Key Features 2008

New Caledonia Health Profile

DASS
Direction des Affaires Sanitaires et Sociales

Main health facilities in New Caledonia 2008

* The health facilities and stay available to the people of New Caledonia are detailed in Chapter II : Health Services

** The Koumac and Poindimié hospitals have a medico-psychological unit attached to CSH A. Bousquet

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Population

Demographic characteristics

As at 1st January 2008, the population was estimated to number 244 410, representing an increase of 5.9 % over the figure from the previous population census.
Distribution by province remained stable in comparison with the previous population census (Southern: 72.1 %, Northern: 18.7 %, Loyalty Islands: 9.2 %).
The population comprises 50.4 % men and 49.6 % women.

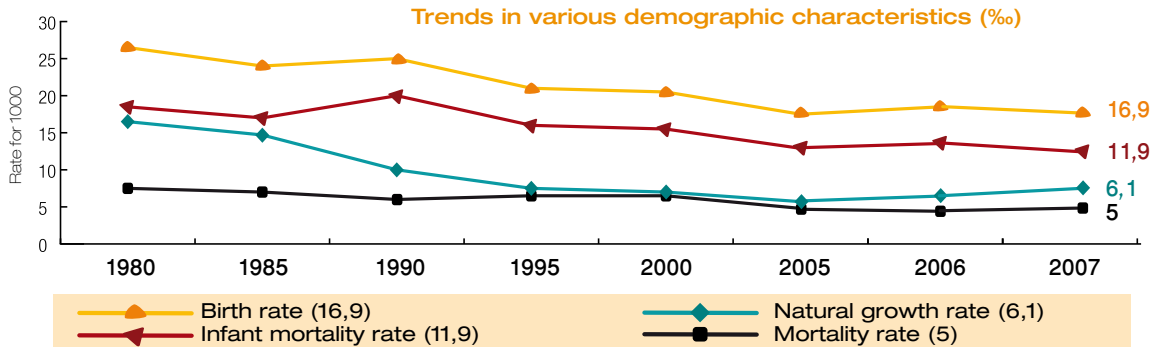
Main demographic indicators As the 2009 population census is currently in progress, ISEE has not communicated the population figures as at 1 January 2009. For this reason, the data remain unchanged at 30 / 06 /09.

	Population as at 01/01/08	Rate of increase (‰)	Number of births according to mother's place of residence	Birth rate (‰)	Fertility index	Crude infant death rate (‰)	Number of deaths according to place of residence	Crude mortality rate	Crude perinatal mortality rate (‰)	Life expectancy at birth
New Caledonia	244 410	11.9	4138	16.9	2.2	5	1207	5	13.5	75.9
Islands Prov. *	22 570	10.7	387	17.2	2.4	18.1	145	6.4		72.7
Northern Prov. *	45 700	9.3	701	15.4	1.9	7,1	277	6,1		73.2
Southern Prov. *	176 140	12.7	2982	17.1	2.2	4	766	4.4		76.9
France (2006)	63,75 million	4.7	830 900	12.9		3.6		8.45	7 (96)	84.4
Fr. Polynesia (2006)	279 882			17.8	2.01	6.8		4.69		76.9
Australia (2005)	19,9 million	1.2		12.7		5		6.4		83.5

* Only persons residing in the province.

The natural growth rate[1] fell in 2007, from 13.0 to 11.9 ‰.

The birth rate[2] - 16.9 ‰ - has been constantly falling since the 1960s, from 34.5 in 1965, to 23.4 in 1985, then, after a spectacular recovery in 2000, declining to its lowest ever level in 2007.



Fertility index[3]: 2.2 per 1 000 women of reproductive age.
A decrease in the fertility rate range by age between 1981 and 2005 with a rising average age for motherhood (from 26.4 in 1980 to 28.8 in 2006) can be observed.

Crude mortality rate[4]: 5 per 1 000 (6.1 ‰ for men and 3.8 ‰ for women)
After a distinct drop in the 1970s and 1980s, the crude death rate decreased at a lower rate until 1998.
Since then, it has varied little and has remained slightly above 5 deaths per thousand since 2005.
Male mortality is higher, with a peak between the ages of 20 and 25.

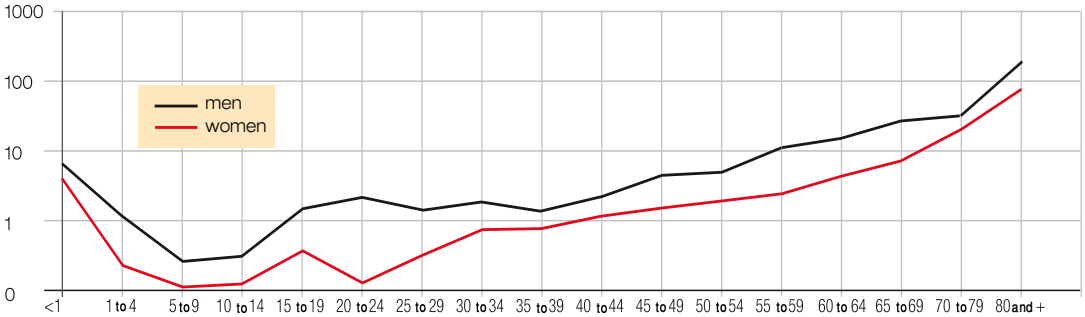
1 Natural growth rate: difference between crude birth rate and crude death rate, expressed as a per 1000 population figure.

2 Birth rate: ratio of annual number of live births to total population at the half-way stage of the year concerned, expressed as a per 1000 population figure.

3 Fertility index or conjunctural fertility indicator: sum of all fertility rates by age for the year concerned.

4 Crude mortality rate: ratio of annual number of deaths to total population at the half-way stage of the year concerned, expressed as a per 1000 population figure.

Mean annual mortality rate (‰) from 1996 to 2007, by age group and sex.



In 2007, the crude mortality rate gradually rose in the Loyalty Islands Province (6.4) and the Northern Province (6.1). In the Southern Province, this rate remained relatively stable (4.4).

Life expectancy at birth[5]: 75.9 years (men: 71.8; women: 80.3), is characterized by a regular increase, with higher gains for men than for women over the last 20 years and a continuing gap between men and women.

Infant mortality rate[6]: 6.1 ‰. After a sharp drop in the 1970s, this rate, which is an indicator of a country's socio-economic and health development status, fell more gradually until the early 1990s, when it dropped below 10 ‰. Since 2001, a regular but less marked decrease can be observed, with the rate moving increasingly closer to that of metropolitan France and the European countries.

New Caledonia still has a young population (43.1 % under 25 yrs old).
Improvements in socio-economic and health conditions have helped in improving life expectancy and reducing mortality, in particular infant mortality, which is now close to the developed country rate. However, the fall in the fertility rate, which is still higher than that necessary to maintain current population size, points to future difficulties associated with an ageing population.

Medical causes of death

1 172 medical death certificates were issued in 2008 (men: 695; women: 477). 24 deaths could not be assessed directly by a physician and were coded as Group XVI (inadequately defined disease status).
It can be noted that the following classification by disease varies only slightly from year to year.

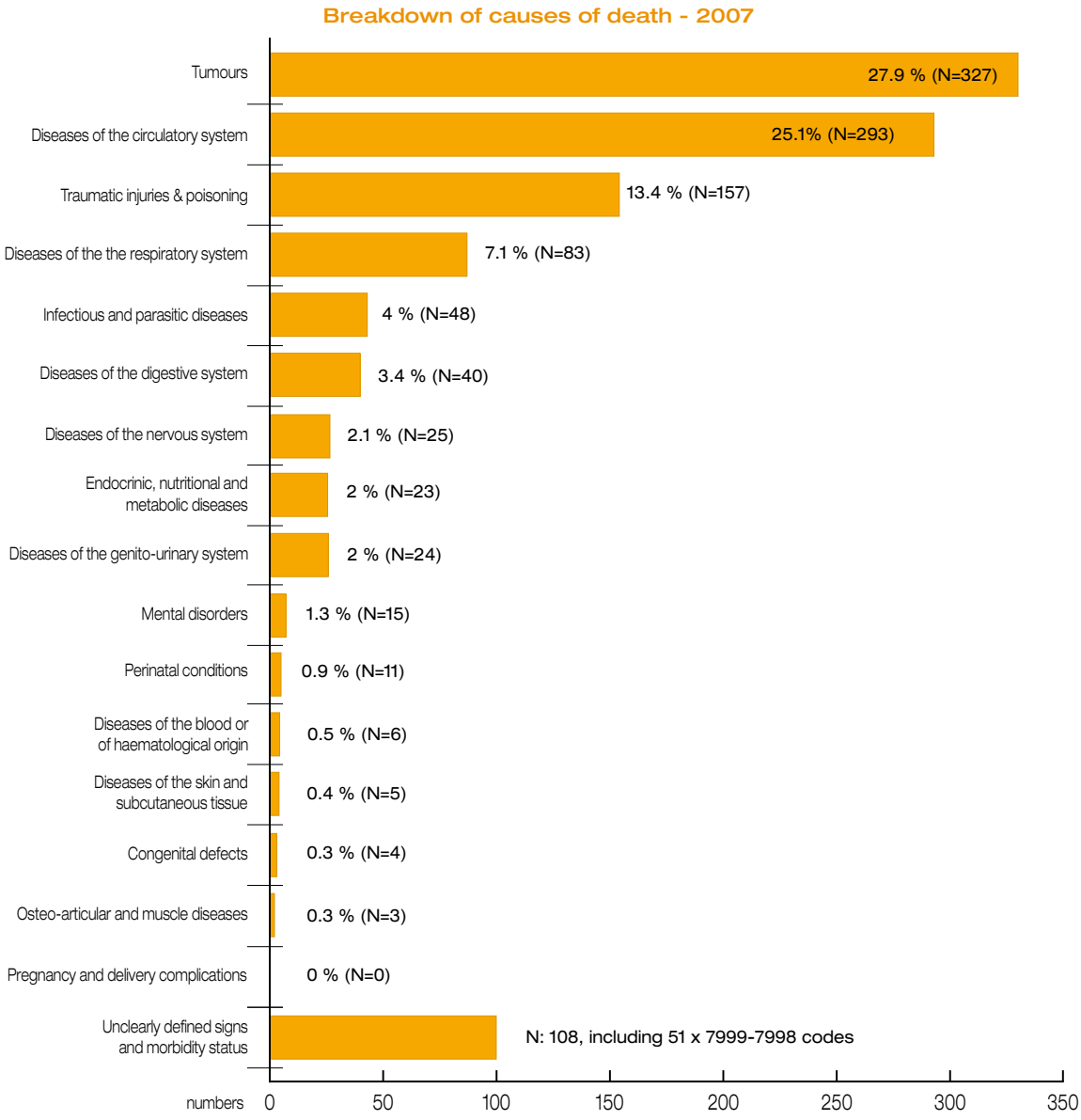
The 5 main causes of deaths vary according to sex as follows:

	Men	Women
Tumours	27.2 %	28.9 %
Circulatory system	23.7 %	27 %
Traumatic injuries	18 %	6.7 %
Respiratory system	7.5 %	6.5 %
Inadequately defined disease status	7.5 %	11.7 %

It is noteworthy that **traumatic injuries and poisonings** remain the principal cause of death in the young population, accounting for 64,0 % of deaths in 1-24 year-olds and 45,8 % of deaths in 25-44 year-olds for the 1991-2008 period. This group represents the leading cause of premature death in both sexes in New Caledonia, with 74 098 years of potential life lost (YPLL) between 1991 and 2008. This premature mortality is particularly high in males with 58 975 years of life lost, as compared to 15 123 years for females.

5 Life expectancy at birth expresses the mean number of remaining life years for a new-born child if the mortality trends prevailing at the time of birth do not change.

6 Infant mortality rate: ratio of number of deaths of children under one year of age to 1000 live births during the year concerned.



