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1. Describe the pattern of disease in Vanuatu, discus this in the context of global health

Observation of hospital inpatient, outpatient settings and rural medical clinics revealed the prevalent health complaints in Vanuatu to include chronic and infectious diseases. Malaria was endemic, cases of falciparum and vivax had risen as per usual with the recent rainy season. Posters were seen within the hospital informing people of the potential mosquito breeding sites and symptom recognition. Tuberculosis was common enough to warrant an isolation ward in the hospital grounds. Whilst there we knew of two patients whose stay extended beyond our own. There was no screening for chronic health conditions, so diseases such as diabetes were diagnosed and managed after presentation with a complication such as foot ulcer. We saw many patients with respiratory complaints such as chronic obstructive pulmonary disease and asthma, prompting inquisition about the smoking habits of the Ni-Van people. The blame was attributed to the practice of burning refuse including plastics in residential areas, rather than tobacco smoke.

From childhood Ni-Vans are taught to carry and use bush knives; emergency department admissions for accidental bush knife injuries were common. Sadly there were occurrences of non-accidental bush knife injuries, violent attacks by fathers on there children were the most common report. Injuries resulting from domestic violence were treated, however no social support could be offered.

2. Describe the pattern of health provision in Vanuatu contrast this with the UK

Espirito Santo one of the largest islands of Vanuatu, its main town Luganville is home to the northern district hospital. This facility has an emergency department, inpatient wards for medicine, surgery, maternity, paediatrics and an isolation ward for tuberculosis, bed numbers varied according to need and ability to squeeze another bed in. There is an outpatient department and dispensary on site as well as a laboratory.

The staff included doctors from Fiji, China and England; nurse practitioners trained locally organised wards, patients and staff. Patients access health care by queuing, sometimes for many hours, to register and pay for consultation. The price varied for adults, children and elderly, but was in the range of 200 Vatu, approx. £1.50; prescriptions were also paid for by the individual. The health care professional seen depended on the staffing that day, we arrived soon after a retired British GP begun work at the hospital, so saw him in clinic many days. Alternatively patients may have seen a nurse practitioner who could refer to a doctor if needed. Other smaller islands of Vanuatu had variable levels of local health care provision, dependent again on voluntary agencies. We met Project Hope workers who assisted in providing health screening and provision in rural settings both on Santo and other small neighbouring islands. It was not uncommon to hear of a patient's two day journey from a remote island to get their child to the hospital.

Inpatient ward rounds, much like in England, were senior led and took place each morning. Medical students fulfilled a similar (non-essential) role often. Communication was sometimes made difficult by the mix of languages represented on the round, for instance a Chinese doctor, with English students using a pocket translator and us to speak Bislama to a woman

whose first language was an unknown dialect. Patients were very appreciative of their health care provision, the Ni-van people tended to be polite and respectful of HCPs. I saw no evidence of anyone questioning their management plan or the care they received, this struck me as different to the UK. The patients' and their families were often quite active in their care whilst in hospital, taking charge of, for instance the personal care and feeding of their loved ones. This perhaps reflected the high ratio of patients to HCPs.

3. What are the prevalent chronic diseases in Vanuatu and how are they managed

Type two diabetes was common in adults, once detected it was managed with oral hypoglycaemic agents in the outpatient setting. Capillary blood glucose measurements could be taken at the hospital, but there was no provision for daily CBGs at home. Oral hypoglycaemic could be stepped up and used adjunctively, however there was little chance of stepping up management to insulin. Without screening programmes in place the detection of diabetes relied upon the patient presenting with symptoms or complications of diabetes. Efforts had been made to educate people as to the symptoms indicative of diabetes, posters could be seen around the hospital.

Asthma in children was very prevalent, maintenance therapy was not considered, but reliever inhalers could be prescribed. Education was always foremost in management, advising parents to keep their children away from bonfires and smokers. Adults presenting with COPD had their chest auscultated, and the pharmacy could facilitate medicinal management akin to the UK. In neither respiratory illness were lung function tests such as peak flow or spirometery available, so assessment of disease progression was history and examination assessed. Pneumonia in COPD patients was a common presenting complaint, diagnosed without chest X-ray upon examination findings. The difference was notable between the limits of investigative resources in Vanuatu compared to those at our hands in western medicine and the obligation to utilise such facilities in deciding management.

4. How is paediatric health care delivered in Vanuatu, how is this similar/different from UK

The inpatient setting within the hospital included three open wards with bed numbers one to six painted on the walls around each room, underneath which eight to ten adult beds were squeezed in. Parents slept with their children in these beds whilst in hospital, there were no restricted visiting hours as in the UK. Parents played an active role in caring for their child in hospital, nursing staff were occupied with medical management, so responsibility for washing and feeding the child was left to family.

All children born in hospital were given the full set of vaccinations, including BCG; however many children were born at home in rural settings and there is no national policy for community health visitation. Education was limited to those that could be accessed. Once in hospital, nurse practitioners often took the opportunity to educate mothers about nutritional needs of their children; we were surprised to see so many malnourished babies occupying inpatient beds. The medical staff reported that pneumonia was the most common admission to the department, which at the moment had plenty of antibiotics.

Many conditions progressed untreated in children, until free health checks were offered by

the pacific partnership doctors. We saw chronic recurrent ear infections in whole families of children, who had previously received no management. Tropical ulcers of yaws disease affecting multiple areas of young children's bodies again were not presented to hospital, perhaps because of the cost associated. This differed from the early presentation of most children seen in the free UK NHS service.