woman's daughters who are married and who live at a distance should be told of their mother's illness if it is serious, if it is chronic, or debilitating. It is usual for a daughter to go home to attend the bedside of a sick parent, especially that of her mother.

Communication can also be withheld, as when siblings are jealous of each other's interactions with parents, or when a person has not upheld familial exchanges and interactions.
In a society where all close relatives are expected to attend the bedside of someone who is sick, those who fail to do so are held accountable for their absence and are criticized for it.

A man who is ill might tell his spouse or mother, or he may go and seek treatment without communicating with anyone in the household about it. Men who work in the towns or are independently employed as taxi owners, or own hauling trucks or their own business cannot easily take the sick role. They cannot afford the loss of income. They often treat the illness at home with over-the-counter drugs, home remedies or they consult a private doctor or attend the OPD at the hospital. When the illness is acute, the process of communication to the wider kinship network and social network is effected; the community as a whole is aware of the disruption in the particular family, and comes to its aid. Elderly men usually tell their spouse, or a son and his wife who inform the wider kinship network in the community. When the sickness is serious kinsmen at a distance from the community will also be notified.

Finally, among the Indo-Fijians in the settlements there is a sense of community and a belief that seya, (service to humanity) is rewarded, so that the indigent in a community are taken care of by neighbours if need be. Although they may not communicate illness to others, people look after the 'lok' (people) who 'belong' to the settlement, and in such times will go to their aid whether it is with home remedies or to help to make choices and decisions about where the person should seek treatment and to provide transport and other needs.

I have now briefly discussed the types of illness situations which arise and when illnesses are communicated to others in order to interact to make decisions about choice of diagnosis and therapy. People use communication as leverage in their social relationships with others. If one wishes to remain part of the social network amongst whom information flows, there are obligations and social exchanges to maintain. Empirically, this points out the situation of the woman orijah, for instance, who had a vast network of woman patients who divulged their concerns to her. They did so because they knew she had information to share but that she was
circumspect in her exchanges. Sickness episodes compel people to reflect on their lives, on their values; and to reinforce their commitment to their social order.

Thus far I have focused on communication from patient to the therapy management group. Communication from healer to patient in the traditional medical system is between people who have the same ethnic background and world view. There is a common basis for understanding and knowledge so that in the process of communication the healer knows that the patient understands the context of their interaction. I have shown that the da'i communicates with the pregnant woman in a number of ways. I noted that there is a difference between the degree of intervention daïs of different ethnic origin exhibit during the birthing process. Intervention is a form of communication and of caring and nurturing. The data point to a higher degree of intervention on the part of South Indians, a group which has probably moved quite recently from matriline to patriline in Fiji. It was my impression that this group of women consistently interacted with each other more warmly.

Similarly, in the Western Biomedical system the differences in communication were noted between doctors of different ethnic origins and patients in the hospital. Interaction between people of the same ethnic group was more empathetic and there was better understanding of illness, diagnosis and therapy. There were many misunderstandings between members of different ethnic groups, mostly based in lack of, or faulty knowledge of, the social structures of the other ethnic group and their specific needs and the reasons for their types of responses.

Nevertheless, in spite of differences, I also noted that between women who were in the birthing situation there was a communitas which was not apparent in other spheres of interaction in the hospital. Communication between patients and medical staff in the Labour and Obstetrics Wards was Intense, showing caring and empathy. Indo-Fijians communicated a
greater need for reassurance, and exhibited pain more than did the Fijians. These responses were related to the socialization and knowledge of the patient.

In the clinics, doctors spent little time with each patient because of the time management schedule of the hospital. The hours scheduled for the clinics were too short for the number of patients who appeared for examination and this resulted in various types of impediments to communication. They related to social factors such as language differences, class differences, ethnicity, lack of knowledge, fear and misunderstanding, stereotypical expectations on the part of doctors to the ethnicity and class of the patients. The latter are so ingrained that training will be needed to change such attitudes.

Because of training and time management, doctors have an interactional style which generates just those question and answer formats that construct the physical ailment but limit the social contextual factors which are viewed as unhelpful time consuming anecdotal interaction in the construction of the illness episode, unless the patient or the person accompanying the patient is able to communicate in English clearly and to use medical jargon.

Time management emerges as one of the most critical factors in the interaction between doctors, nurses and patients. In the clinics staff time is limited, the patients are examined hurriedly and only those who ask specific questions are engaged in any extended mutual exchange of information. In these cases, class is an important factor in the social exchange between doctors and patients. The patients who know the medical idiom and who ask questions, are the ones with whom the doctor interacts at a deeper level, and from whom the doctor gets satisfaction. These are the educated, upper class people in the town and the patients from the tourist hotels. Very few of these people attend the OPD since most go to private doctors in the town. People in the professions and those who are self employed cannot wait the long hours for examination in OPD that the rural people can. Also, there is a stigma attached to waiting in the
OPD waiting room with the rural folk, so that townspeople seldom are there. The social setting of the OPD has a significant effect on interaction styles.

Doctors in OPD do not ask probing questions, nor do they communicate very fully with the patients. The general ambience is one of dominance/subordination. Their dialogue with the patient is structured in such a way that the patient is reduced to answering “yes” or “no” and no time is given to social context or history of the ailment. Indo-Fijian doctors use both Fiji-Hindi and English with Indo-Fijian patients; and a mixture of English with a smattering of Fijian words when interacting with Fijian patients. Most of the expatriate doctors speak English with occasional words or short phrases in Fijian or Fiji-Hindi. Most patients who attend the OPD clinic do not have a facility with the English language or with the biomedical idiom in any case. As a result the doctor-patient interactions in OPD are carried out with little or no variation in the questions asked from one patient to the next, thus increasing the impersonality of the situation. As a result of hospital time management policies, the doctors have very little time with each patient. To make matters worse, the doctor is interrupted by phone calls, other staff, other patients who walk through the room, or discussion with the pharmacist in the adjoining room, about a prescription. In sum the communication in OPD is vague, detached, impersonal and insensitive at least part of the time.

Lack of confidence in the ability to communicate the felt disease, language differences and impersonal mutual interaction leaves the patient anxious about the illness, its prognosis and the way the therapy functions. This is one of the factors which leads to seeking alternative therapy from the Traditional Healers where anxiety is reduced.

As a consequence the patient often did not communicate well with the doctors and nurses. Somatized illnesses are almost always diagnosed as physical ailments because the patient does not know how to communicate the real ailment and because doctors and nurses do not know how to, or have time to, elicit social histories. They do not care to know those aspects which they cannot
change. I mentioned the instance above of the intern at the hospital who did not want to know why
the woman had consulted an *orij* though she was wearing a *dore* at the time we examined her.

There are few social workers to help with the work load in Fiji. Those few social
problems medical personnel do have to contend with, such as wife battering, suicide attempts,
unwanted pregnancies, abortions and mental disorders are time consuming, and many require
extra work such as completion of forms and interviews with police. Most staff at the hospital do
not have the time, even if they are empathetic, and they dislike the interactions and the
processes which involve law.

The conclusion reached in this research is that the members of the hospital auxiliary
could be effectively used to assist with these cases by the process of eliciting a history of the
abuse and by completing forms which the consulting doctor could review during diagnosis and
examination. Furthermore, in the absence of social workers, the auxiliary members could start
a self-help clinic for women suffering from wife-battering, desertion, and other social
problems not effectively dealt with in the hospital. Traditional procedures for dealing with these
circumstances today are often ineffective because people move away from the areas where they
have extended networks of kinsmen, to find work elsewhere, or more often to find land which can
be leased in another area.

Ethnicity is a major variable in the interaction between patients and doctors. Between
doctor/patient dyads of a single ethnic group, communication is enhanced by sharing a common
language, social structure and social organization, that is by their socialization in one culture.
But a doctor no matter what the ethnic group membership is distanced by his or her socialization
into the biomedical basis of medicine.

Between Indo-Fijian doctors and patients, there is a dominance/subordination
interaction style. Nevertheless, the patient is able to communicate the experiential disease and
to understand the doctor to a greater extent than with any other practitioner in the biomedical
system. Indo-Fijian doctors use the Indian language and they explain the diagnosis using Fiji-Hindi and English anatomical terminology.

Interaction was mainly authoritarian between Indo-Fijian doctors and patients, except where there was a perceived similarity in class. With those people who were in the professions such as teaching, nursing, and in the banking or hotel business, the doctor/patient interaction was more congenial and more time was spent eliciting the patient's experience and knowledge about the illness and in exchanging information. The interaction was collaborative, illness was explained, diagnosed and legitimized. Again this was perhaps the result of the interview being more satisfying to the doctor inasmuch as the patient understood the medical idiom, gave the appropriate responses and asked the correct questions (within the biomedical idiom). When a patient needed a "sick form" for employers, doctors wrote and signed it.

Class difference sometimes appeared to take precedence over common ethnicity in the interactions of the Indo-Fijian doctors. The Fijian patient by contrast showed deference, but the doctor did not appear to emphasize class distinctions.