Medical causes of perinatal death

In 2008, 67 child deaths were reported through specific perinatal death certificates, bringing the number of deaths to 1 099 for the 1993-2008 period. Of these 1 099 certificates, only 250 (22.7 %) were not reported to the civil status office.

For the 1993-2008 period, 167 certificates involved **medical terminations of pregnancy (MTP)**, the most frequent reasons for which were congenital disorders (nervous system: 29.9 %, chromosomal defects: 16.2 %, other congenital anomalies: 26.9 %).

Of the 932 neonatal deaths not including MTP, 33.6 % had no determining **foetal or neonatal cause**. For the remaining **619** certificates, the cause was child-related in 89.4 % of cases and mother-related (maternal condition or pregnancy complications) in 10.5 % of cases. Among child-related causes, **intra-uterine hypoxia** and/or birth asphyxia accounted for 34,1 % of cases and **congenital defects** 18.4 % of cases.

Infectious diseases

Notifiable diseases (not including cancers - see specific chapter)
In 2008, 2 471 notifiable disease cases were reported, not including cancers and rheumatic fever (RF). Following the establishment of the register of RF patients by the health agency, RF has been covered by detailed analysis in a special chapter (see summary in the following pages).

Group A, diseases justifying exceptional national and international measures (cholera, plague, smallpox, yellow fever, rabies, exanthematic typhus, African haemorrhagic fevers): none of these diseases have been notified since 1986.

Group B, diseases justifying local measures, which are detailed in the following chart:

Notifiable disease of group B	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Amoebiasis	18	31	13	20	11	6	0	1	1	1	0
Whoping cough	1	3	3	0	1	0	1	72	4	1	0
Dengue fever	2612	354	12	34	105	5673	792	46	48	47	1179
Diphteria	1	0	0	0	0	0	0	1	0	0	0
Typhoid and paratyphoid fever	1	0	0	3	0	0	0	1	0	1	0
Viral Hépatitis B	94	119	40	49	31	39	29	11	9	31	102
Viral Hépatitis C	3	0	0	1	0	0	0	0	0	2	0
Leprosy	5	7	7	7	2	4	8	4	7	2	6
Leptospirosis	132	200	28	23	49	23	13	40	65	53	157
Meningococcal meningitis	13	6	4	9	10	11	3	5	7	13	9
Indigenous and imported malaria	0	4	3	1	1	5	6	0	0	0	2
Measles	0	1	0	0	0	0	0	0	1	0	0
HIV - related syndromes	20	22	21	15	17	8	7	13	10	21	15
Tetanus	0	0	0	1	0	0	0	0	0	0	0
Collective food poisoning (foci)	7	5	3	9	1	6	0	8	10	8	6
Tuberculosis (incl. talent infection)	148	109	171	100	112	82	84	72	90	67	80

In 2008, no cases of poliomyelitis, botulism or brucellosis were observed. 157 cases of leptospirosis and 1 179 cases of dengue were reported.

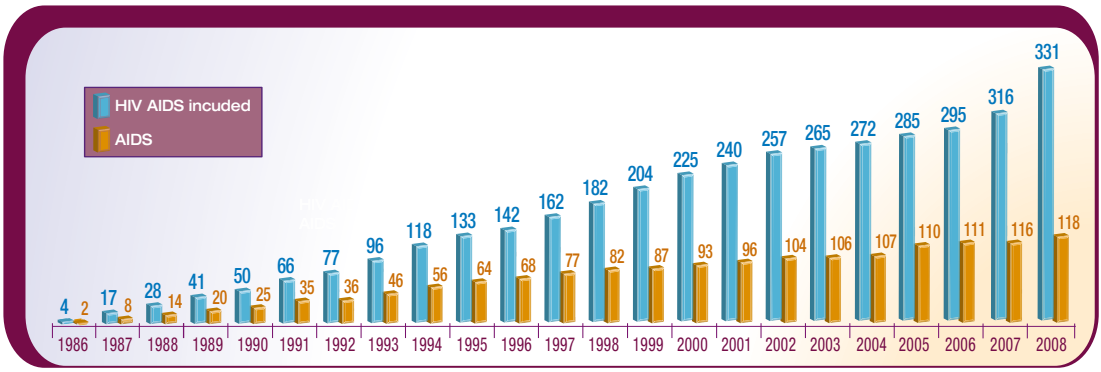
Group C, sexually transmitted diseases

Notifiable diseases of group C	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Condyloma acuminatum	48	26	26	27	28	26	17	3	12	22	28
Genital herpes	3	5	2	3	3	5	4	2	3	10	8
Mycoplasma infections	165	121	115	119	107	90	93	108	134	219	184
Genital chlamydial infections	119	89	94	96	71	86	88	71	96	148	191
Gonococcal infections	95	54	52	55	49	31	33	35	58	82	90
Syphilis	36	17	24	16	11	10	20	15	21	37	36
Urogenital trichomoniasis	125	139	250	203	156	171	152	114	98	199	113
Other venereal diseases	252	298	339	225	182	102	62	62	80	60	67

HIV-AIDS

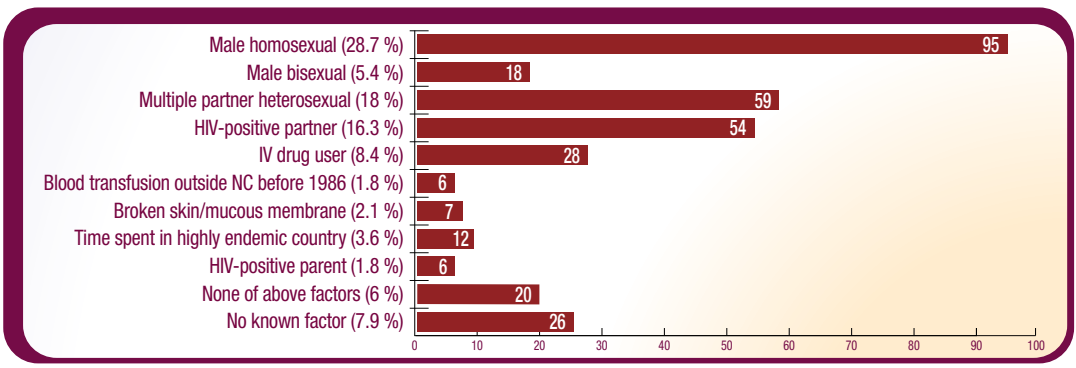
Statistical data regarding HIV infection come from notifiable disease surveillance activities and from specific initial notification forms and supplementary notifications of HIV-induced syndromes.
15 new HIV-positive cases were recorded in 2008 (including 11 confirmed by laboratories outside New Caledonia and 4 confirmed by IPNC).
This brings to 331 the accumulated number of cases since 1986.

Annual progression depending on the stage of infection (accumulated cases)



As at 31st December 2008, the sex-ratio of accumulated cases was 3 males for 1 female.
The most affected age group, as in previous years, was the 20-39 year group, with a rate of 29.3 per 10 000 population.

HIV risk factors



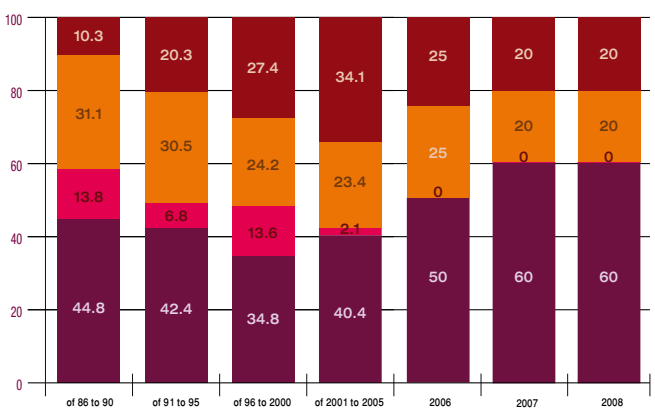
Breakdown of 316 HIV-positive cases by risk factor

With regard to the cases whose risk factors are known, it can be noted that 74.1 % are linked to a sexual mode of HIV transmission, 50 % of which (113/226) are male homo/bisexuals.

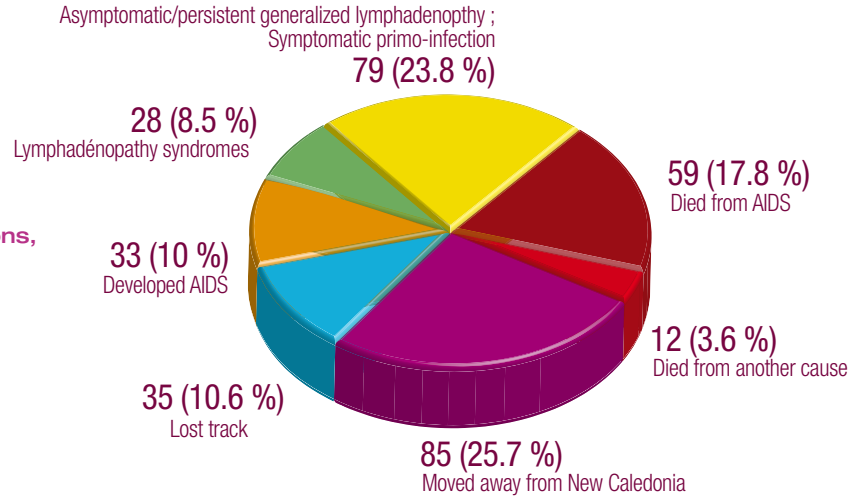
Over time, the 'HIV-positive partner' percentage has increased considerably, from 10.3 % (from 1986 to 1990) to 34.1 % (from 2001 to 2005) in sexual risk factors.

Of the 28 (9.2 %) intravenous drug users (4 women and 24 men), 16 had been residing in the territory for less than 6 months at the time of notification; 11 had been residents for more than 6 months and 1 often travelled outside New Caledonia.

Percentage change in sexual risk factors from 1986 to 2008



Breakdown of 331 HIV-positive persons, by last known status



Last known status of HIV-positive persons

'Last known status' refers to the assessment contained in the latest supplementary report prepared by the attending physician. Of the 331 HIV-positive patients, 71 have died (including 12 of a cause other than AIDS), 120 have moved away from New Caledonia or are no longer being monitored. Among the latter, some have probably left New Caledonia for good.

In New Caledonia, of the 15 cases recorded in 2008, 15 (73.3 %) were at the asymptomatic stage, 3 (30 %) were at the symptomatic non-AIDS stage and 1 (6.7 %) at the confirmed AIDS stage.

Free and anonymous testing and counselling centres (CDAG)

In 1992, the Territorial Congress Standing Committee introduced free and anonymous testing and counselling centres (CDAG) for the human immuno-deficiency virus (HIV) (Resolution N° 211/CP dated 30 October 1992).

This resolution was superseded by Resolution N° 154/CP dated 16 April 2004, specifying the standards of training required and the operating conditions for these CDAG.

The consultation is conducted by a consulting physician or a midwife approved by the Medical Inspector after receiving specific training on counselling in relation to HIV infection testing. Approved personnel receive patients either in their surgery (private practitioners and midwives) or at the counselling centres (these centres must meet requirements laid down in the resolution: the venue must be part of a multi-purpose medical centre, the counselling must protect the confidentiality and anonymity of the process and the staff must have received special training for counselling).

Each consultation must include a counselling session covered by a questionnaire, developed by the Medical Inspector and completed by the doctor or midwife.

Since November 2005 and in 5 successive training sessions, 75 health professionals (52 doctors and 23 midwives) have been trained and are approved and active in New Caledonia. It should however be noted that, for 21 of theM (12 doctors and 9 midwiVes), their approval has only been operational since early 2009. The CDAG 2008 records were therefore compiled with contributions from 44 professionals (of the 54 possible, I.E. 81.5 %of them)

An analysis of the 2 835 questionnaires, strictly anonymous, completed in 2008 and returned to the DASS-NC Health Action Section, showed a 42.6 % increase in the nomber of reports received in 2008 as compared to 2007.

