Vanuatu - experiences and insights from an elective in paradise

K.A. Michalak

Introduction

When planning my medical elective, I sought a location which would enable me to gain an understanding of the care provided particularly to women and children in a community with relatively limited technology and resources and to contrast this with my experience in a major tertiary hospital in Victoria. At the same time, I hoped to experience a new culture and way of life and perhaps even learn a new language. Vanuatu fulfilled all these criteria.

Vanuatu is an archipelago of about 80 islands, 69 of which are inhabited. It gained independence in 1980 after more than 70 years of colonisation by Britain and France and the influences of both countries remain visible in Vanuatu culture and language with English, French and native Bislama all spoken. Nevertheless Vanuatu retains some of its traditional "Kastom" culture and way of life.

Despite recent economic growth, Vanuatu continues to face many health challenges, including ongoing difficulties with the provision of essential health and education services to remote rural communities. Some 80% of the population of Vanuatu live rurally and are predominantly engaged in subsistence agriculture; only 60% of the population have continuous access to clean water. Infant mortality remains 5 times that in Australia with only 79% of women having skilled birth attendants present and only 84% of pregnant mothers attending at least one antenatal visit. Australia continues to spend between $3 and $4.5 million on health assistance to Vanuatu each year.

For my medical elective and with the assistance of the Andrew Dent Scholarship, I chose to spend nearly 5 weeks in early 2011 in Luganville on the island of Espiritu Santo in northern Vanuatu. There the country's second largest hospital, the Northern Districts Hospital, provides emergency, outpatient and inpatient medical, surgical, paediatric, and obstetric services to a population of approximately 32,000 people. On arrival I found myself to be one of 8 Australian medical students from 3 medical schools. We were immediately made to feel very welcome and valued for our skills but free to choose both our work hours and activities. We were encouraged to attend in the mornings and to observe the "siesta" between 11.30am and 1.30pm. Afternoons at the hospital were typically quieter, allowing time for sightseeing and relaxing. My interest lying primarily in obstetrics, I chose to spend the majority of my time whilst at the hospital in the maternity ward.

Experiences on the maternity ward

The maternity ward at the Northern Districts Hospital (NDH) comprises 16 beds plus a 3 bed delivery room. It also includes a neonatal "nursery" but in reality even premature low-birth weight babies are roomed in with their mothers. In addition to midwives, the clinical work is currently shared by 2 obstetrician-gynaecologists – a Ni-Vanuatu male obstetrician and a visiting Chinese female obstetrician (the Hospital has an agreement with the Chinese Government and hosts a variety of Chinese specialists). They take turns doing outpatient, ward and on-call work. The maternity ward is supported by a busy 4 & 1/2 days a week antenatal clinic which also provides family planning and gynaecology services. Midwives deliver approximately 2 babies a day, with backup from the obstetricians. Whilst lacking some of the modern equipment that is commonplace in Australia (for example oxygen is housed in enormous cylinders, there being no infrastructure to make gases available via wall fixtures at the bedside as is the norm in Melbourne hospitals) it was sometimes surprising what was available – for example, the midwives had access to a portable Doppler ultrasound to listen to fetal heart sounds whilst also being very proficient in using the old-fashioned plastic Pinard stethoscope. Notably, a lack of paediatric (and in fact, adult) intensive care at the NDH means that infant survival is limited to approximately 32 weeks gestation (whilst in Melbourne it is

limited to approximately 24 weeks) – corticosteroids being available but neonatal intubation and pulmonary surfactant being unavailable. The paediatrician described to me how some time ago she kept the premature baby of a missionary alive via manual ventilation until it was airlifted out – unfortunately such a scenario would be financially unfeasible for the local Ni-Vanuatu.

I was surprised to find that the principles of obstetric care were little different at the NDH from those I had learned in Australia, with all the paperwork such as antenatal records and partograms using identical (and notably, English) terminology. However in practice a number of differences became apparent, being both due to cultural and practical reasons. For example, the antenatal clinics are primarily run by midwives, with an obstetrician available only for more complex cases one session a week. Unlike routine care in Melbourne, antenatal visits at the NDH have no fixed schedule. Frequently women present to the antenatal clinic for the first time during the 2nd or even 3rd trimester of their pregnancy and midwife discretion determines how many weeks later their return visit occurs. First trimester dating scans and 20 week morphology scans are not routine at the NDH, and many women won't have an ultrasound at all during their pregnancy despite ultrasound being available in the Radiology department. In turn, no Down's Syndrome screening is carried out, any fetal abnormalities that won't otherwise cause external cause for alarm (such as small-for-dates which might be investigated with a scan) are missed and antenatal sex determination is unusual. This also means that the staff rely on women's recall of the date of their last menstrual period to calculate their expected date of delivery. Subsequently, staff are less concerned about post-dates, blaming any delay in parturition on inaccurate dating: during my elective I saw a number of women in clinic who were 43 or 44 weeks gestation by dates but no woman was induced for post-dates during my time there. Interestingly, whilst Vanuatu is a strongly Christian society, it was not unusual to see teenage and unmarried women presenting to the antenatal clinic. Whilst the midwives quietly disapproved of such women my impression was that these young mothers tended to be well supported due to the fact that many continue to live in extended families. There is currently no legal option for terminating a pregnancy in Vanuatu.