Language is another crucial factor in exchanges. The interaction between Fijian doctors and Indo-Fijian patients, and Indo-Fijian doctors and Fijian patients, is limited by their mutual understanding of English and by their understanding of the common "pidgin" usage of each other's language. This idiom limits the communication to that in which the questions and answers for the diagnosis are extremely simple. Do you have fever? Where does it pain? How long has it pained?

Where patients of one ethnic group (i.e. Indo-Fijian) listen to the interaction of a doctor and patient of another group (Fijian), there is always the nagging doubt that when it is one's own turn the doctor will not understand the communication, and in some cases not care as much.

In OPD where the patient is referred to the examination area, the clinic nurse assists with the actual examination, the medical history is more thorough and the patient is given more
time for communication and discussion of the onset of the illness and the discomfort it causes. In
general nurses who work regular hours in the clinics and wards have much more time than do
the physicians who are conducting the clinics.

As "clinical anthropologist" in these circumstances I was able to elicit the social context and in several cases to discuss them with the doctors and to negotiate a different outcome than might have been the case otherwise. The case of the woman diabetic in the Women's Ward, mentioned above is illustrative of 'intervention' or patient advocacy which helped to secure a reassessment of the patient's condition. The language of understanding and communication was a somewhat poor Fiji-Hindi, but no Fijian. By providing some meaning of the patient's situation, and by mediating the conceptualizations of the patient and the doctor, an anthropologist can enrich history taking, and help to accomplish collaborative diagnosis and therapy. Both patient and physician were assisted to negotiate the most appropriate therapeutic outcome.

Communication between expatriate doctors (who were both Southeast Asian in this case) and patients suffered from the same impediments to communication imposed by the fact that English was also their language of medical expertise. Neither however, had a facility with either Fiji-Hindi or with Fijian. Again the short phrases, broken English and use of some words in the other languages helped. Both doctors could comprehend more of the two languages than they could speak. One doctor took a patient-centered approach to communication, helping the patient to make his symptoms clear and assisting with the interpretation as well as asking probing questions. The other doctor was extremely authoritarian. The patients felt she showed favouritism to Fijian patients over Indo-Fijian, and in general was quick and short-tempered in her interactions with the latter. In general in the OPD, it was my impression that patient anxiety was not reduced by the interactional styles of the doctors. Inability to communicate effectively was a significant factor in the choice made by some patients to seek alternative therapy from private doctors and from the traditional healers. In both these medical areas, the
patient's communication was understood and more time was given during the initial visit to find out about the illness and the expectations of the therapy management group. In these situations the likelihood of compliance to therapy is greater because the whole group is in charge of it rather than it being the private concern of the individual patient.

Finally, the interactions between medical staff have an effect on, or implications for, the workings of the hospital at every level and especially on communicational processes. People who worked together in the biomedical profession had their own associational loyalties such as common ethnicity, professional associations, unions, religious affiliation, status in hierarchical organizational arrangements which resulted in rostering, etc. Each of these pulled a person in several ways at once depending on the context of the situation. For instance an element of incongruence was introduced for some people when loyalties to a union meant that strongly held ethnic issues had to be held in abeyance, or when religious affiliation determined invitation to a meeting or event in the hospital, with hospital staff, or when a party broke up into factional segments.

In sum, language differences, ethnic differences, medical socialization, time management, associational loyalties, class differences, individual personality styles of doctor and patient, all impact on the interaction of the patient and physician, on their communication and consequently on the therapeutic outcome.

3. Who diagnoses and legitimates the sick role, and by what process?

The process of diagnosis of illness, when a patient has made it social by processes of transactions of explanation and description, involves the diagnostic social network (mainly kinsmen) in exchanging information identification, evaluation and classification in terms of cultural categories. The decisions and choices about therapy arise out of interactions between patient, and the therapy management group based on their knowledge, values and available resources, emotional and intellectual participation. It is informed by the symptoms, observed
behaviour, environment, biography and psychosocial aspects of the situational context of the patient. Thus information is transected, constructed and modified by the interpersonal event or process of diagnosis after which the illness is legitimated. Then the decision about etiology and classification is made and a therapy chosen.

From the data, I conclude that during the diagnosis in the Traditional Medical sector, Indo-Fijians distinguish between several categories of disease. They distinguish on the basis of illnesses with known causation, second on the basis of hypothesized cause, third on the basis of healer specific illnesses, lastly on the basis of illnesses requiring purification and religious rites.

In the first group are illnesses with physical symptoms which are considered minor although discomforting in which case the decisions about therapy are routine and the choice of therapy restricted to the home. Therapy is administered by kinsmen at home in the form of ghar dawai, nurturing care through tactile and verbal means, as well as through the preparation of special diets and minor rituals. The list of ailments in this category are shown in Table 5-2 in Chapter 5.

Most Indo-Fijians rely heavily on the Western Biomedical system in Fiji and they have a family physician in the private sector or a doctor whom they prefer to consult in the hospital. For treatment of acute physical symptoms, in an urgent or emergency situation, the therapy management group decide to escort the patient to the hospital, or to a private doctor for diagnosis and treatment. The examples of the child who came into hospital with serious burns shows the process in detail. And the accident and suicide attempts documented above are other instances of the interactions and processes in that type of situation.

In the hospital the diagnostic and therapeutic techniques are those which rely on the technology of the Western Biomedical system. Indo-Fijians know that recourse to X-rays, injections, chemically and scientifically developed medicines (pain killers and antibiotic
drugs), surgery, all of which contribute to fast relief by suppressing the symptom, and then healing. Diagnosis is arrived at by the patient and the therapy managing group (the escort) who together consult the doctor about the physical symptoms of the ailment. (I have discussed the communicational aspects of seeking therapy in the Western Biomedical system above.) In this setting the interaction time between patients and physicians is limited and the illness is not transacted or negotiated, and diagnosis is quickly arrived at based on a few questions meant to elicit a medical history of the onset, duration and possible cause of the sick state. The Indo-Fijian family physician usually knows the social context of the patient and family. Language is not a problem, nevertheless the biomedical assumptions about diagnosis, and anatomy, and time management in the clinic, are integral parts of the outcome of the biomedical training of most physicians.

But in the hospital, the social context of the patient is not elicited. In many instances the patient did not fully comprehend the questions, diagnosis or therapeutic regimen. Lolas states that in medical practice diagnosis means "...a statement about the disease, its natural course, its prognosis, its treatment and outcome" (1985"1356). Although he is not giving credit to the many physicians (and medical curricula) in the Western medical schools who are progressively more interested in a biopsychosocial approach. Lolas' definition however, which does not include social causes, is applicable to the situation in Fiji. Many Indo-Fijians have an incomplete knowledge of diagnostic techniques, and anatomy as understood in the biomedical system, or of the rationale for the prescribed course of therapy.

Today, older Indo-Fijians who have long had contact with the biomedical system are in the process of constructing an anatomical reality based on Indian notions of physiology and of Western ideas of it as they understand them. The idiom of this understanding is labelling with English words, often as functional symbols for the anatomical feature, as when the uterus is labelled "baby bag" by the Obstetrician when talking to Indo-Fijian women. (I mentioned above,
in this respect, the woman orjah who used this term as well as "baby pump", in her description of the cause of barrenness.) Diseases are described as "pressure ha" for high blood pressure, "sugar ha" for diabetes. As in these cases, either symptom or causation is often used to label and classify the disease.

Since contact with the Western Biomedical system, treatment for pregnancy and menstruation is sought as for illness, the first diagnosed as such in the Western Biomedical system but not in Indian conceptions, and the latter in the Traditional system, but not in the Biomedical system. Both states are linked to Indo-Fijian ideas of purity and pollution and require some therapeutic or purificatory (or both) procedures in the Traditional system. They have religious implications as well, which have been discussed at length above and other chapters so will not be recapitulated here.

Another group of ailments diagnosed are those with diffuse symptoms which are chronic, and give rise to unease; and those which sometimes cause patients to manifest erratic or other unusual behaviours. These are diagnosed by the family on the basis of interaction with the patient as ailments due to tundi bimari (cold illness or rheumatism), or on the basis of observation of behaviour, past history of the patient and events, and knowledge of psycho-social stresses on the patient arising out of the social structure. The diagnosis may be possession by some type of supernatural agent or due to the action of a human agent. The only time that these are treated in the Western Biomedical sector is if they are somatized as physical complaints. Then, Indo-Fijians seek therapy concurrently from both sectors of their medical system. The diagnostic process in these cases is based on interpretation of signs and verbalizations as well as on the patient's behaviour, "the telling and the doing". The syndromes on which diagnosis is based in these cases are often transacted between a wider social group in which the lineal and affinal kinsmen, the community, the social and economic network form the matrix of social relationships. There is uncertainty about cause, it is postulated as plausible, or hypothesized
after discussion and negotiations between lineages, between patient and therapy managers. In cases of uncertainty when people must resort to faith, they make the best possible choice they can after discussion and debate with a wide social network.