- Under-35s accounted for over ¾ (77.8 %) of patients (47.1 % between 15 and 24 years and 30.2 % between 25 and 34 years).
- European patients accounted for 42.5 % of consultations. Melanesian patients represented a little under one third (38.6 %).
- 'Risky behaviour' was referred to in 41.5 % of cases far more than 'early stage of relationship' (14.9 %).
- 'Pregnancy' was a reason for coming in 8.4 % of cases (for 5.8 % of women) and 2.6 % of consultation by a spouse or partner.

It should be noted that 136 patients (4.8 % of patients) reported a split condom.

Conclusions

The 2008 analysis confirms conclusions from previous years:

- The vast majority (52.5 %) of the data analysed in 2008 relates to the Noumea 'ESPAS CMP' (the Multi-purpose Medical Centre of DPASS Southern Province, referred to in previous years as the Noumea CDAG). The expansion in 2006 to 54 professionals approved to conduct consultations should make it possible to gradually increase and diversify the CDAG's range of patients, mainly through increasing territorial coverage. In this way, the number of sessions conducted outside the ESPAS CMP structure increased from 231 in 2006 to 412 in 2007 and to 1 347 in 2008
- In 2008, 21 more professionals were approved. They now number 75 altogether (only in 2009 will their contribution to the number of free and anonymous consultations come through). These newly approved professionals reinforce the service available to the community in terms of testing and prevention. In 2008, the number of consultations conducted outside the ESPAS CMP structure is likely to expand considerably.
- The importance of the ESPAS CMP (especially the pilot training and incentive role played by the team there) is evident in the high number of tests carried out and the number of people who, over 16 years, have enjoyed personalised treatment whether or not followed by testing.
- Research on patient characteristics has enabled us to detect risky behaviours and lack of understanding of preventive methods and virus transmission.

Sexually transmitted diseases

780 notifications were received in 2008, the majority (93,1 %) from the provincial medical districts and the Southern Province dispensaries (ESPAS-CMP multi-purpose medical centre, mother and infant health protection centre and family planning services) because of under-notification by the private sector.

Despite this under-reporting, prevention, information and screening work should be kept up, even if certain diseases such as syphilis are less common.

The number of notified STD cases remains higher in women than in men; the female/male ratio is 4. This should be related to the reproductively active age period when women see a practitioner more often to start or check contraception, but also for prenatal care.

STD / Sex	Male	Female	ND	Total	%
Molloscum contagiosum	0	1	0	1	0.1
Genital herpes	2	6	0	8	1.0
Condyloma acuminatum	2	26	0	28	3.6
Syphilis	14	18	4	36	4.6
Urogenital candidiasis	6	56	1	63	8.1
Othe venereal diseases	7	60	0	67	8.6
Gonococcal infections	55	32	2	89	11.4
Urogenital trichomoniasis	3	110	0	113	14.5
Mycoplasma infections	38	146	0	184	23.6
Chlamydial genital infections	44	131	16	191	24.5
Total	**171**	**586**	**23**	**780**	**100**

Medical laboratory data also emphasize the need for surveillance and data collection. In recent years the trend is a clear drop in the number of STD notifications (especially in the private sector from 2000), while the demand for biological testing and positive results (at IPNC in particular) are not decreasing.

Those discrepancies underline the need to improve the STD notification process, and therefore obtain more representative results at the scale of New Caledonia.

Viral Hepatitis

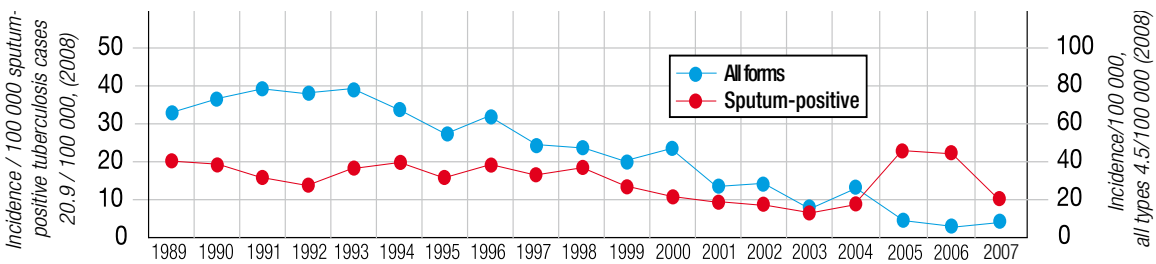
102 new cases of hepatitis B were recorded in 2008 . 96 cases concerned adults.
The proportion of cases of children under 15 years has diminished as a result of the introduction of systematic vaccination of all newborns in 1989 (38% in 1992, 5.8 % in 1996, 6.4 % in 1998, 2.5 % in 2000 and 0 % in 2005).
The 3 cases in 2003, which raised the rate to 7.7 % for that year and confirm the need to vaccinate at childbirth, should be noted. There were 2 cases of Hepatitis C in 2007.

Tuberculosis 2008

The World Health Organization has already advised that the number of tuberculosis cases has risen spectacularly in Europe and North America in the last few years.
Among the factors contributing to this resurgence, WHO reports the deterioration of tuberculosis control programmes and the link between tuberculosis and HIV. Also, new drug-resistant bacteria are developing throughout the world.

In New Caledonia, **51 new cases** of tuberculosis were notified in 2008 (47 in 2007), including **35 cases of pulmonary tuberculosis** (31 in 2007). After a drastic fall of the incidence rate in 2003 (16 per 100 000 population), the incidence rate in 2008 is equal to **20.9 per 100 000**. Even though there has been a downward trend since the beginning of the 1990s, it remains at high levels in comparison to industrialized countries, and at a lower level than world incidence.
There are **11 cases** from direct positive testing (14 in 2007) or **31.4 % of pulmonary tuberculosis** cases (45.2 % in 2006). Contagious tuberculosis enables tuberculosis infection to perpetuate itself. Diagnosis must occur as early as possible, treatment strictly followed and the identification of infected persons commenced as soon as reliable treatment starts. The incidence rate of tuberculosis from direct positive testing **(smear-positive)** was **4.5 per 100 000** (6 in 2007).

Incidence/100 000 of all forms of tuberculosis and sputum-positive tuberculosis



Treatment

By definition, tuberculosis is considered cured when sputum specimens are negative two and five months after the beginning of treatment. If these tests are not performed, treatment is said to be completed or finished. The WHO strategy regards a programme to be efficient if the rate of cure is above the 85 % mark.
For patients tested in 2007, a **rate of cure of 71.4 % (sputum-positive)** was recorded.

Patient characteristics

A detailed study of the 671 tuberculosis cases notified during the last 10 years, all types combined (from 1998 to 2008) shows that 70 % of the cases are pulmonary forms and that all areas are affected by the disease, which is more frequent however in the communes of Belep, Ponerihouen and Houaïlou, where rates are higher than in other areas.

The diagnosis was made from clinical signs in 71.9 % of the cases. 9.7 % of new cases were relapses.
In metropolitan France, this disease still occurs, with an incidence rate equal to 8.9 per 100 000 in 2007. Regional disparities are observed, with the highest rate in the Ile-de-France region where it reaches 18.4, a figure similar to that of New Caledonia.

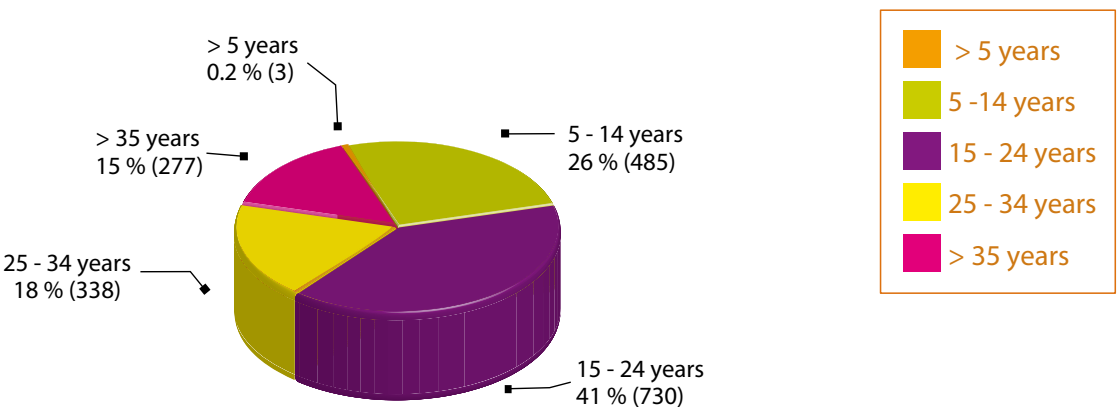
High notification rates were observed in certain population groups, such as persons born abroad (41.5/100 000), in particular in sub-Saharan Africa (130/100 000) and those having arrived in France less than two years previously (251/100 000) as well as persons with no fixed abode (214/100 000) and persons aged 80 years and over (21.7/100 000).

Rheumatic fever (2008)

Rheumatic fever (RF) mostly affects children and adolescents and is a disease with severe medical, human, social and economic consequences.
Rheumatic fever is a possible consequence of a probably auto-immune mechanism of bacterial angina due to a group A beta-haemolytic streptococcus (GABHS). It is common among children but in New Caledonia outbreaks can occur very late in life (age 35).
By a resolution dated 11th August 1994, the Territorial Congress decided that rheumatic fever was one of 9 priority preventive programmes.
A register was set up tu monitor the situation.

As at 28 February 2009, 2 372 cases had been recorded, including 222 now archived because they had completed their treatment, or because of a chronic rheumatic cardiopathy being attended to by cardiologists.
The **active list** is equal to **1 833 patients**. Only 31 % of the rheumatic fever cases listed in the register were voluntarily reported by the attending practitioner.

The prevalence is estimated at 7.5 per 1 000 in New Caledonia, all ages combined, and varies depending on commune (referring physicians assigned by commune):



Breakdown of the 1 833 cases of rheumatic fever by age group

A slightly higher prevalence is noted in women: 7.7 0/00 (as against 6.9 0/00 in men).
Prevalence by province per 1 000 of the population:

- 14.7 in the Northern Province;
- 10.8 in the Islands Province;
- 5.2 in the Southern Province.

Between 28/02/2008 and 28/02/2009, 136 cases were added to the RF register.

Conclusion

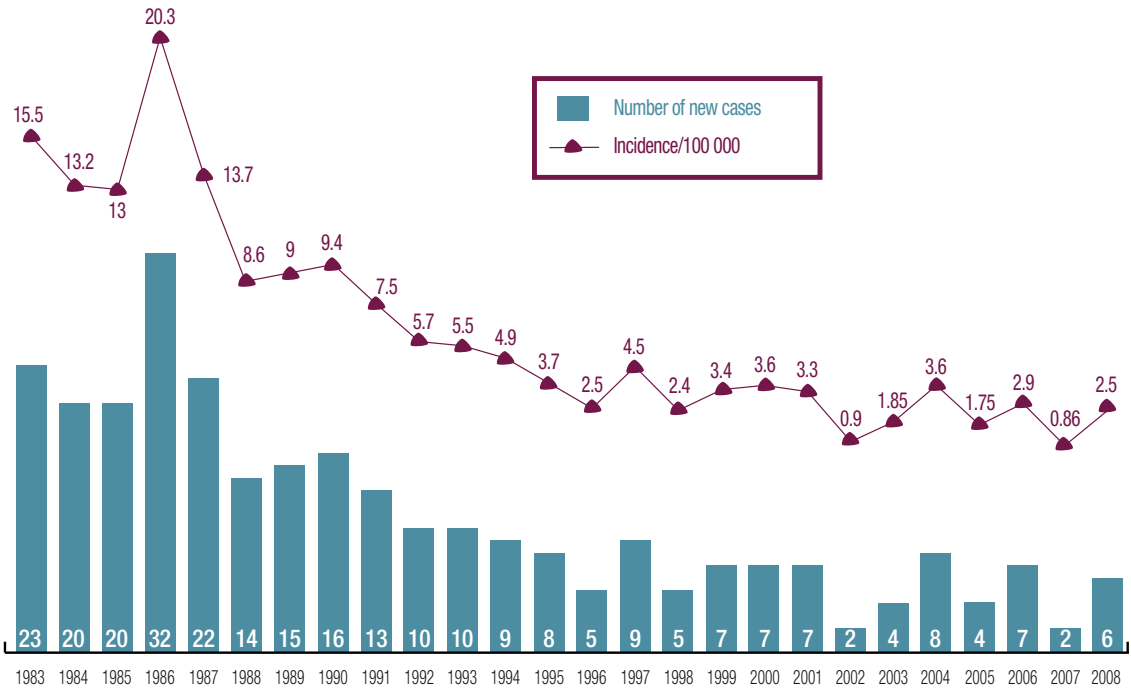
Despite RF being a notifiable disease, it is extensively under-reported.
DASS conducts systematic surveys in order to offset this weakness.