In addition to differences in antenatal care, I also found several large differences when it came to parturition. It was not unusual for women to arrive at the hospital late in the first stage (or even early second stage!) of their labour, possibly having never presented for antenatal care. These women were typically those from rural locales and may have traveled a full day or two to the hospital. Women usually arrived accompanied by a female companion (often their mother); husbands arrived only once the baby was delivered and in fact I discovered that the midwives believed that women did not labour effectively when their husbands were present. Once moved into the delivery room women almost invariably delivered alongside only a midwife – very rarely did they have a support person with them. Most dramatically, the Ni-Vanuatu women laboured reasonably quietly without any pain relief whatsoever, even for forceps deliveries. Epidurals were entirely unavailable, and I soon found out that it is in the nature of the Ni-Vanuatu to consider crying and "fussing" to be wasteful and unseemly. Women were scolded by the midwives to labour quietly and to employ their energy to deliver their child rather than to thrash about. Afterwards, the majority underwent suturing without any local anaesthetic; most women received only panadol once removed to their shared ward room. And all this in incredibly hot, humid conditions – though in fact the delivery room was the only room in the maternity ward with an air-conditioner (the ward rooms themselves had not so much as a ceiling fan). I also witnessed one Caesarian Section, undertaken for a multiparous woman in obstructed labour. This Caesarian was done very reluctantly and only when it became clear no other option was available. It took me some time to understand the significance of this decision -- to do a Caesarian on a mother who must return to a rural community potentially several days travel away, with the limitations the inevitable 6 week recovery has on her wellbeing and ability to manage a new baby, and the lack of specialist medical care if she should need it, is quite a different thing to doing a Caesarian on a mother residing in a large urban centre.

Experiences in outpatients, emergency and surgery

In addition to my time on the maternity ward I also had the opportunity to spend some time in outpatients, emergency and surgery and observe the differences and similarities between our own services.

The outpatients department at the NDH is effectively a general practice with patients presenting with all manner of ailments. It consists of several consulting rooms and a large open-air but tiled and covered waiting area; patients wait patiently on long benches for their number to be called and may wait all day if they are late to arrive, register and pay their small fee. In outpatients I sat with one of the doctors or nurse practitioners. I was surprised at being allowed to write (and sign) scripts for patients. A big challenge was understanding the patient's descriptions of their illness; this was where learning some Bislama was a necessity. Bislama is a descriptive language and a mixture of English, French and Pidgin amongst others. For example, 'constipation' in Bislama is "no sit sit" while 'diarrhoea' is "sit sit wota (water)". It was a pleasure to learn Bislama and not overly difficult – with only 6000 words in the vocabulary it seemed to me that I might be fluent had I the opportunity to spend 5 months in Vanuatu rather than only 5 weeks.

The emergency department at the NDH comprises 3 beds and is run by a Nurse Practitioner. The NDH has no ambulance but does have a transport service in the form of an open-tray truck similar to a large utility vehicle; this was a popular vehicle type in Luganville and it was not uncommon to see two dozen people, including small children, travelling in the back of such a truck downtown. Due to the ongoing belief in "Kastom" (traditional village) medicine and their distance from the hospital many patients presented to emergency late in their illness only after they had tried and failed to get relief from Kastom remedies. This sometimes meant for spectacular presentations such as enormous abscesses – I saw several of these drained in theatre. There were also frequent presentations with fever, and unlike in Australia, the obvious first step in Vanuatu was to undertake malaria testing for which there were frequent positives. Unlike myself and my visiting medical student colleagues, the Ni-Vanuatu do not take malarial prophylactics and my understanding is that it is not uncommon for patients to get malaria a number of times.

The surgical ward comprises around 30 beds with no gender division. Surgical ward rounds occurred every morning and the surgical ward was always full. A large number of the patient cohort were there following amputations for diabetes-related peripheral vascular disease; diabetes is a major problem in Vanuatu. It was also interesting to see two men undergoing traction for trans-femoral fractures – as internal fixation for fractures is unavailable at the NDH (there being no orthopaedic specialist), this traditional technique was employed instead and meant a very long hospital stay for the men – one had been an inpatient since October of 2010. It was on the surgical ward that I discovered another interesting aspect of care at the NDH -- while the hospital provides food for patients, it was widely acknowledged that this provision was insufficient and that were it not for family bringing additional food, the patient would go hungry. I wondered, what happened to those patients unlucky enough to not have family, or with family too far away to travel to them?

Experiences outside of the hospital

Outside of the hospital there was, unsurprisingly, a wealth of sight-seeing to do and activities to try and everywhere there were friendly and politely curious Ni-Vanuatu who greeted me on passing. The waters around Santo Island are incredibly blue and warm, filled with stunning tropical fish. During my stay I was fortunate to get my scuba diving license and dive one of the most famous ship-wrecks in the world – the SS President Coolidge. One weekend a group of us hired a van and visited the aptly named Blue Holes, the pristine Port Olry and the famous Champagne Beach. We were also lucky enough to be invited by the cook at the hospital to spend a day in her village in South Santo, to

which we traveled, like real locals, in the tray on the back of a truck. A day spent trekking through the jungle and traversing a cave by torch-light followed by drinking coconut milk directly out of the coconut completed the experience of a lifetime.

Conclusion

All in all, my time in Vanuatu was unforgettable and I am extremely grateful for the opportunity that the Andrew Dent Scholarship, and the wonderful staff at the Northern District Hospital, have afforded me. It was fascinating to observe both the similarities and the differences in clinical practice in the hospital, especially in my particular area of interest in obstetrics. I had an extremely rewarding and enriching experience and hope that I was able to give back a little through my own limited skills and knowledge.

During my stay there was a Sydney-based GP and his UK-based friend and colleague who volunteered at the hospital for two weeks. They had also spent many years volunteering for short periods in Fiji and intended to return to the Northern Districts Hospital in 2012. I hope that once I am qualified I may be able to do the same in the future.