4. Who in the family interacts to decide on therapy; and how do people arrive at their decisions and choices?

Decisions and choice of therapy are based on the etiology of the illness, as it is socially constructed by the familial and local diagnostic network. Values, ideas about worthwhileness, social aspects (faith in the healer, availability, interactional or transactional styles, communication, knowledge, rapport), and economic cost (transportation to and from the healer, fee structures, cost of materials, time lost from other activities, cost of healing technology and pharmaceutical items) are considerations in the decision-making process.

5. What are the alternative strategies and procedures that exist in seeking health care? What qualifying conditions help to establish alternative goals?

Indo-Fijians make the decisions for choice of therapy based on diagnosis, but if the illness does not respond within a few days, it is usually rediagnosed with new hypotheses about causation. A subsequent decision is usually made to seek alternative therapy from another source. When the diagnostic and therapy management group is more diverse, and includes a wider kinship group, a lack of consensus and the potential for conflict about the recourse to therapy is greater. In these cases several therapies may be undertaken concurrently, or alternatively or sequentially. Diagnosis may also take the status of the patient into consideration to a greater extent and the sick role may not be as easily negotiated or legitimated (i.e. the example of married women with children and heavy farm labour or supervision requirements by some categories of people).

According to Indo-Fijian beliefs and practices, some illnesses require specific healers. Thus diagnosis is not difficult since it is based on the syndrome of symptoms the patient is
exhibiting. The therapy management group know through their experience and knowledge that the illness requires that specific type of treatment. The illnesses diagnosed in this way are mainly acute illnesses with sudden onset of pain, dizziness or other symptoms, for which a doctor must be consulted for diagnosis and therapy.

Other illnesses which are healer-specific are those such as possession by a malevolent supernatural being, by human agents, or by a deity, which are diagnosed on the basis of behavioural, biographic and psycho-social circumstances. The diagnosis and decision about therapy is transacted with the patient, and between kinsmen and their social networks, based on evaluations they feel are pertinent to the precipitating events in the cultural context. They classify the illness as one which they think will be best healed by dais, orjehs, pujarís, maulvis or pandits, in their particular venue.

Finally, there are the diagnoses about physical conditions (i.e. birthing) which require the removal of impurity and pollution, and perhaps illnesses which require special rituals (i.e. menstruation). These are diagnosed interactively with patients based on past experience, cultural values and knowledge, religious prescriptions and proscriptions, sharing of the experience and situational context of the patient.

In all of the diagnostic situations mentioned above, the diagnosis is carried out interactively with the patient. But when Indo-Fijians resort to the Traditional sector it is not uncommon to include one of the traditional healers in the decision-making therapy group. In the Indo-Fijian settlements, there is a strong sense of community when a crisis or potential crisis emerges. Many traditional healers are part-time healers and full-time residents of the settlement. Where they are neighbours or kinsmen (especially in the case of religious specialists), they may volunteer evaluation and take an active role in deciding on the most appropriate locus of therapy.
As a matter of course many Indo-Fijian families have one doctor, a private physician or someone at the local hospital, as their principal medical practitioner. For diagnosis and treatment of acute illnesses, most Indo-Fijians consult a doctor trained in biomedicine. Historically, Indo-Fijians have had recourse to no other trained professional medical practitioners, and for acute illnesses a doctor is the first practitioner a patient will consult. Nevertheless, unless the patient shows rapid recovery, the family will feel they cannot rely solely on one doctor’s therapeutic regimen and they consult alternative sources of healing including other doctors, and traditional healers.

Indo-Fijians do not usually turn over custody of the patient to a healer or to an institution. When a patient seeks diagnosis, he or she is accompanied by an escort. And if hospitalized, the patient has one member of the family who stays close by. During visiting hours, at least one person is with the patient but more usually many relatives and friends visit. For the duration of the hospitalization some relative is either in the visitor’s waiting area, out on the grounds, or in the nearby town. Hospital patients have many visitors and are never isolated from their kinsmen.

In the case of acute illnesses emergency decisions are made and therapy is sought immediately in the hospital or from a private doctor. At other times when Indo-Fijians interact during the decision-making process, they often have alternative strategies about therapeutic processes they are willing to try.

Indo-Fijians undertake alternative strategies about the therapeutic intervention when there are obstacles to the means to be employed for the attainment of the end result of therapy. Such obstacles occur in situations when kinsmen in charge of decision-making about therapy disagree, that is out of a conflict situation, for instance when a patient does not want to comply with the therapeutic choice made by kinsmen. Affinal and lineal kinsmen too, often each select a
different series of therapeutic arenas as their choice. Or, there may be generational differences in the decision about where the most appropriate locus of therapy lies.

When an illness is labelled by a senior generation, and according to knowledge and understanding in terms of Indo-Fijian conceptions of anatomy, they may insist on traditional sources of therapy; whereas an educated person in the family with a different understanding of anatomy and causation may insist on biomedical treatment. Transactions like this, between people who hold competing paradigms of medicine, sometimes lead to the use of multiple therapies for one illness. Or the patient may be a bystander to two factions of kinsmen and decision makers, torn between the alternatives and the lack of agreement or consensus about treatment to be sought. Affinal and lineal kinsmen of a patient sometimes also have differences in opinions and thus alternative strategies emerge. And there are intergenerational differences, as well as gender differences, in decision-making about locus of therapy to achieve healing.

I have described this situation in the extended examples of therapy for barrenness in Chapter 7. In the first case, I pointed out that N. and her mother-in-law sought help from orjahs, even though N.'s husband who is a pandit (Brahman) felt that recourse to this healer (a magical/sorcerer) was inappropriate for someone of his caste and his belief system. The two women felt that given the conditions (social structural) prevailing in their case they wanted to seek therapy from every possible source. N. is the wife of the eldest son in the oldest lineage of Brahmins in the settlement. Both women felt some urgency that she should bear a child for his lineage. Because of their political circumstances they could not ignore the potential efficacy of a cure by Fijian healers, so they were also consulted. In the second example of barrenness too, we saw that conflict about choice of therapy occurs in families along structural lines of demarcation, such as those between the beliefs and values of lineages of affinal and lineal relatives and their interests and those of the patient. This example was selected because it showed syncretism in beliefs. The family resorted to a healer who had the power to deal with the
Fijian spirits of the dead, by using the *vagona* complex and praying to Daqwaka, the Fijian God. Their ultimate response, one they felt was most efficacious, was to return to the familial fold. Resolution at other times can only be sought by going to a number of healers sequentially or concurrently to please all factions.

Often Indo-Fijians consult a number of doctors in succession. If the therapy is not effective within a very few days, they may go from doctor to doctor seeking a cure for a chronic condition for which there might not be a remedy. For some chronic conditions therapy can only provide relief from symptoms. This was the situation for example when an asthmatic child whose parents took him to the Outpatients’ Department at the hospital to be treated, then later on the same day took him to a private doctor in the town. Indo-Fijians sometimes do not understand the concept of some chronic conditions such as allergies and asthmatic conditions which children may outgrow.

Inadequate knowledge and understanding are other variables which condition the search for therapy from multiple sources. Indo-Fijians say the cost and inconvenience are nothing, as long as the cure is effected. Many Indo-Fijians do not understand scientific medicine and in their search for a remedy they go to number of private doctors who do not know that the patient is “making the rounds”. In this way some patients acquire prescriptions for medicines which are contra-indicated if taken together.

Conditions which help to establish alternative therapeutic sources are gender, age and role of patient; and the resources available in terms of costs, transportation, time and availability of the therapy chosen.

Perhaps the most important impetus to seeking alternative therapies relates to the perceived efficacy of healers. Indo-Fijians know of instances when healing has not proven efficacious; the patient continues to suffer and the therapy management group suffers the stigma
of accusations of negligence. Thus people are prone to seek therapy from every possible source if there is doubt about the ability of any one source to heal the patient.

I have discussed some of the situations under which a group of close kinsmen makes decisions and choices about locus of therapy for Indo-Fijian patients. And some of the conditions under which they seek alternative therapies have been reviewed. Now, I go on to discuss healers as role-holders (a basic analytic unit) in the medical systems.

Indo-Fijians utilize a number of sources of medical care or therapy. They, very pragmatically, say that a certain type of symptom and illness is best treated by a certain practitioner because that is his "kum" (work). Analytically, we may say the kum (or work) in this situation is synonymous with "role" of healer. The roles of interest are those of pandit, pujari, oriah maulvi dai, doctor and nurse, which once activated, determine what the healer does when interacting with the patient in the healing process. But, as I have shown with reference to the Western Biomedical system, the healer's role is affected by such factors as age, sex, ethnicity, personality, views of the patient with whom they are interacting, class and residential status in Fiji, as well as by many other factors. The healer's role does not exhaust all of the positions he has in society such as spouse, parent, church member, that is his statuses.

I have shown that interactions between persons of different ethnic backgrounds and social class condition the diagnostic process, relate to the type and effectiveness of communications, and have implications for therapy and compliance. Because my research took as its theme the description of interactions and processes in several medical systems, it did not undertake quantitative measurement of the efficacy of therapeutic interventions as they were affected by such variables. These are problems posed for further research.