Leprosy

Leprosy (or Hansen's disease) is a chronic infectious disease caused by the acid-fast bacillus (*Mycobacterium leprae,* formerly Hansen's Bacillus), transmitted through direct, intimate and prolonged contact with an infected person. The leprosy registry covers 26 years, from 1983 to 2008 and comprises 285 records.

The Hansen's disease control programme is conducted by the dermatology department of the Nouméa CHT (Territorial Hospital). Screening in New Caledonia is essentially passive, the large majority of patients being referred by either their attending physician or their dispensary physician.

The multidrug leprosy treatment (MDT) programme has reduced the prevalence of leprosy in New Caledonia and this disease is no longer a major public health problem.
With 6 new cases in 2008, the incidence rate is 2.5 per 100 000.
In 2008, the 5 new cases were multi-bacillus.



In the 285 cases recorded since 1983, the following was observed:

- A male predominance: 186 men and 99 women.
- An ethnic disparity, with higher representation of the Melanesian community (239 persons) than other ethnic groups (Europeans: 30 cases; others: 16 cases).

Prevalence

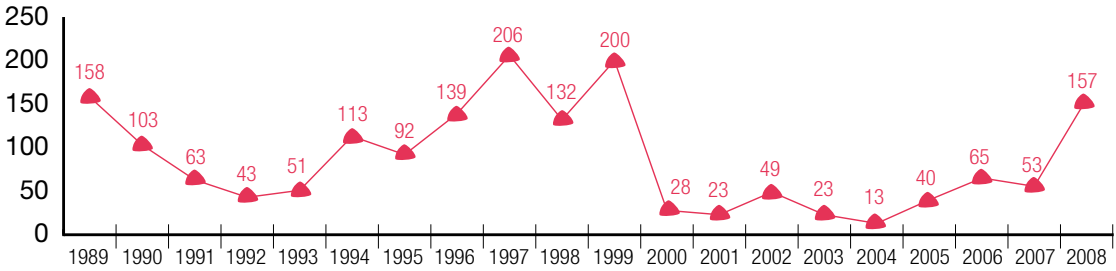
In 2008, only 8 patients were treated with multidrug therapy, which represents a prevalence rate equal to 0.33 per 10 000 population.

International situation

Source: WHO
The number of new cases detected in the world in 2007 was 254 525.
This number has fallen by 4.2 % over 2006. This drop results mainly from a fall in the number of new cases in India (367 143 cases in 2003 and 260 063 cases in 2004, 169 709 in 2005 and 139 252 in 2006, or 17.9 % fewer in one year).
In 2007, the number of cases in India represented 67.4 % of the total number of cases in the world.

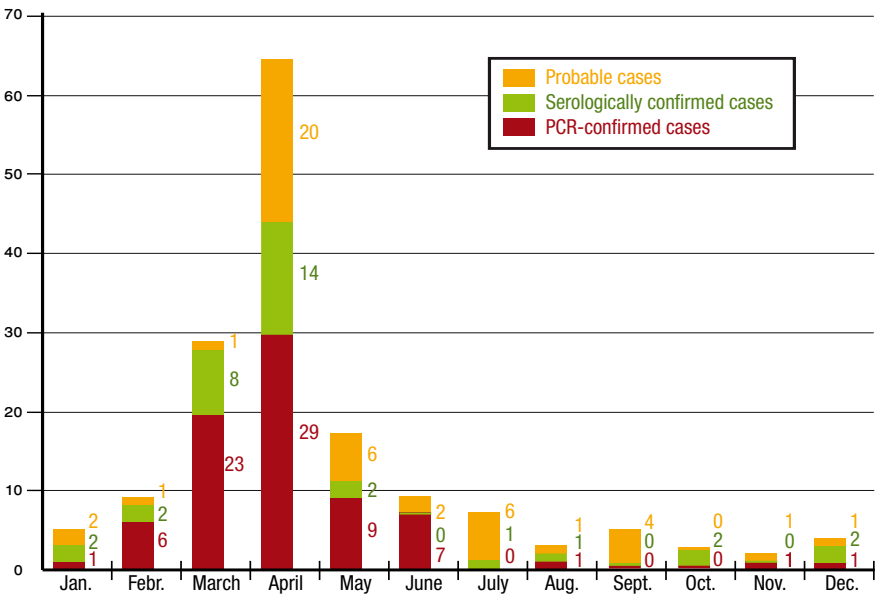
Leptospirosis

In New Caledonia, leptospirosis is an endemic disease that can surge to outbreak status depending on the weather.
In 2008, **157 cases were reported**. As shown on the figure below, in the last 16 years, only two major outbreaks have occurred: the first in 1997 and the second in 1999.

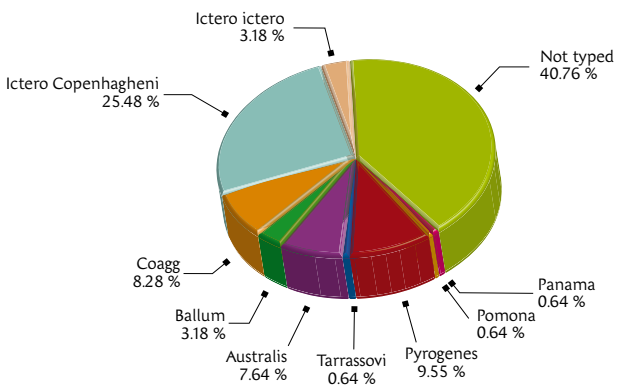


In 2008, this disease mainly affected men (64.3 %), and young adults: (the average age is 36 years). Infection is probably due to risky behaviour, through daily or occupational contact with infected animals or contaminated soil.
Infections in children and adolescents can be linked to exposure during leisure activities such as bathing in fresh water. Most cases were reported between January and March (36 %).

Monthly distribution of accumulated cases in 2008



In 2008, 6 deaths were directly due to leptospirosis. A study of cases over the last 10 years shows geographical disparities, with average incidence higher in Bourail and Hienghène.
The most frequently identified serogroups in 2007 were: *Ictero-haemorrhagiae copenhagheni, Pyrogenes and Australis*.



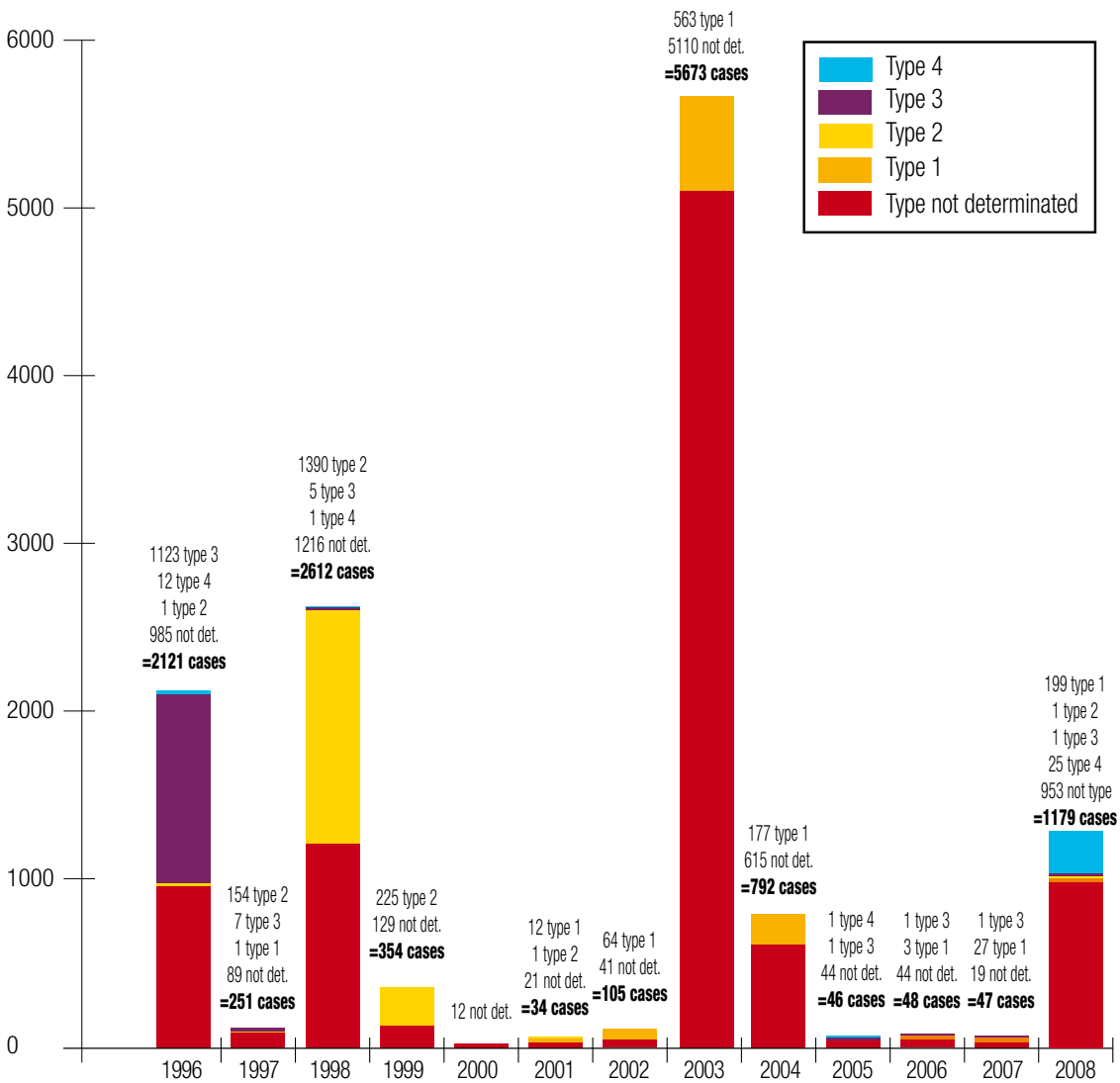
Dengue fever

Dengue fever is a viral condition transmitted by the *Aedes aegypti* mosquito that lays its eggs in clean water (empty tin cans, etc.).
This arbovirus has 4 serotypes, without cross immunity, but giving permanent immunity for each of the serotypes. Reinfection by another serotype can cause the onset of a more severe form of the disease.

After the 2003 epidemic, during which 5 673 cases and 17 dengue-related deaths were recorded, the 2005 - 2007 period was were much calmer (46, 48 and 47 cases respectively, no deaths).
Residual virus transmission occurred during the first half of 2004; then no new cases were confirmed by identification of the viral genome apart from 2 imported Dengue 3 and 4 cases in September 2005.