While Indo-Fijians seek therapy for some illnesses from doctors, for others there is only one particular healer who can heal. For instance peri can only be healed by Pandits. Astrological grahas (dangers), illnesses related to karmic influences, rituals of purification
after births and deaths, and misfortunes, are also treated by recourse to pandits. They cannot be satisfactorily treated by any other healer.

Dais have the work of attending to some female ailments (narde okarde) and some children's ailments such as hasli okarde, problems during pregnancy, post-natal care of mother and child, and birthing (including washing to remove pollution of childbirth [in a secular way]). Today, the work of birthing has been almost completely taken over by the Western Biomedical system, and most pregnant women attend pre-natal and post-natal clinics at the hospital, the District Nursing station, or the Medical Centre; and deliver the child in the hospital. The Biomedical model was early adopted by Indo-Fijian women for its safe obstetrical methods, and care of the pregnant woman and newborn infant in the hospital, in the event of any problem. In the early days of indenture, maternal tetanus was a serious condition which women sometimes died from in Fiji.4

Only in cases of emergency is the dai now called to attend to a birth in the settlement; and it is a rare occurrence for people to seek the alternative of the home birth. As a consequence of this and because it is difficult to recruit new trainees, the practice of the dai is in a decline and in all probability will only be continued in rural areas where the need cannot be met by the Western Biomedical system. Unless the role is given some legitimacy by the medical profession, the role will continue to decline and home births that occur in the settlements will be assisted births in cases of emergency and necessity. Even if it is legitimated now, the time is long past when women can be recruited to fulfill it. Structurally, it will be a different role, perhaps similar to the midwifery role in the West. If that were the case Indo-Fijian women with high school education (but who perhaps have not achieved graduation) would eagerly apply for training. The new role would be optimally effective if the training were to include ideas for post-natal mother and child care as Indo-Fijians value them, and as they have described them for this research.
I have shown that for illnesses with malevolent supernatural causation, Indo-Fijians go to either the oriah, pujari, or maulvi for treatment, or they may consult one or more of these healers. The choice between these healers is based first on the proximity of the healer, the healer's ability to control the afflicting power, and whether the patient has faith in the healer. Traditional healers in the role of oriah are good listeners so they serve a cathartic purpose in cases where the differences in world views between generations produce unresolvable conflict and misery. Intermarriages between the several groups of people with origins in India also create disjunctions in social relationships by introducing ambiguity about the cultural (religious and social) forms that will be followed. Traditional healers understand and help to resolve the contradictions which arise out of structural sources of anxiety. Orjahs, maulvis and pujaris treat these and other illnesses with social structural, magico-religious and supernatural causes.

6. What other factors external to and/or internal to the therapy management group, not mentioned in the above questions condition the decisions and choice of healing system utilized?

Today, the younger Indo-Fijian generation has to deal with rapid social change and employment opportunities which mean greater mobility and changes in norms. Structurally, residence rules, marriage rules, and many other traditional mores are changing as people adapt to new opportunities such as new types of occupations, and social conditions. They contend with the paradoxical situations of traditional systems interacting with modern mores, and the ensuing conflict with older generations and their expectations. Some people cannot easily resolve the problems of the changing value structure and have doubts about the meaning for them of cultural rules which conditioned the lives of their parents and grandparents. Many young people are confronted with the change from a rural life style to urban ways and new moral norms and standards, as they seek employment in the towns.

More specifically, discord also arises out of the structural relations concerning the
More specifically, discord also arises out of the structural relations concerning the roles of women, for women are at the center of notions about exchange and transactions. They are the focal point of vulnerability in the social structure and create and refract disharmony through their roles. Social relations related to women can disorder a community. Women often express the pressures and anxieties in supernaturally caused illnesses. Disjunctions in social relationships manifested as illness (somatized) are also a way of resolving conflicts in the community. Healing them involves people in reflecting on the cause in terms of cultural ideas such as marriage rules, residence rules, religious affiliation, and appropriate action. In terms of Moore's analytical framework, causation is often situated in factors requiring situational adjustment and regularization, as well as resolving factors of incongruence, or in elements undergoing societal change 'dissolving into incongruence'.

For example stresses are apparent in illnesses which are linked to the structural position of many young married women whose own ambitions and needs are in conflict with the expectations of their affines and societal norms. For these women possession by supernatural beings (bhut, churel, and deities) manifested in very unorthodox behaviour, are a way they can gain attention and nurturance, take the sick role for relief from overwork, and perhaps return to their parents for a time for respite from causal stresses.

I have discussed the example of one family, overcome with bad luck, deaths and illnesses whose structural position in the community as wealthy agriculturalists, and as relatives of a man blamed with fraud, had made them the focus of attention and envy, and made their life in the settlement difficult and uneasy. At times stresses such as these from relationships in the community affect a whole family or lineage. Economic concerns, concerns about land leases and unexplainable misfortune, accidents and death, which happen in rapid succession to one group, are sometimes treated as sorcery. In these cases, people often seek therapy and protection but they also seek countermeasures. Only healers with very strong "power" can counteract sorcery.
to do sorcery. Other factors which influence the choice of healing system utilized are those related to prestige. Many people feel it is prestigious to go to the Western Biomedical system for healing. On the other hand, they may not have faith in the local biomedical system. (Since this fieldwork, I notice that some Indo-Fijians come overseas to Canada for treatment if they can afford it. I was told that many people, Fijians and Indo-Fijians, seek treatment in New Zealand and in Australia.)

(Although I have not noted this above, choices and decisions about medical care are influenced by media sources which are used by the Ministry of Health to promote preventive utilization of biomedical resources as well as for emphasizing the curative. Especially in the case of childbirth, family planning, and diabetes, external sources of advertising, educational seminars and radio programmes in Fiji-Hindi [such as women’s programmes] help to condition the choice of healing system Indo-Fijians utilize.)

I have discussed factors external to the therapy management group which condition the choice of healing system used. Factors which are internal to the group are those such as the knowledge base of the people in interaction, circumstances preceding the illness event, new factors in the situation, as well as potential circumstances may affect the choice of therapy. The personalities of the people who make the decisions, their socialization and basic value orientation and interests, are other variables which influence choice and decision. In addition, everyday pragmatic things such as the labour involved in preparation and coordination as well as the cost of the healing and availability of the healer, will affect a decision to undertake a particular type of healing. For instance the preparation of temple rituals is expensive in terms of the foods that must be purchased and prepared, the gifts for the “goddess” and the additional costs such as contacting and inviting kinsmen and social networks, new clothing, and travel and accommodation. Interpersonal factors between the individuals who make up the decision-making
accommodation. Interpersonal factors between the individuals who make up the decision-making group may also influence the choice of healer.

Healing in the Western Biomedical system also incurs a substantial outlay of resources. Hence costs are an internal problem a family must consider when deciding on therapy. In these cases the decision about the choice of therapy is more or less prescribed by the event since an acutely ill patient is usually taken to the nearest District Nursing Station, the Health Centre or directly to the hospital or to a private physician for treatment. If a patient is taken to the District Nursing Station or Health Centre, the nurse may refer the patient to the hospital. Most people in the settlements recognize acute illness and are most likely to go directly to the hospital if it is relatively close. Those who accompany the patient and stay around the hospital for long hours, are giving up either earned income or labour on the farm and their other obligations.

The costs which the 'therapy management group' must pay are those for taking the patient to the hospital, such as transportation costs, patient fees, and costs to notify kinsmen about the illness. Kinsmen who must come to attend the bedside of a sick relative in a hospital have the additional cost of travel as well as the lost income for the day or several days of attendance.

The settlement or 'community' influences the decisions and choices of the therapy managing group in a number of ways. First, a community is a force behind the normative structure of a group, and monitors the decisions and choices of treatment indirectly through its power of sanctions (i.e. gossip). In small settlements which are mainly networks of kinsmen, the community may also take an active role in helping to make decisions, in providing aid in terms of transportation, assistance in the household, and if need be monetary aid. As well, a kinship network has extended networks based on marriages and economic ties which provide knowledge of potential sources of therapy in other areas. The settlement is very critical and judgemental when the general feeling is that a family are negligent in their duty. In settlements
where the details of every event or situation soon become common knowledge this serves to promote right action on the part of its constituents. The community or settlement is a constraining force as well as one which provides incentives for correct action and behaviour.

Health care is an interactive process in which the patient role, the therapy management group, and the choice of healer, are transacted between interested individuals, usually to alleviate a crisis.

In this thesis I have answered the question posed in Chapter one. The processes of communication, diagnosis, and therapy and a set of key questions stated at the beginning of this chapter directed the enquiry.

The task of the enquiry has however turned out to be broader than that. First, it was to accurately and in depth describe the health care scene in the two Indo-Fijian settlements and in relation to Indo-Fijians in a Biomedical Hospital, in an area in the Western Division of Viti Levu, Fiji Islands. The elements taken as most important in the descriptions have been social relationships rather than symbolic representations. This does not mean that the social is more or less important than the cultural, but that it was the type of analysis chosen for the fieldwork circumstances. There is a vast symbolism that begs analysis on that dimension.

The task was also to discuss the interaction of several medical systems, and that has turned out to show the syncretic aspect of them. In this I showed that the Traditional healers are incorporating both material items and deities from sources external to the Indic traditions such as Fijian, Islamic and European traditions. Also Indo-Fijian notions of anatomy are syncretic, like a mylar (transparency) overlay on a map; and Indo-Fijians are attempting to make sense of the way in which their knowledge meshes with their understanding of what doctors tell them in the Western Biomedical system. Syncretism is a major feature of life in a plural society and in Fiji it shows in the interactive use of multiple languages, in situational adjustments of one group to another and of one healing system to another, as well as in the religious practices.
Importantly, in the emergence of one system of health care based on the notion of utilization, Indo-Fijians do not think of two systems or traditions of health care, but they do think of multiple healers, each with his own work; and amongst whom some individual healers are sometimes and in some cases, more proficient than others. As a corollary to the belief in the fallibility of healers, they often seek healing in a number of healing spheres, and often from multiple healers at once.

Moore (1978:52) refers to processes of situational adjustment, a conceptualization which suits the Indo-Fijian utilization of available health care and to social change in Fiji. She states:

People arrange their immediate situations (and/or express their feelings and conceptions) by exploiting the indeterminacies in the situation, or by generating such indeterminacies, or by reinterpreting or redefining the rules or relationships. They use whatever areas there are of inconsistency, contradiction, conflict, ambiguity, or open areas that are normatively indeterminate to achieve immediate situational ends. These strategies continuously reinject elements of indeterminacy into social negotiations, making active use of them and making absolute ordering the more impossible. These processes introduce or maintain the element of plasticity in social arrangements.

She also refers to processes of regularization which transform a "social reality [that] is fluid and indeterminate" into something more fixed...yet can never entirely or completely lose all of its indeterminacy..."

The syncretism found here within and between what we may distinguish analytically as two systems of health care (themselves pluralistic) is an attempt by Indo-Fijians to achieve such a transformation. Indo-Fijians transcend the plurality, their medical system although made up of many 'systems' of healing, has unique elements. Emphatically Indian in its ideology but without the practice of the therapies of professionalized Indian medical systems, it has retained religious healing and reconstructed and synthesized folk healing traditions from many parts of India, and added herbology and massage from Fijian medical traditions. While it is also Western in its use of professional therapies, it lacks the ideological foundations of biomedicine.
Footnotes:

1 The Ministry of Health and Social Welfare, Annual Report for the Year 1984, Parliament of Fiji, Parliamentary Paper No. 1 of 1986:98, under the category Menstrual Disorders, shows a total of 820 cases of which 592 are "Indian", 186 are Fijian and 42 are "other".

2 A clear, concise definition of social interaction as it is used here is that by Arnold W. Green (1964:57) who states: "By social interaction is meant the mutual influences that individuals and groups have upon one another in their attempts to solve problems and in their striving toward goals. Social interaction discloses the concrete results of striving behaviour upon roles, statuses, and moral norms."

   N. J. Smelser (1976:183-86) writing about Parsons' work gives the ingredients of his "general action theory" as an actor who is goal oriented, that is motivated to seek means towards an end for which he strives. In order to do so, he must surmount conditions which are regulated by normative standards. "These standards underscore the fact that all action is basically social in character. It is continuously influenced by norms that arise in the interaction among individuals."

3 Alan Rew in Social Images and Process in Urban New Guinea: A Study of Port Moresby, although he is discussing a colonial town writes:

   "In certain towns, colonialism has created a plural social structure: here the political dole system prescribes all other role-relationships, hampering urban differentiation. Thus the urbanization of Fijians in Suva, Fiji, and their retention of Fijian cultural traditions (Nayacakalou and Southall, 1973) must be seen within the wider political framework of Fijian, Indian and European relationships and the unique position of Fijians as the autochthonous landholders within the legal pluralism set up by the protectorate and continued within independent Fiji."

   The political framework Rew refers to is as applicable to Fiji today. During the time of this fieldwork, one year before the coup of 1987, relations between the two main ethnic groups were extremely tense.

4 See Appendix 6 about conditions obtaining in Fiji during the 1920's and 1930's. Mohammed Haniff graduated as an Indian Medical Practitioner in December of 1929 (Guthrie, 1979). The article appeared in The Native Practitioner, Vol. 2, pp.147-49, which was inaugurated in November of 1930. (Obtained by me from the Fiji Archives, Suva, in 1986.)
GLOSSARY: Transliteration of these words is not necessary for they appear in this form in many texts dealing with Indian ethnography or anthropology. They are now standard English usage of the Hindi word.

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<tr>
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<td>acha</td>
<td>fine or good</td>
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<tr>
<td>ahimsa</td>
<td>non-violence</td>
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<tr>
<td>ahir</td>
<td>traditionally, a goat-herding caste in India</td>
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<tr>
<td>alagsi or alagi</td>
<td>to keep separate</td>
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<tr>
<td>arthi</td>
<td>prayer plate</td>
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<tr>
<td>babut</td>
<td>sacred ash</td>
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<tr>
<td>badan</td>
<td>human body</td>
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<tr>
<td>bat</td>
<td>language</td>
</tr>
<tr>
<td>behos</td>
<td>unconscious</td>
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<tr>
<td>beju</td>
<td>seeds (semen)</td>
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<td>beti</td>
<td>daughter</td>
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<tr>
<td>bhabi</td>
<td>brother's wife</td>
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<tr>
<td>Bhagwan</td>
<td>God</td>
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<tr>
<td>bhaini</td>
<td>sister</td>
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<td>bhut</td>
<td>ghosts of people who died a violent death</td>
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<td>bimar</td>
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<td>bimari</td>
<td>disease</td>
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<td>bokhar</td>
<td>flu</td>
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<td>chaku</td>
<td>small knife</td>
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<td>chamiar</td>
<td>a low caste person, a leather worker</td>
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<td>chapatis</td>
<td>Indian flat bread</td>
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<td>chardo</td>
<td>broom</td>
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<td>chej</td>
<td>thing</td>
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<tr>
<td>cherata</td>
<td>a bark-like object with medicinal properties imported from India to Fiji</td>
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<td>chetti</td>
<td>ritual cutting of an infant's hair shortly after birth</td>
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<tr>
<td>chewra</td>
<td>bracelet</td>
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<td>chula</td>
<td>open cooking hearth</td>
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<td>churel</td>
<td>ghost of a woman who has died in childbirth</td>
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<td>dai</td>
<td>mid-wife, usually a lower caste woman</td>
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<td>dal</td>
<td>a lentil soup</td>
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<td>dalchini</td>
<td>cloves</td>
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<td>dan</td>
<td>a witch</td>
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<td>datun</td>
<td>a twig for cleaning the tongue</td>
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<td>deri, deri</td>
<td>slowly, slowly</td>
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<td>dharam</td>
<td>religious calling or religious belief</td>
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<td>dhaniya</td>
<td>coriander</td>
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<td>dore</td>
<td>a healing thread</td>
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<td>bride</td>
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<td>garam</td>
<td>hot</td>
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<tr>
<td>ghar-dawai</td>
<td>household medicine</td>
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</table>
gol mirch  peppercorn
grahas  dangerous astrological times
haldi  turmeric
halwa  a sweet usually also made as a sacramental food
harar  pidgeon peas
hasli  collarbone
hawa  literally, wind. In healing it is usually evil
himat  strength, encouragement
hing  asafoetida
ilachi  cardamom
ilage  heal, to cure
jaddu  sorcery
jawain  cumin
jeera  from the jungle, usually with reference to tribal peoples
juta  polluted
kabiti  Fijian (perhaps a Fijian word which has crept into Fiji-Hindi)
kacha  raw
kaka  Father’s younger brother
kamiz  North Indian garment (upper dress-like part)
kanga  comb
kapoor  camphor?
karela  bitter melon (momordica charantia)
karma  fate, or law of moral consequences
khanna  food, to eat
kheer  a pudding-like sweet made of milk, rice and sugar
ki  of
kum  work
kurta  shirt
laong  cloves
loban  a white powder of some type
mali  polluted
mami  mother’s brother’s wife
mandapa  canopy-like wedding structure
mantras  magical words (the singular is mantram)
mandir  a temple
mattar  peas
maulvi  muslim learned man, usually a religious person, sometimes a healer
mausi  mother’s sister
mehndi  henna
methi  fenugreek
muni  girl
mur  head
mussela  a mixture of with a variety of spices depending on the use.
namaz  Muslim prayers
nani  mother's mother
nazar  evil eye syndrome
neem  a variety of margosa tree, the tree *Azadirachta indica*
okarde  to come apart, to become misplaced, or to break.
ordne  shawl
orjah  exorcist, folk healer, sorcerer
pagla  a mentally ill person, or as an adjective (i.e. 'crazy', 'insane').
panchayat  An assembly of men (usually 5) who arbitrate disputes in villages
pendit  a person of the Brahmin (priestly) caste, usually a person learned in the Hindu sacred texts.
pangi  water
pap  sinfulness acquired through killing or mistreatment of living beings.
pate  abdomen
pati  leaf
peri  yellow fever
pero  hurt, pain
pisab  urine
potnar  uterus
prasad  sacramental foods
prem  love
puja  prayer ritual
pujari  temple priest
rakhi  to keep
rajas  energy, or passions, one of three 'qualities' or *gunas* (light or *sattva*, and inertia or *tamas*, are the other two) from Ayurveda concepts of the mind.
rog  disease
rogi  patient
sadhus  a Hindu ascetic
saf  clean
salga bhagi  spinach like green leaf used for medicinal purposes
sake  to heat or to warm
salvar  North Indian costume (trousers)
sandur  sandalwood paste
sanyasi  hermit
sari  human body
sari  an Indian garment worn by women
seesa  mirror
setan  evil spirit
seva  service
shanti  peace
sont  a drink made with milk and spices to induce lactation; the important ingredient is dried ginger, (see footnote 3 at end of chapter 8, for complete list and latin names).
<table>
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<th>Term</th>
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<td>amulets with sacred words in them</td>
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<tr>
<td>tagit</td>
<td>strength, energy</td>
</tr>
<tr>
<td>than</td>
<td>outdoor shrine</td>
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<tr>
<td>thardi</td>
<td>beard</td>
</tr>
<tr>
<td>tharthi</td>
<td>goddess of the earth, probably a North Indian folk goddess</td>
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<tr>
<td>tika</td>
<td>a spot</td>
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<tr>
<td>tola</td>
<td>ward</td>
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<tr>
<td>tridosas</td>
<td>the 'three troubles' from the Indian humoral equilibrium theory</td>
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<tr>
<td>tulsi</td>
<td>basil (in Fiji, two types are grown for religious worship, red and green</td>
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<td></td>
<td>tuasi)</td>
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<tr>
<td>tundi</td>
<td>cold</td>
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<td>tundroost</td>
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<td>tundroosti</td>
<td>health</td>
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<tr>
<td>vaidyas</td>
<td>Ayurvedic physicians</td>
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</table>