In 2008, of the 1 179 diagnosed cases, 226 were confirmed using the PCR technique.
199 cases were Serotype 1 25 cases were Serotype 4, 1 case was Type 2 and 1 case was Type 3.

Different dengue fever serotypes during epidemics from 1996 to 2008



Diseases under surveillance

Weekly disease reporting by 'grouped data' was introduced in the provincial public health services. Theoretically, they come from the two hospitals in the Northern Province, 26 socio-medical districts in the Loyalty Islands, Northern and Southern Provinces, the mother and child protection centres and the multi-purpose medical centre in Nouméa.

For 2008, about 10 % of the reports expected were received; the breakdown by disease is as follows:

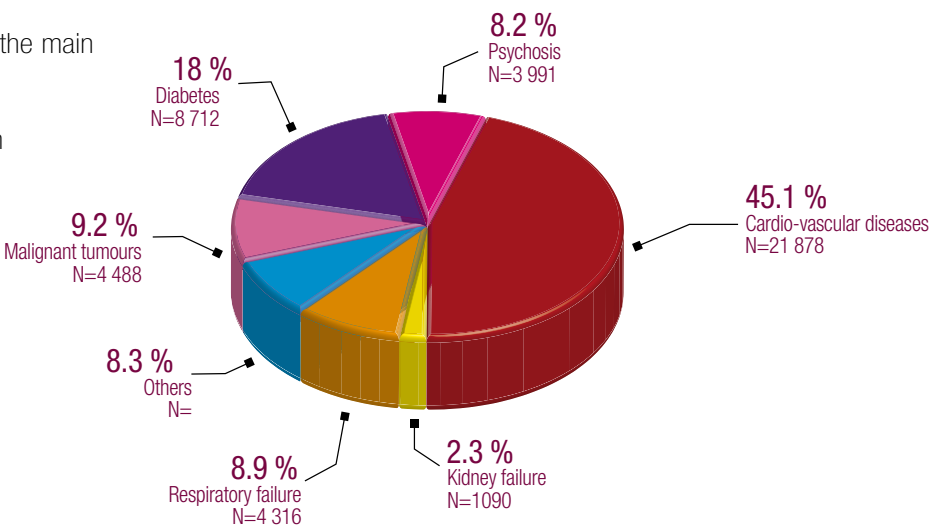
Disease	Nb of cases 2005	Nb of cases 2006	Nb of cases 2007	Nb of cases 2008
Acute conjonctivitis	224	438	304	109
Ear infection	628	1547	949	245
Acute respiratory tract infection	3261	7503	3372	1089
Pneumonia	30	20	19	8
Influenza	254	975	571	144
Salmonella infection without typhoid	0	21	0	40
Shigellosis	0	5	0	14
Other Protozoal intestinal diseases	2	0	1	0
Diarrhoea	276	613	375	95
Acute viral hepatitis other tan B or C	787	68	5	1
Meningitis other than meningococcal	0	8	4	2
Ciguatera	25	67	25	5

Chronic diseases

Most chronic diseases are covered as 'prolonged diseases' under the CAFAT social security system for insured persons and other entitled persons.

Since July 2002, with the creation of 'RUAMM', the number of insured persons has risen considerably to include public servants and other new contributors. It comprised 232 000 beneficiaries as at 31st December 2008.
In 2008, 30 824 persons were covered under the prolonged disease arrangement (12.9 % of insured persons and other entitled persons) for 48 526 conditions (certain patients may be covered for more than one disease).

The breakdown of the main chronic diseases covered in New Caledonia is shown in the graph.



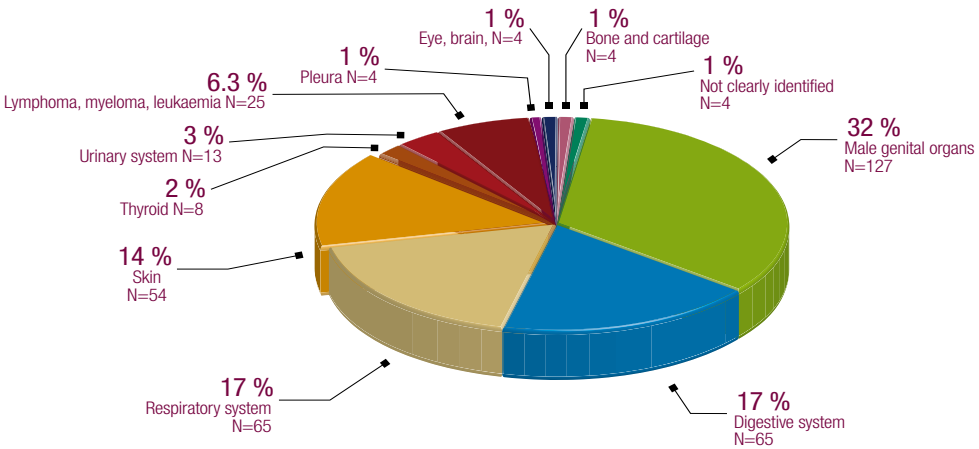
The New Caledonian data come from the Cancer Registry, whose records are compiled from the anatomo-pathological reports from the laboratories, subsequently supplemented by surgical data and notification forms completed by physicians from both private and public practices. Under an agreement, DASS has delegated responsibility for maintaining the New Caledonia Cancer Registry to the Pasteur Institute of New Caledonia. The figures included are data from the records as at 15/06/2009 annd are subject to subsequent modification by IPNC.

- **Included:** data on all malignant and invasive tumours.
- **Not included:** *in situ* malignant tumours, benign tumours as well as all recurrences of already registered malignant tumours and cancer metastasis when the primary site is known and registered.

Since 2001, all skin carcinomas have been included in the register, following recommendations from the INVS (French health surveillance institute). The coding used in the register is that of the World Health Organization International Disease Classification, 10th revision ('ICD 10').

For **2007, 703** new cases of tumours were recorded, 392 in men and 311 in women.
Cancer sites vary between the sexes. In men, the most frequent were:

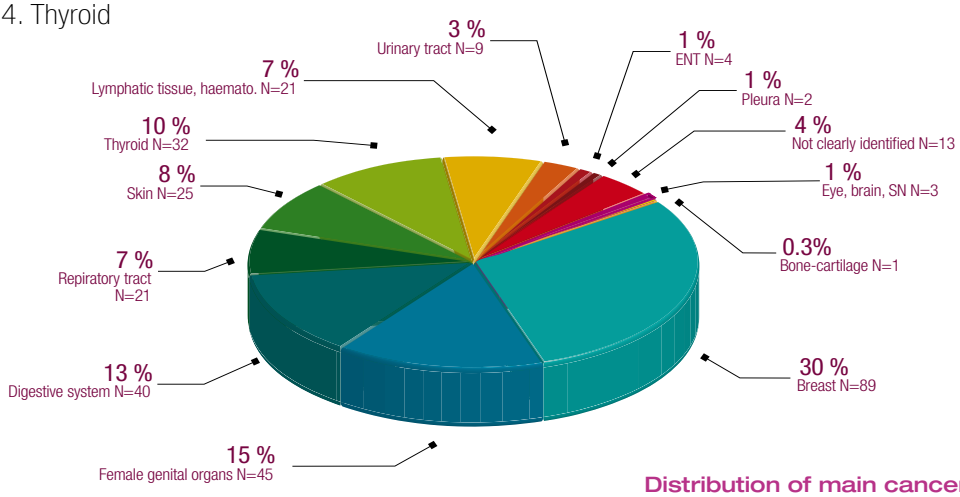
1. Genital organs, principally the prostate (97.6 %)
2. Respiratory tract
3. Digestive system (stomach-oesophagus: 32.3 %, colon-rectum: 49.2 % of the group)



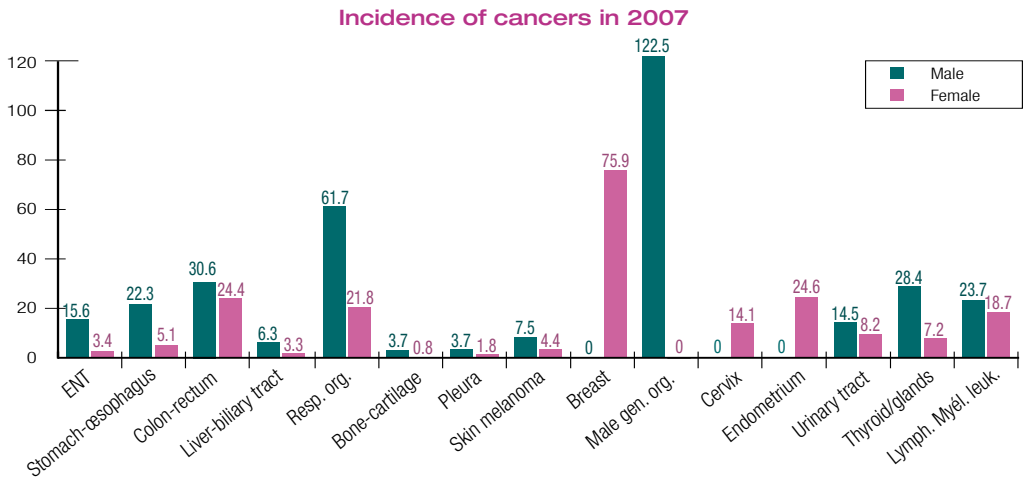
Distribution of main cancer sites in men in 2007

In women, the main cancers were:

1. Breast
2. Genital organs (endometrium: 48,8 %, cervix: 40 % of the group)
3. Digestive system
4. Thyroid

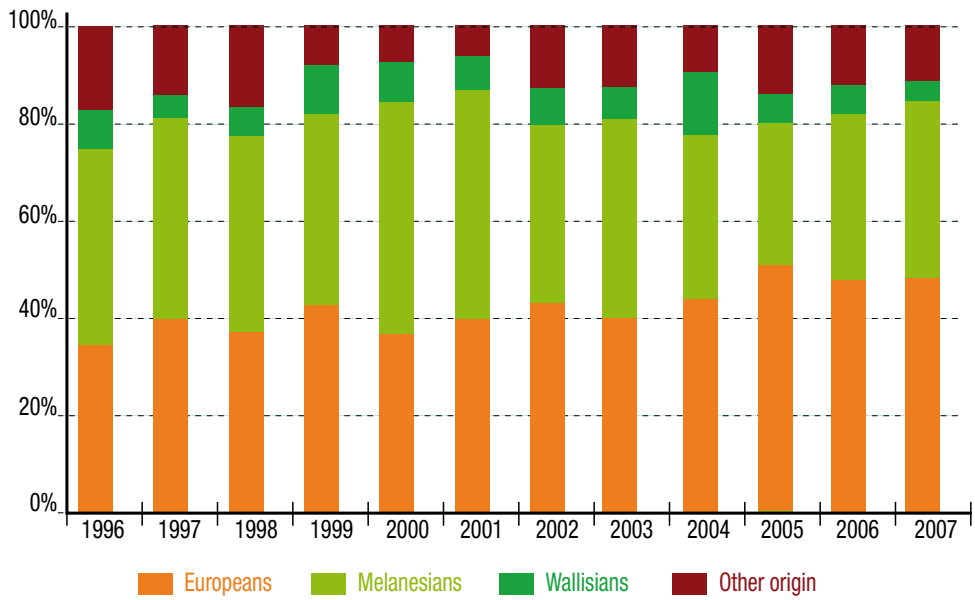


Distribution of main cancer sites in women in 2007



The crude rate is the frequency of new cases per 100 000 population in one year. Standardised rates, computed from the generally used reference world population, make international comparisons possible, by limiting the effect due to the different age structures of the populations concerned.

The crude rate in men, all sites combined, is equal to 336.5 per 100 000 person-years (PY) and the standardised rate is equal to 365.8 PY.
In women, the crude rate is equal to 272.8 PY and the standardised rate is equal to 279.6 PY.
New Caledonia is a high-incidence country for some cancers: thyroid (highest world rate), male genital organs, oropharynx, broncho-pulmonary locations, mesotheliomas, breast, urinary tracts, lymphomas, myelomas, leukaemias and malignant melanomas.
It is in the medium incidence group of countries for cancers of the stomach, oesophagus, liver, biliary organs, cervix and endometrium.