**Phrases:**
- dil me darne - frightened in my heart
- ortha ki ghat - the bathing place of the women
- humari budhi deo - give me knowledge (usually addressed to a god)
- pate saf karna - to clean out the abdomen, usually with reference to a D. and C.
- temple alia kam dhara - healing to be done through the temple
- sub chej hacha ha, bimari nai ha - everything is fine, it is not a disease.
- body both narm ha saurie - the body is very weak post-partum.
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C. DICTIONARIES AND OTHER REFERENCE TEXTS:


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<td>Yes</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Iodine Solution Weak</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Mustine Mixture</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Lignocaine 0.5% Inj. (5mls)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>ITEM</td>
<td>In Stock</td>
<td>Expired date</td>
<td>Satisfactory</td>
<td>ITEM</td>
<td>In Stock</td>
<td>Expired date</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------</td>
<td>--------------</td>
<td>--------------</td>
<td>-----------------------------</td>
<td>----------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Turpentine liniment</td>
<td></td>
<td></td>
<td></td>
<td>Plaster, adhesive...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitfield's Oint...</td>
<td></td>
<td></td>
<td></td>
<td>Wadding, Cellulose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitfield's Lotion</td>
<td></td>
<td></td>
<td></td>
<td>Wool, Cotton...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zinc Oxide Oint...</td>
<td></td>
<td></td>
<td></td>
<td>Cord Ties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stores</td>
<td></td>
<td></td>
<td></td>
<td>Nylon Suture...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kerogene</td>
<td></td>
<td></td>
<td></td>
<td>Needles, Hypodermic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing, etc...</td>
<td></td>
<td></td>
<td></td>
<td>Needles, Surgical...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bandage Calico...</td>
<td></td>
<td></td>
<td></td>
<td>Applicators, Wood [3]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gauze</td>
<td></td>
<td></td>
<td></td>
<td>Spatulas, Wood [3]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lint</td>
<td></td>
<td></td>
<td></td>
<td>Oral Rehydration Salt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condoms</td>
<td></td>
<td></td>
<td></td>
<td>Intrauterine Devices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive Pills</td>
<td></td>
<td></td>
<td></td>
<td>Depot Provera</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2

TABLE XX

INDICATORS OF MATERNAL AND CHILD HEALTH
1975, 1981 - 1984

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Live births</td>
<td>16,794</td>
<td>20,729</td>
<td>21,367</td>
<td>21,543</td>
<td>20,605</td>
</tr>
<tr>
<td>% Hospital deliveries</td>
<td>87.7</td>
<td>92.3</td>
<td>92.8</td>
<td>93.0</td>
<td>93.2</td>
</tr>
<tr>
<td>% District Nurses</td>
<td>5.3</td>
<td>4.5</td>
<td>4.4</td>
<td>4.1</td>
<td>4.4</td>
</tr>
<tr>
<td>% TBA* deliveries</td>
<td>6.5</td>
<td>3.1</td>
<td>2.3</td>
<td>2.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Crude Birth Rates per 1,000 population</td>
<td>29.3</td>
<td>31.7</td>
<td>32.2</td>
<td>31.8</td>
<td>29.8</td>
</tr>
<tr>
<td>Maternal Mortality per 1,000 live births</td>
<td>1.42</td>
<td>0.77</td>
<td>0.47</td>
<td>0.32</td>
<td>0.44</td>
</tr>
</tbody>
</table>

*Traditional Birth Attendants.

TABLE XXI


<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER OF LIVE BIRTHS</th>
<th>NUMBER OF MATERNAL DEATHS</th>
<th>RATE PER 1,000 LIVE BIRTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>20,740</td>
<td>11</td>
<td>0.53</td>
</tr>
<tr>
<td>1981</td>
<td>20,729</td>
<td>17</td>
<td>0.77</td>
</tr>
<tr>
<td>1982</td>
<td>20,367</td>
<td>10</td>
<td>0.47</td>
</tr>
<tr>
<td>1983</td>
<td>20,543</td>
<td>7</td>
<td>0.32</td>
</tr>
<tr>
<td>1984</td>
<td>20,605</td>
<td>9</td>
<td>0.44</td>
</tr>
</tbody>
</table>

From: Ministry of Health and Social Welfare, Annual Report for the Year 1984
Parliament of Fiji, Parliamentary Paper NO.1 of 1986, pp. 43-44
### APPENDIX XIX (a)

#### INFANT MORTALITY RATE 1984

##### BY RACE

<table>
<thead>
<tr>
<th>RACE</th>
<th>LIVE BIRTHS</th>
<th>NEONATAL DEATHS</th>
<th>POST-NEONATAL DEATHS</th>
<th>INFANT DEATHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
</tr>
<tr>
<td>FIJIAN</td>
<td>10,101</td>
<td>92</td>
<td>9.1</td>
<td>131</td>
</tr>
<tr>
<td>INDIAN</td>
<td>9,586</td>
<td>140</td>
<td>14.5</td>
<td>78</td>
</tr>
<tr>
<td>OTHER</td>
<td>918</td>
<td>14</td>
<td>15.3</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20,605</td>
<td>246</td>
<td>11.9</td>
<td>217</td>
</tr>
</tbody>
</table>

##### BY DIVISION

<table>
<thead>
<tr>
<th>DIVISION</th>
<th>LIVE BIRTHS</th>
<th>NEONATAL DEATHS</th>
<th>Posts-NEONATAL DEATHS</th>
<th>INFANT DEATHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
</tr>
<tr>
<td>CENTRAL</td>
<td>7,677</td>
<td>72</td>
<td>9.4</td>
<td>142</td>
</tr>
<tr>
<td>WESTERN</td>
<td>8,196</td>
<td>122</td>
<td>14.9</td>
<td>206</td>
</tr>
<tr>
<td>NORTHERN</td>
<td>3,726</td>
<td>46</td>
<td>12.3</td>
<td>88</td>
</tr>
<tr>
<td>EASTERN</td>
<td>1,006</td>
<td>6</td>
<td>6.0</td>
<td>27</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20,605</td>
<td>246</td>
<td>11.9</td>
<td>463</td>
</tr>
</tbody>
</table>

#### CRUDE DEATH RATE BY RACE

<table>
<thead>
<tr>
<th>RACE</th>
<th>POPULATION AS AT 31ST DECEMBER, 1984</th>
<th>TOTAL DEATHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>FIJIAN</td>
<td>309,533</td>
<td>1,776</td>
</tr>
<tr>
<td>INDIAN</td>
<td>345,461</td>
<td>1,568</td>
</tr>
<tr>
<td>OTHER</td>
<td>35,928</td>
<td>218</td>
</tr>
<tr>
<td>TOTAL</td>
<td>690,922</td>
<td>3,562</td>
</tr>
</tbody>
</table>

From = Ministry of Health and Social Welfare, Annual Report for the Year 1984
### APPENDIX XIX (b)

#### TODDLER MORTALITY

<table>
<thead>
<tr>
<th>YEAR</th>
<th>AGES</th>
<th>FIJIAN</th>
<th>INDIAN</th>
<th>OTHERS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1982</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 - 2</td>
<td>53</td>
<td>9</td>
<td>1</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>2 - 3</td>
<td>19</td>
<td>12</td>
<td>1</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>3 - 4</td>
<td>13</td>
<td>6</td>
<td>1</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>4 - 5</td>
<td>15</td>
<td>-</td>
<td>1</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td>100</td>
<td>27</td>
<td>4</td>
<td>131</td>
<td></td>
</tr>
</tbody>
</table>

| **1983** | | | | | |
| 1 - 2 | 32 | 8 | - | 40 |
| 2 - 3 | 26 | 4 | 3 | 33 |
| 3 - 4 | 9 | 11 | 1 | 21 |
| 4 - 5 | 9 | 2 | 1 | 12 |
| **TOTAL:** | 76 | 25 | 5 | 106 |

| **1984** | | | | | |
| 1 - 2 | 68 | 13 | 1 | 82 |
| 2 - 3 | 25 | 7 | 2 | 34 |
| 3 - 4 | 16 | 7 | 3 | 26 |
| 4 - 5 | 17 | 4 | 3 | 24 |
| **TOTAL:** | 126 | 31 | 9 | 166 |

From: Ministry of Health and Social Welfare, Annual Report for the Year 1984
APPLICATION for a SPECIAL GRANT from THE ROTARY FOUNDATION

1. The sponsoring Rotary Club: The Rotary Club of Sigatoka District: 992

2. Brief description of the project:

RENOVATING and ENLARGING the SIGATOKA DISTRICT HOSPITAL

BACKGROUND

The Sigatoka District Hospital is a 56-bed facility serving people living in the Sigatoka Valley and in coastal communities along the Southwest coast of the Island of Viti Levu, Fiji. Since its official opening in 1969, the hospital, together with its very busy out-patient clinics, has been the primary [and in many instances, the only affordable] source of essential medical service for a majority of the area’s population.

During its first year of operation [1970], the area served had a population of 14,655. By 1985, that population had more than doubled to 35,909.

The population of the area is multi-racial. In addition to a significant percentage of indigenous Fijians, the area is also home to second, third and, now, fourth generation descendants of East Indian labours who were brought to Fiji in the late 19th and early 20th Century to work in the sugar cane.

The Sigatoka Valley, located along one of Viti Levu’s major rivers, is a fertile agricultural area that sustains small family-operated sugar cane and market vegetable farms. Although on fertile ground, most of these farms operate at a near subsistence level because of their small size and the mercurial local and international markets for their produce.

In addition to serving this resident population, the facility is also the primary source of hospital care for tourists who frequent the growing number of small and international standard hotels located along the Southwest coast both East and West of the hospital. The existence of the hospital and the availability of good medical service are essential to the successful operation of those hotels.
In 1970, the hospital admitted 2,050 patients. By 1980, admissions had increased to 3,126; and by 1982 to 3,846.

Over the years, the hospital’s out-patient clinics have become increasingly important contributors to the area's medical and health care. By 1980, annual out-patient attendance had grown to 41,810; and by 1982 it had further increased to 48,045.

The hospital's obstetric and gynaecological clinics play a major role in protecting the health of the women and children of the area. By 1982, attendance at the increasingly active ante-natal clinic had grown to 1,363 -- that represents the total number of pregnant women who were seen weekly, bi-monthly or every month on a rotating basis at the hospital's various obstetric clinics.

The hospital also offers specialized examinations with subsequent referrals to the Lautoka and Suva hospitals.

THE PROPOSAL

The Rotary Club of Sigatoka is submitting this proposal to The Rotary Foundation to assist the Sigatoka Hospital Auxiliary in its objective of greatly increasing the operating efficiency of the existing facility by building:

1. two extensions to the existing hospital; and,

2. a covered corridor to connect an existing Block with one of the proposed extensions and to provide a badly needed, protected waiting area for the adjacent wards and clinics.

In addition to adding needed space to the hospital, these relatively small extensions will permit, and provide the necessary basis for, relocating existing facilities to greatly enhance efficient hospital operation. The resulting ability to relocate existing wards in a significantly more functional and operationally appropriate pattern will dramatically compound the expected benefits of this relatively modest construction proposal.

The attached schematic drawings show a construction proposal whereby:

a. BLOCK B will be extended by a 2,520 square foot (36' x 70') addition;

b. BLOCK D will be extended by a 1,280 square foot (42' 8" x 30') addition; and,

c. a 985 square foot (10' x 98' 8") covered CORRIDOR will be built to connect Blocks B and C.
The completion of these additions will allow a major reorganization of present inefficient operating patterns imposed by the limitations of the existing facility.

Use of the existing wards can then be changed so:

a. the Men's Ward now in Block C, can be moved to Block D; while,

b. leaving the children's ward in Block C; then,

c. the Women's Ward can be moved from Block D to Block C;

d. the Nursery and Obstetrics Ward can be moved from Block D to the new Block B extension (Block B already contains the Labour ward); and,

e. the Ante-natal and Gynaecological Clinics can be moved from the congested middle of Block E to the outside end of the Block B extension.

The proposed construction will make it possible to implement a physical reorganization of wards and treatment centers that consolidates all medical services for women and children into contiguous areas on one side of the hospital.

The proposed 10-foot wide connecting corridor then becomes a comfortable, covered waiting area for patients served by all the facilities located in Blocks B and C -- well removed and out of the way of the vital internal traffic of the hospital.

Part of the existing Block D and its proposed extension can then house the Dentistry and other outpatient clinics with a separate entry from the hospital's main drive -- well away from the Emergency Room. These clinics should be separate from the rest of the hospital because the traffic pattern required to efficiently serve the kinds and numbers of patients involved presently disrupts other functions.

RATIONALE

It is apparent that the population of the area served has outgrown the hospital's present size and operating configuration.

Dramatic examples of the existing inadequacies are provided by the size and location of the obstetric and labour wards and the related ante-natal and gynaecological clinics.

The labour ward [Block B] and the obstetrics ward [Block D] are presently very far apart. At any one time, there are only two nurses on duty serving these critically related, but widely separated, wards. When both nurses are urgently needed for a delivery, one of them may be tending patients at the other end of the hospital. This happens frequently enough to cause near emergencies!
In the ante-natal and gynaecological clinics, both presently situated in Block E, up to seventy women are examined a day. These women are examined in a 117 square foot (11'6" x 10'2") room that must also accommodate a desk, the examination table, cupboards, double sink and drainboard, two chairs, a stool and a doctor's scale.

The examination table has a curtain across the front, but patients must change into examination gowns in full view of other patients and staff.

In addition to the necessary clinical equipment, there are usually three staff members [the doctor, a clinical nurse, and either a family planning nurse or a hospital auxiliary volunteer] and three patients [one being examined; one preparing for examination; and one completing examination procedures] in this room.

This same examination room is, and must also be, used for consultations with husbands and wives regarding common or urgent medical problems; or regarding confidential personal problems and procedures.

The entrance to this examination room abuts the main hallway and the doors to the Emergency Room and other outpatient clinics. The crowd of pregnant women (and frequently their husbands and children) waiting for admission to the ante-natal and gynaecological clinics obstructs essential access to the Emergency Room and the other clinics -- dangerously congesting other critically important areas of the hospital.

The existing hospital facilities are clearly too small and inefficiently organized to provide the efficient medical services required by the greatly increased population of the area served.

This proposal seeks to enlarge and then physically reorganize the hospital so that the resulting facilities will assist the medical staff in providing improved essential medical care to the area's growing population.

While the proposed extensions are relatively small in size, the resulting positive impact on the operating efficiency of the hospital promises to be enormous!

The attached schematic drawings show the proposed extensions and how their completion will provide the basis for an efficient reorganization of the hospital's pattern of operating functions and facilities.

CURRENT STAGE of PROPOSED ACTION

The membership of the Sigatoka Hospital Auxiliary -- which has helped formulate this proposal with the sponsorship of The Rotary Club of Sigatoka and which will be active in implementing the proposed project -- includes two trained
midwives, a community service worker, several retired (but otherwise active) nurses, a medical doctor, and a medical anthropologist. Several Auxiliary members are experienced and skilled in the organization, coordination and operation of volunteer service organizations. The treasurer is an accountant with the Sigatoka Branch, Bank of New Zealand.

The Auxiliary has raised almost $1,500 in anticipation of proceeding with this project. Since December 1985, its members have contributed more than 600 hours of volunteer work in the hospital by assisting the obstetrician in the ante-natal clinic and by teaching nutrition, basic hygiene, breast-feeding advantages, post- and ante-natal exercises, and family planning. Auxiliary members have also assisted with non-medical chores such as sewing, hanging curtains and generally helping to update and maintain the wards in attractive and good medical order.

The Auxiliary is currently pursuing a special fund raising drive to buy bedding and cot covers for the babies' nursery and is already assured of raising $300 with these endeavors.

Sigatoka civic clubs are planning a week long August festival to raise funds for the area's social institutions. The Auxiliary plans to be actively involved and is planning two days of activities in connection with Women's and Children's Day events. In addition to the resulting monetary benefits to the hospital, it will also benefit from the general public's increased awareness of its services and needs that these activities generate.