In total

In 2007, the most common cancers in New Caledonia were cancers of the prostate, the digestive system, the breast, the respiratory organs and the skin. This order varies with gender.
Improvements in data collection, screening and diagnosis mean that the number of new cases of cancer increases each year with diagnosis occurring at an increasingly earlier stage.

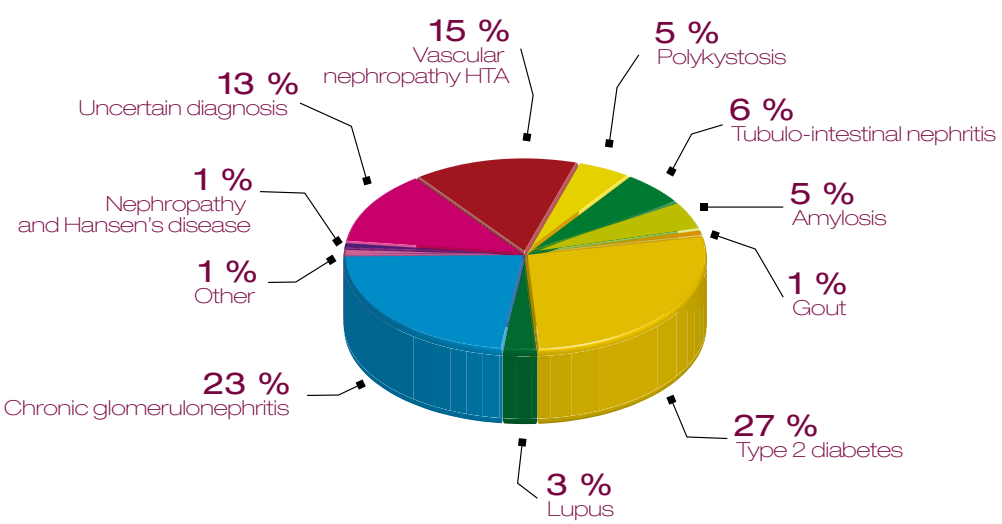
Chronic renal failure

Chronic renal failure (CRF) can be defined as the gradual loss of filtration, excretion and endocrine secretion functions by the renal parenchyma, as a consequence of irreversible anatomical lesions.
Most renal diseases develop, albeit at different speeds, towards a stage called chronic uraemia. When CRF reaches an advanced stage, it becomes essential for the patient's survival to offset the failure of the sick organ, either by kidney transplant or graft, or by extra-renal purification.

Three facilities provide extra-renal purification through Haemodialysis and Peritoneal Dialysis.
Depending on the options chosen, these two processes are broken down into several treatment plans.
Haemodialysis can take the form of hospital haemodialysis, simple haemodialysis, home haemodialysis or auto-dialysis.
Peritoneal dialysis comprises continuous ambulatory peritoneal dialysis (CAPD) and Automated Peritoneal Dialysis (APD).
The third compensatory technique is Renal Transplantation, but this is not available in New Caledonia. Pending the introduction of a local transplant programme, patients are sent to Metropolitan France or Australia.

The increasing number of patients treated for chronic renal failure makes this condition a public health problem. As at 31st December 2008, 402 patients were under treatment for CRF, an increase of 7.7 % over 2007 and a prevalence rate equal to 1 585 per million population (PMP), a crude rate 1.5 times higher than in Metropolitan France in 2007 (1013 PMP).
With 51 new patients in 2008, the incidence rate is equal to 346 per million, which is the rate in Japan where the prevalence rate was already higher than 1 800 PMP.
The breakdown by mode of treatment shows that haemodialysis remains the principal method of treatment and concerns 67.5 % of patients, followed by peritoneal dialysis (13.5 %). Kidney transplants (19 %) began in 1984.
Chronic glomerulonephritis and Type 2 diabetes remain the major two causes of chronic renal failure in New Caledonia.
These two conditions represent half of all new patients being treated, as shown in the following figure:

Breakdown of diseases causing chronic renal failure



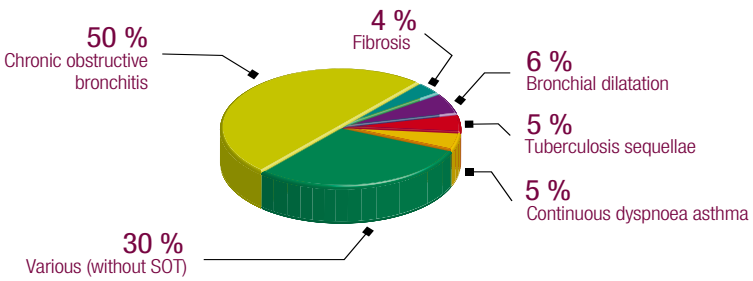
The crude incidence and prevalence rates of renal failure treated in New Caledonia are relatively high overall and comparable to those of countries such as Japan and the United States.
These figures characterise the breadth of the range of health care services available for renal dysfunction in New Caledonia, but do not permit an accurate assessment of the frequency of chronic renal failure.
To do so, further research would have to be considered.

Four facilities offer home treatment for respiratory failure patients in New Caledonia.

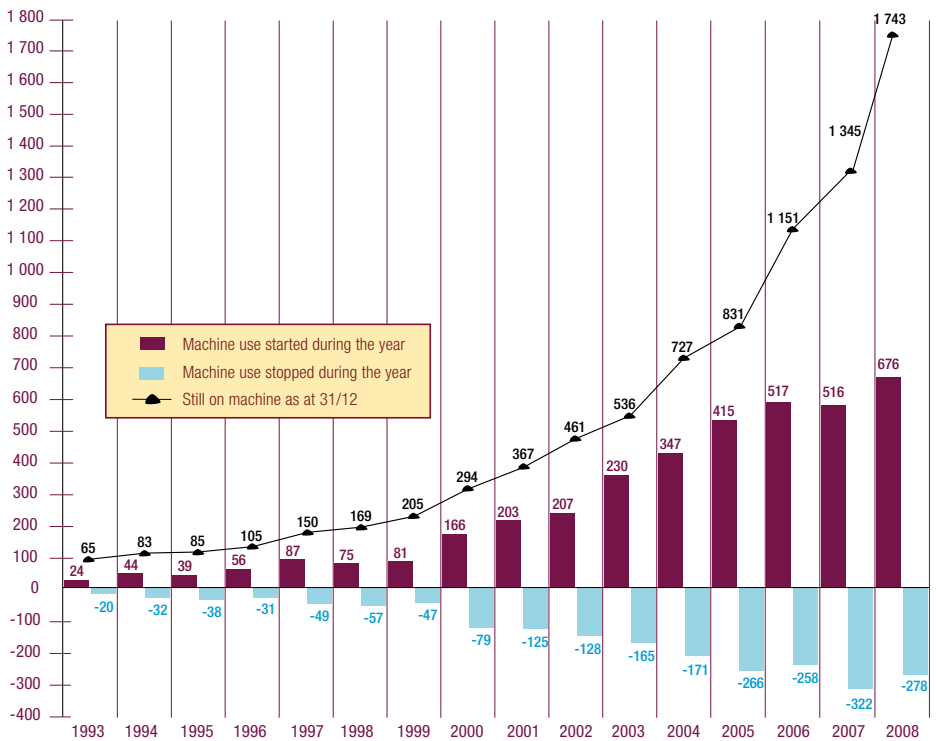
- 'Service d'Assistance Respiratoire à Domicile' (SARD-NC), an association set up in 1990;
- 'Oxygène Confort', a private company established in September 2004;
- 'Respire', a private company set up in August 2007;
- 'Respidom', a private company incorporated in November 2007.

The diseases covered can be broken down into two major groups: chronic respiratory failure and sleep apnoea syndrome which require two main kinds of treatment: oxygen therapy and positive-pressure ventilation. To these two categories, in significant numbers since 1997, can be added cancers (terminal care or otorhinolaryngology) and various diseases that remain unknown because of the mode of decision on treatment for short-term oxygen therapy (SOT) which is offered on prescription and yields no information on the disease requiring such treatment. The leading cause of chronic respiratory failure in New Caledonia remains chronic obstructive broncho-pulmonary disease (50 %).

Leading causes of chronic respiratory failure in New Caledonia



The number of patients on machine-assisted treatment has shown exponential growth trend since 2000, when short-term oxygen therapy began.



Until the beginning of short-term oxygen therapy, after 2000, the main reason why treatment with machines ceased was patient death, which accounted for 70 % of cases of treatment discontinuation.

In 2008, deaths only represented 27.7 % of disconnections from machine treatment.

Deaths mainly occurred in patients with respiratory failure and terminal cancer.

The average age of patients enjoying machine treatment is 60 years.

The group concerned comprises 73.6 % men and 26.4 % women (2007).

Management

Patients are either cared for in the private sector by specialists (psychiatrists, psychologists) or in the public health care system.

In the public health care system, the hospital sector is structured as follows:

1 - The **General Psychiatry Department** with a number of 'Functional Units' addressing two sectors:

- **In-patient hospital sector** with 6 units (Ward 2 - 3; Ward 4; Ward 5; Ward 6; Ward 7; ergotherapy).
- **Out-patient hospital sector** with 7 units: (Psychiatric Treatment, Orientation and Emergency Unit ('UAOUP'); day hospital; Medico-psychological Centre (CMP); Medico-psychiatric unit for prisoners (UMP); consultation and ambulatory care services unit (UCSA), Medico-psychological units in Poindimié, Koumac and Lifou; therapeutic workshops.

In-patient hospital activity 2008	Short stay			long stay	
	Ward 7	Ward 5	Ward 6 (Secure unit)	Ward 2-3	Ward 4
Direct admissions	377	358	17	8	1
Days of hospitalisation	5 498	6 815	3 304	12 906	7 005
Average length of stay	11.4	17	183.5	176.8	250.2
Occupation rate	71.53 %	93.10	90.27	88.15	95.70

Out-patient hospital care 2008
UAOUP: 662 consultations
Day hospital: 4 421 hospitalisation days
CMP: 3 759 psychologist consultations; 2 694 home calls
Penitentiary : 11 161 somatic treatments; 1 857 psychiatric treatments
Medical and psychology centres: 3 107 treatments

2 - The general child psychiatry department comprises 5 functional units on 3 sites in Nouméa:

- Magenta, with the Early Childhood Unit (UPE) and the Medico-psychological Centre (CMP);
- Anse Vata with the Part-time Treatment Centre (CATTP) and the Day Hospital;
- Rue Dezarnaud with the Treatment and Care Centre for Adolescents (CASADO).

The dispensaries at Paita and Kamere conduct decentralised consultation activities.
In 2008, the active list, comprising 3 189 patients, showed an increase over 2007: + 27.6 %.

Activity / Unit 2008	CMP		Outlying units (islands)	Dispensaries Kamere, Paita	CATTP	Day hospital	CASADO
	UPE	Children over 6 years					
Treatment	3 148	4 534	2 351	48	1 737	3 065	1 961
New cases	268	313	52	Nd	27	12	501
Active list	637	685	214	129	64	65	1 013

3 - The gerontology Service comprises 2 functional units: the Limited Stay Accommodation Unit (UDSL) and the Unlimited Stay Accommodation Unit (UDSI).

In 2008, there were 24 releases and **26** admissions at the UDSI. 185 patients were admitted in 2008 from the 232 admission requests received by the UDSL.