The vigorous Sigatoka Hospital Auxiliary is also actively seeking and negotiating for local assistance from other Fiji organizations (Fiji Pine Commission, the Royal Fiji Military Forces, and the National Council of Women) to obtain a temporary, movable building for use as interim housing for the ante-natal and gynaecological clinics.

A favourable response to this application for a SPECIAL GRANT from The Rotary Foundation will significantly assist the Sigatoka District Hospital in providing better and much needed health and medical care to the families and children of the area.

3. Estimate of all costs:

The costs for the proposed project have been estimated based on Fiji costs in Fiji Dollars; and have then been converted to and are presented below in close US Dollar equivalents.

The estimated cost of the proposed project is $108,000.00, consisting of the following components:
General Construction:
Labour $35,000.00
Materials $45,000.00

Subcontracts:
Electrical $9,000.00
Plumbing $4,500.00
Painting $3,500.00

Renovation and moving costs of reconfiguring the facility after the extensions are completed $11,000.00

TOTAL Estimated Costs $108,000.00

4. Proposed financing:
Sponsoring Rotary Club of Sigatoka 1,000.00
Requested from THE ROTARY FOUNDATION 97,000.00
Other sources (please specify):
Nadroga / Navosa Festival 5,000.00
Sigatoka Hospital Auxiliary 2,000.00
Private individual donations 3,000.00

TOTAL Proposed Financing $108,000.00

5. Name, address and business telephone of the person or company to whom payment should be made, if the grant is approved. Payment cannot be made to a Rotarian, the relative or dependent of a Rotarian, or to any Rotary Club or district.

Branch Manager,
Sigatoka Branch
BANK of NEW ZEALAND
Sigatoka, Fiji
011 [679] 50-466,
as custodian and for the benefit of:
The Sigatoka Hospital Auxiliary
Post Office Box 13
Sigatoka, Fiji

6. Briefly describe the anticipated active participation by Rotarians in this project.

The Rotary Club of Sigatoka has actively supported and been involved with the Sigatoka District Hospital since the Club was established in 1972.

In the past, the Club has donated furniture, wheelchairs and drugs to the hospital. The Club is currently raising funds to build a canteen and waiting shelter at the hospital. This project will cost approximately $10,000. The Club intends to start construction by the end of May 1986 and to complete it in about eight weeks.
The Rotary Club of Sigatoka

APPLICATION for a SPECIAL GRANT from THE ROTARY FOUNDATION

SIGATOKA
DISTRICT
HOSPITAL
as it presently exists

and with the proposed extensions

Proposed extension of Block B

Proposed extension of Block D
The Rotary Club of Sigatoka
APPLICATION for a SPECIAL GRANT from THE ROTARY FOUNDATION

SIGATOKA DISTRICT
HOSPITAL showing the major components and the present use pattern discussed in the proposal.

Block A
- KITCHEN and LAUNDRY
- PREGNATAL and GYNECOLOGICAL CLINIC

Block B
- LABOUR Room
- DELIVERY Room
- SURGERY Operating Room

Block C
- STORAGE & Service
- STAFF and Waiting Room
- MEN'S WARD
- CHILDREN'S WARD

Block D
- NURSERY
- SERVICE Waiting Room
- OBSTETRICS WARD

Block E
- EMERGENCY ROOM
- MAIN ENTRANCE

Showing the improved use patterns resulting from the proposed extensions and reorganization.

Block D EXTENSION
- STORAGE and Service
- SERVICE Waiting Room
- MEN'S WARD
- WOMEN'S WARD
- CHILDREN'S WARD

Denta/Ortho/Out Patient Clinics
- Storage and Service
I would like to describe some of my first experiences in medical practice at Navua immediately after my graduation at the Central Medical School in December, 1929. On the day I arrived in Navua, early in January, 1930, an epidemic of dysentery broke out, and I had to get busy straight away fighting this disease. One of the local schools was taken over by the District Commissioner for use as a temporary hospital, and I was given two native nurses and one ward-boy as assistants. I went from house to house searching for patients and giving advice on sanitary measures to prevent the spread of the dysentery. Some of the patients used to hide away as soon as they saw me coming. Several times I found them hidden away behind the bags of paddy rice or under a bed. There were ninety patients admitted to the temporary hospital during the epidemic, and we had four deaths. In each case death was due to delayed treatment and to late admission into hospital.

Following the dysentery epidemic I settled down to my routine duties in the district. Some of my first and most interesting work was in midwifery work among my own race. May I describe one or two special cases? One night I was called out to attend a case of delayed labour at the Tokatoka settlement. I went there, and found the patient in a very serious condition. She had been in labour for four days. She was extremely weak and exhausted, and could hardly speak. Her vagina was extremely swollen. The midwifery nurse told me that the foetal movements had ceased four days ago. On examination no foetal sounds were audible, and no fontanelle pulsation was obtained. The foetus was dead, but it was in a normal position. Its head was fixed in the pelvis, and could not be moved. I gave the mother a sedative mixture to cause her to sleep and to obtain a little rest, but she immediately vomited. I then gave her an injection of 1/4 gr. morphia, and waited a short time. Then I got hold of a sharp pair of scissors, as no obstetrical forceps were supplied to me, pushed my hand into the vagina, using the usual antiseptic precautions, right up to the foetal head, and guarding the points of the scissors with my index finger, and then pierced the skull, opened the scissors, and evacuated the cerebral contents. The mother was extremely weak and exhausted, and the uterus was absolutely inert. I therefore inserted my middle and index fingers through the scissors opening, and bent my fingers inside the skull so as to form a hook, and then pulled. It was a very difficult task, and my fingers were very sore and stiff, but I would not give it up, and I was determined to save the mother’s life. At last I managed to move the foetal head a little downwards, and then a little downwards, and then a little more, and then I was able to use both my hands, and at last the foetus was extracted. I may add that I had been pulling with my feet against the mother’s thighs. I then ordered.
a lysol douche twice daily to keep down the septic condition, and in two weeks' time the mother was practically normal again.

3. On another occasion, I was called out to attend another case of delayed labour at Naitata. I went there and found the patient with oedema of the whole body, and a very foul-smelling discharge of blood and serum coming from the vagina. Her condition was very serious. The foetus was dead but lying in a normal position. Encouraged by my previous success I again made up my mind to save the mother's life by following the same procedure. This I did, but it took a longer time, and the case was obviously a more septic one, and on extraction the foetus and its membranes were very offensive. I was worried about the sepsis so I very carefully instructed the Indian midwifery nurse to give a lysol douche three times daily. The urine contained albumin, so I gave the patient a diaphoretic mixture, and mag. sulph. also. Again the mother made a good recovery.

4. Shortly after this I had a case of retained placenta in an abortion case of a half-caste woman. The retention was for more than two hours. With antiseptic precautions I inserted my hand into the uterine cavity and removed the placenta with my fingers. The placenta was put into a basin of water which showed that a small portion was left behind. This I managed to remove digitally. I ordered a lysol douche twice daily, and she made a satisfactory recovery.

5. On one occasion I was called out by a European resident at midnight to attend his wife who was bleeding profusely from the vagina. On arrival I found the patient in a very weak condition. I tried to insert a vaginal speculum to see the bleeding point, but it was impossible. There was no time to spare owing to the loss of blood, so I immediately started to make small swabs about the size of a finger nail, and soaked them in lysol 1 in 160. A highly respected European lady assisted me in making the swabs. Then I packed the vagina with the swabs as tightly as possible, and the bleeding was arrested. The swabs were removed after 12 hours. Lysol douches twice daily were ordered, and complete rest. Without treatment I feel sure that this patient would have died from the arterial bleeding. The following day the patient was sent into Suva by launch to Nurse Morrison's private hospital.

I wish to thank Dr. Harper especially for his very clear lectures and clinics in midwifery which have shown me how to treat these difficult cases.

6. I would like to explain that among the Indians in Fiji the old superstitions and beliefs are still held firmly. They regard midwifery work as the dirtiest work in the world. For this reason low caste Indian midwifery nurses, called "chamars," are appointed to do this dirty work. Outside people will not enter into a house where there has been a confinement for six whole days. When a confinement takes place in a house...
The room is tightly closed on all sides so that the evil spirit called "Jamoga" does not see and attack the baby. It is said that Jamoga attacks only during the first six days. At the end of six days a feast is held, and people come with gifts, &c., and have a merry time. During the first six days if the nurse wants to go out to do any washing, &c., she will take with her a weeding-knife or a pocket-knife to scare off Jamoga or otherwise this evil spirit will enter the room with her. I have often inquired of them how can it be known when Jamoga is attacking the baby. They say that the child becomes very stiff with opisthotonos and with twitchings of the body. This clearly shows that tetanus is the disease they are afraid of, but the real cause is obviously the dirty surroundings in which Indian confinements take place. When an Indian midwifery nurse is called to a house for a confinement case she will arrive in very dirty clothes, and nearly always brings with her a very rusty knife, razor or scissors to cut the umbilical cord. These instruments have never been washed at all, and it is very difficult to understand why sepsis does not occur many times more frequently than it does.