Suicide: one aspect of mental illness

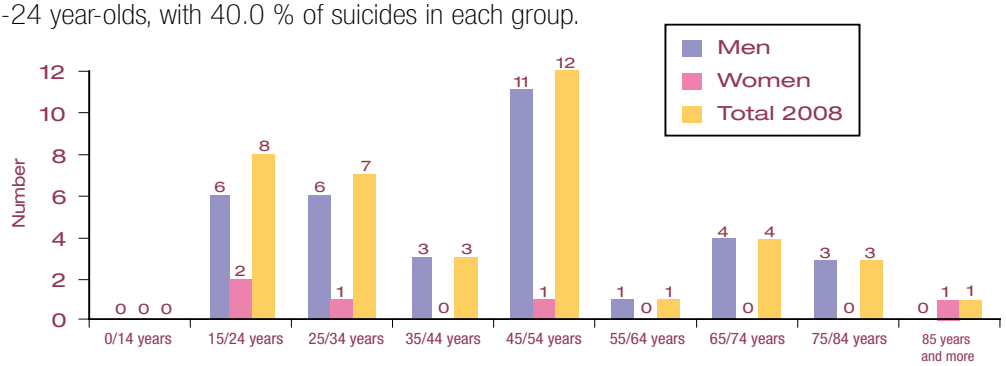
Suicide is a major public health problem in the world and particularly among adolescents. In metropolitan France, suicide is one of the major causes of premature deaths compared to other causes, especially among young adults.

Since we do not have data concerning attempted suicides, only data on deaths will be used.

In 2008, 39 deaths by suicide were recorded, or 3.3 % of all deaths (N=1 172) and 24.8 % of violent deaths (Group 17 of IDC 9, representing a crude mortality rate equal to 16 per 100 000 of the population (men: 27.50 per 100 000; women: 4.17 per 100 000) and a standardised rate equal to 15.27 (men: 27.07 per 100 000; women: 3.79 per 100 000).

If we look at the number of suicides by age group for both sexes, the age groups the most affected are the 15-24 year-olds (N=18) and the 45-54 year-olds (N=12).

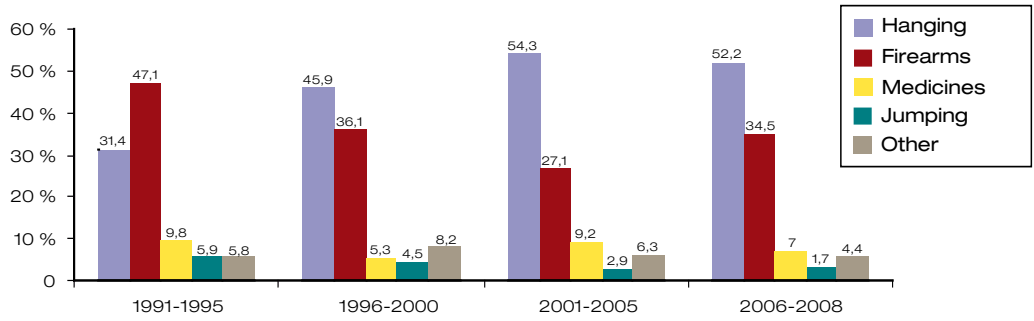
In men, the most affected group is the 45-54 year-olds with 26.5 % of suicides and in women it is the 15-24 year-olds, with 40.0 % of suicides in each group.



Distribution of deaths by suicide by sex and age group in 2008

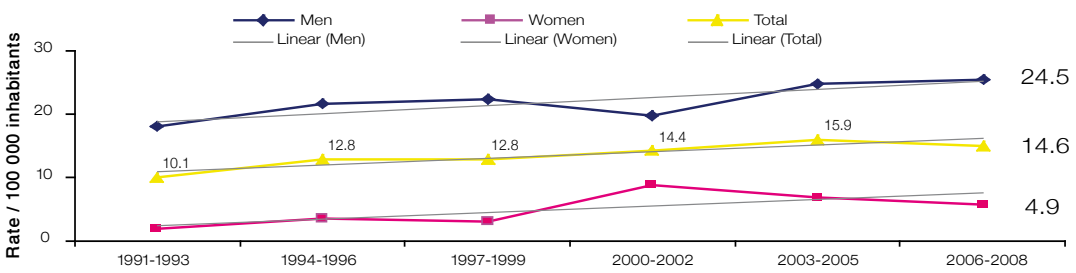
As in previous years, the 2 main methods of suicide in 2008 were hanging (61.5 %) and the use of firearms (30.7 %).

Over the 1991-2008 period, the proportion of suicides by hanging increased in comparison with suicides using firearms.



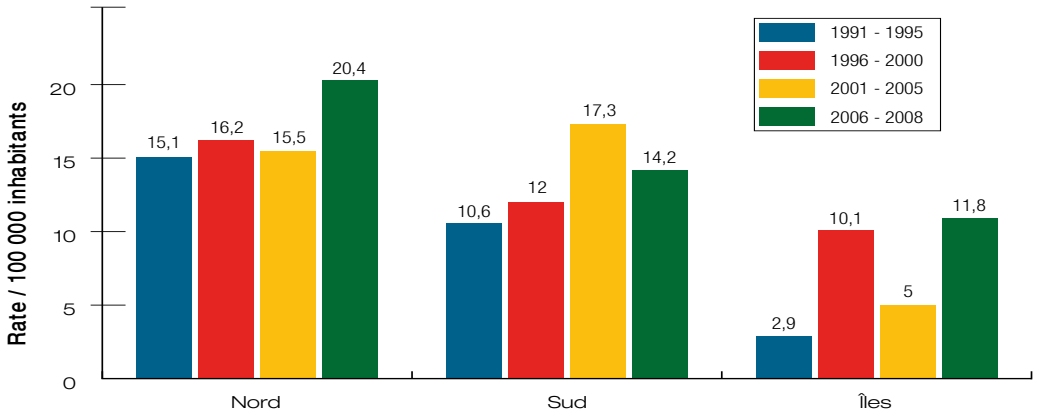
Trends in the main suicide methods for both sexes combined

The **crude annual mean rate** has been tending to increase in men since 2000 and to decrease in women over the same period.



Trends in the crude annual mean rate by sex

When these death by suicide rates are related to the population concerned, an increase in the mean annual rate over the 2006-2008 period can be observed in the Northern and Islands Provinces.



Crude mean annual rate of death by suicide by province of residence

Comparison with the European area

The standardised mean rate observed in New Caledonia was 21.94 per 100 000 in men and 5.13per 100 000 in women. The combined rate was 13.65 per 100 000 depending on age and is lower than for metropolitan France (16.1 deaths per 100 000).

France is in 3rd position in Europe behind Finland and Austria (22 and 16.3 per 100 000 respectively).

Conclusions

Suicide is a public health problem that, according to the WHO, can be avoided to a great extent and each death by suicide has devastating emotional, social and economic consequences for many families. Numerous underlying and complex causes are described as producing suicidal behaviour, especially poverty, unemployment, the loss of someone close, arguments, separations in relationships and work-related worries or brushes with the law. Family precedents as well as abuse of alcohol and drugs, sexual abuse during childhood, social isolation and some mental disorders like depression and schizophrenia play a determining role in some cases.

In New Caledonia, suicide seems to be a less worrying cause of death than in European countries and less significant than deaths by road accident. However, even if the rate of suicide is lower than the rate of deaths by road accident, it is still a significant cause of death among young men that could be avoidable.

Early detection of mental disorders and appropriate treatment are a good preventive strategy, particularly for young people. Health care professionals, teachers and social workers have an important role to play in this area by creating youth mental health care networks.

Psychotropic drug consumption

All importations of psychotropic drugs for human use from mainland France are recorded by DASS-NC. Consumption levels remain stable or show a very gradual increase over the observation period.

The only exception is tetrazepam, which is being prescribed in significantly growing quantities. This drug is a benzodiazepine not indicated for its psychotropic properties (that do exist nevertheless) but for its myorelaxant qualities. As most other myorelaxants have disappeared from the market or are no longer eligible for reimbursement, this product is showing increased use, although it induces the side effects or contra-indications of the other benzodiazepines.

As a result of the recording of abuse or misuse of these drugs, the conditions governing the prescription of flunitrazepam and high doses of oral clorazepate (20 and 50 mg) have been tightened in France. These regulatory changes, although not applicable in New Caledonia, have led to a reduction in the use of these substances, beginning in the early 2000s.

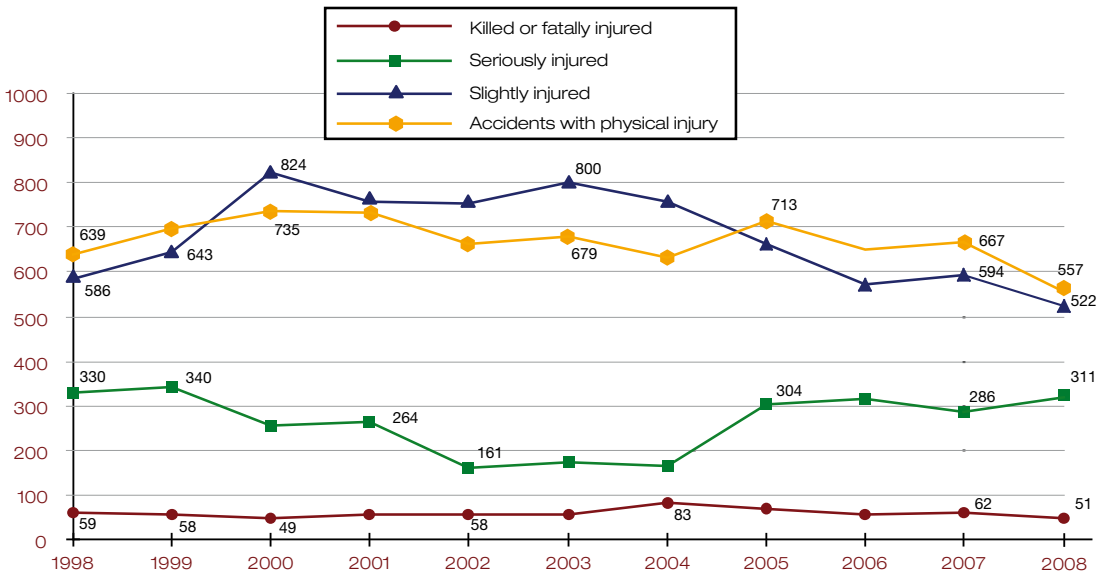
The drug-dependency observed with certain hypnotics had also justified restrictive measures over their prescription in France.

Comparable action was taken in New Caledonia in May 2008

Number of vehicles on the road: annual vehicle sales are constantly increasing with, in 2008, **14 960** new vehicles registered in New Caledonia.
The total number of vehicles on the road in New Caledonia is estimated at **140 000** according to the 2008 Police report, or 1.1 vehicle per inhabitant over 20.

Accidents causing physical injury: In 2008, **557 accidents causing physical injury** were recorded for the whole of New Caledonia, producing 51 deaths or fatal injuries, or 6 % of the **833 victims** (311 seriously injured and hospitalised and 522 injured but not hospitalised).
The record shows a decrease of 16.5 % in the number of accidents causing physical injury over 2007 with more hospitalisations (+8.5 %) and less unhospitalised accident victims (-12 %).

The number of road accident deaths in 2008 is however under the annual mean figure for the past 10 years (N=60).



Annual trends in physical injury, death, serious injury and slight injury due to road traffic accidents

Three main causes of accidents
In the city of Noumea, the three main causes of accidents concerning **77 %** of the 413 accidents are:
- loss of control of vehicle - speeding: 157 cases, or **38 %** of accidents;
- failure to give way: 93 cases, or **22.5 %**;
- drink-driving : 71 cases, **17.2 %**.

Outside the urban area: the three main causes of accidents account for **84 %** of the total of 144 accidents.
- 73 accidents were due to drink-driving, or **51 %**.
- 47 were due to speeding or loss of control of the vehicle, or **33 %**.

Comparatively worldwide, New Caledonia has a crude rate of **209 deaths** per 1 million population and metropolitan France 78 deaths per million population.
Source: INSEE. pop as at 01/07/08.

3 agencies offer industrial medicine services in New Caledonia.

1 - 'Service Médical Interentreprises du Travail' (SMIT), responsible for occupational medicine for workers under CAFAT coverage for companies that do not have their own service. In 2008, SMIT catered for 78 121 workers in 13 607 companies. In 2008, 30 423 examinations were conducted in comparison with 27 364 in 2007.
The number of regular examinations was 14 364 and the number of non-regular examinations was 16 059.
Counted in the non-regular examinations were hiring examinations, work resumption examinations and occasional examinations.

A total of 29 931 decisions was taken during 2008. Of the persons examined, 26 641 were found to be fit for work. The others were declared to be fit with restrictions or unfit. 11 occupational diseases were detected. Musculo-tendon disorders represent 72.7 % of cases of such diseases. Others were deafness due to noise (5 cases), sciatica (1 case), eczema (1 case) and dermatosis (1 case).

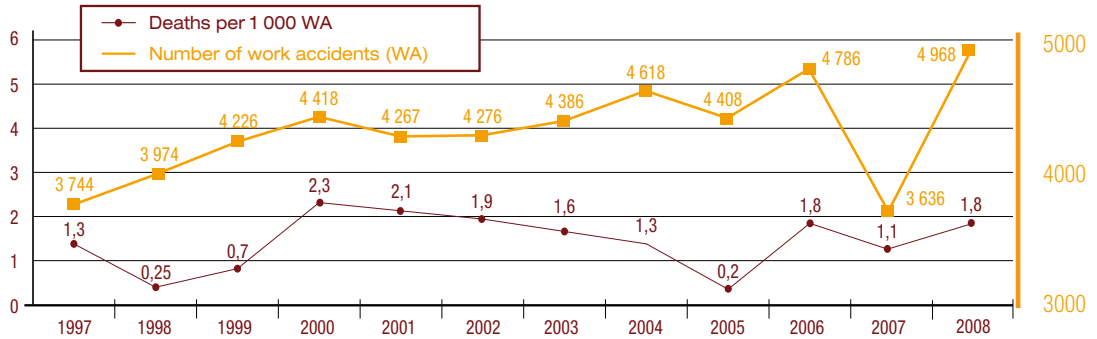
2 - Medical department of the SLN (Société Le Nickel) company, comprising two services: care medicine and preventive medicine. The medical care service takes staff without appointments and performs vaccinations. The preventive medicine service examines new staff at the hiring medical examination and conducts regular examinations. Most staff are examined annually. Highly exposed workers, such as electrode welders, undergo a regular six-monthly examination. It conducts special medical surveillance, work resumption examinations and additional screening.
It also attends to the disabled and pregnant women. Workers under special medical surveillance are those assigned to dangerous work environments or involving risks specified in **Order N° 4775-T dated 10th December 1993, article 1134 para. 1, line 2 and line 3**. Work resumption examinations are carried out after work accidents, occupational diseases, absences of more than one month and repeated absences.
Additional examinations are: chest x-rays, biological tests, basic respiratory tests, audiograms, ophthalmologic tests, toxicology, nickeluria, urinary tests and PSA dosage tests.

2007 figures: 6 worksites, employing 2 305 workers, were monitored by the industrial medicine physician. 1 394 workers were under special medical supervision.
A total of **4 484** medical examinations was carried out, including 1 880 regular examinations and 165 for hiring examinations, work accidents and resumption examinations. 9 262 additional examinations were performed (blood tests, urine tests, x-rays, ophthalmology, toxicology, etc.).

3 - The Occupational Medicine Service at CHT Gaston Bourret, opened in January 1998, is operated by one physician and two nurses. It is located at Gaston Bourret Hospital. It is responsible for the medical surveillance of staff at the four CHT sites: Gaston Bourret, Magenta, Raoul Follereau leprosy centre and Col de la Pirogue tuberculosis treatment centre. It also oversees staff working at the Albert Bousquet (CHS) psychiatric hospital. It supervises 2 600 people altogether.

Occupational accidents
According to CAFAT data: In 2008, 4 968 occupational accidents (an increase of 36.6 % over 2007) 120 commuting accidents (-7.7 % over 2007) and 94 occupational diseases (a 5.6 % increase) were recorded. The number of compensated sick leave days (59 131) increased by 5 % in comparison to 2007 and the average duration of a period of sick leave increased from 26.18 days in 2007 to 28.9 days in 2008.

NB: Since 2004, the number of deaths has been relatively low and varies between I and 10 per year. As the graph below shows, the death rate is between 0.2 and 2.3 deaths per 1 000 work accidents (WA).



Annual trends in number of WA and number of deaths following a WA

In 2008, an increase in the number of occupational accidents, deaths and commuting accidents was observed, but also an increase in the number of occupational diseases.

Addictions: alcohol, tobacco, narcotics

Alcohol

Consumption

In 2008, **1 738 164 litres of pure alcohol** were consumed in New Caledonia, 10.4 % more in than 2007.

In 2008, beer consumption accounted for **40.1** % of total alcohol consumption.

Also to be noted is a very slight increase in this figure (1.6 %) over 2007.

A slight decrease can be observed (-1.3 %) in wine consumption over 2007. In 2008, it accounted for **38.4** % of total consumption.

Spirits accounted for **21.4** % of the total, a very slight decrease of 0.4 % in comparison to 2007.

Consequences of alcoholism

In New Caledonia, the consequences of alcohol consumption and in particular excessive consumption are commonly social issues or, in the health area, traumatic injuries.

Mortality

In New Caledonia, medical death certificates recorded 40 deaths totally or almost totally due to alcohol consumption in 2008, or 3.4 % of the total number of deaths, a crude annual rate of **16.7 deaths** per 100 000 population.

These 577 deaths between 1991 and 2008, account for 3 % of the total of **19 287 deaths over the past 18 years**, or a crude mean rate equal to **15.9 deaths** per year per 100 000 inhabitants. In addition to the 577 deaths between 1991 and 2008 for which the initial cause was totally due or closely linked to alcohol, the figure can be extended to include deaths for which acute or chronic alcoholism was quoted as an item of further information, i.e. **549 extra deaths**, increasing to **1 126** the number of deaths that can be attributed to alcohol (23 extra deaths for 2008)

Since 1991, **5.8 %** of deaths are due to alcohol consumption in New Caledonia, a crude annual mean mortality rate equal to **31.05** per 100 000 population.

Addictology prevention and treatment

A fully-equipped functional unit specifically devoted to alcohology case management (CATA) was set up in 1993 under an agreement between the CHS and the APAA ('Association pour la prévention

des abus d'alcool' - Society for Alcohol Abuse Prevention). Even if alcohol abuse problems represent 98 to 99 % of its operational activity, the service also treats drug addicts, mainly involving cannabis dependency in New Caledonia (and tobacco and psychotropic drug dependency as a secondary activity).

This unit has been superseded by a new agency (addictology prevention and care programme) under the supervision of DASS New Caledonia.
Its main goal is to reduce the health and social consequences of tobacco, alcohol and cannabis use. It comprises a section responsible for introducing a prevention programme, an addictology treatment centre and a liaison team between the hospital sector and the care centre.

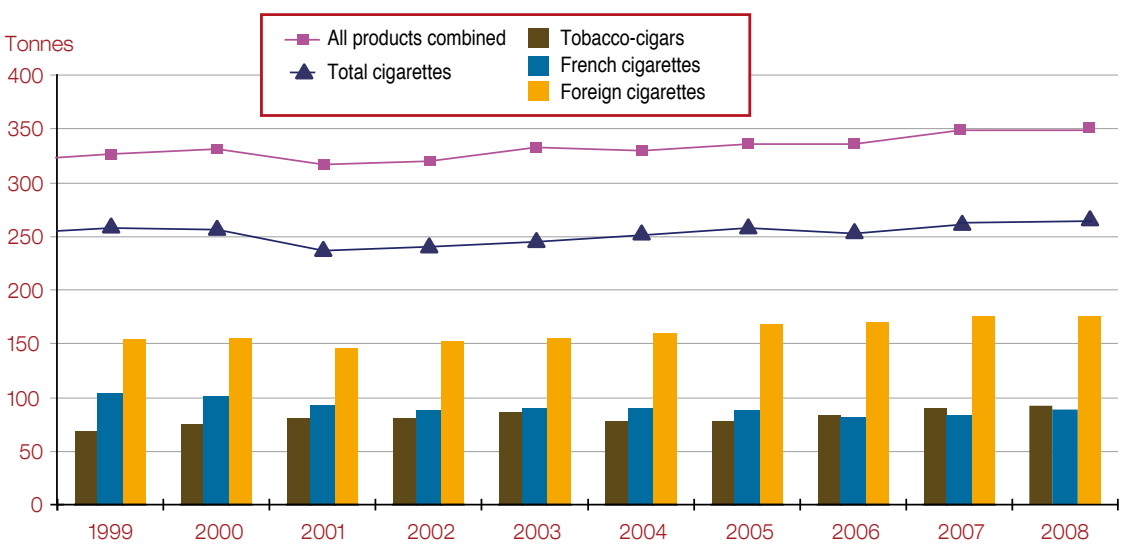
Youth behavioural trends (ESCAPAD 2005 Survey)
Alcohol and its excessive consumption remain a major public health issue, in young people especially. New Caledonia seems in general terms to be fairly comparable to mainland France when it comes to youth alcohol and cannabis consumption. Usage levels may appear to be dropping slightly but risky alcohol use is becoming a more frequent behavioural trend. These results conceal major disparities between population groups of varying ethnic and cultural affinity, with lifestyles and alcohol habits that vary greatly. The figures do, however, make it possible to obtain reliable and objective data to design more rational prevention projects more accurately tailored to the youth population of New Caledonia.

Tobacco
The tobacco trading monopoly in New Caledonia was initiated by a Decree dated 17th October 1916. The 'Regie Locale des Tabacs', a section in the miscellaneous contributions department within the tax department, is in charge of supplying tobacco monopoly products. In this chapter, 1 tobacco unit is: **1 cigarette = 1 cigar = 1 gram** (Seita agreement).

For 2008, the total sale of tobacco products amounted to: **348.9 tonnes**.

Despite a gradual increase in annual tobacco consumption in New Caledonia, taking all tobacco products together over the past 10 years,, a very slight and regular decline was observed in 2008 as compared to 2007

Trends in the consumption of various products



In 2008, the consumption of each product was virtually the same as in 2007. The drop in French cigarette use and rise in foreign cigarette consumption is a trend that has remained steady over 10 years, whit the proportion of French cigarettes falling by 18.7 %.The estimate for daily tobacco consumption, all products combined, per adult 15 years old and older, was 5.3 grams/adult/day. This downward trend would seem to be continuing, because over 10 years the figure has fallen from 6.06 grams/adult/day to 5.3 grams/adult/day.

Tax revenues collected by the local tobacco monopoly increased by 2.4 % from 2007 to 2008.

Consequences of smoking

Morbidity: The main diseases related to smoking for which we are able to collect data in terms of morbidity are respiratory cancers (lungs and bronchial tubes, larynx) as well as, in some instances, the respiratory diseases covered by home ventilation or oxygen therapy.
New Caledonia cancer register figures show that, over the past ten years, on average **72 new cases of respiratory cancers are recorded per year**.

These cancers mostly affect men. Smoking is the main cause for the onset of lung cancer. It has been established that the risk of developing lung cancer can be 20 times higher in smokers than in non-smokers, depending on the length and intensity of the habit.
The breakdown of lung cancers by gender is a result of former smoking habits, dating back several decades.

New Caledonia therefore remains a high-risk country for these types of cancer.

Mortality

In the same way as with morbidity, it is possible to quantify the mortality due to smoking from an assessment of the death certificates issued in New Caledonia since 1991. The number of deaths due to smoking is obtained by multiplying the total number of deaths due to a given cause by the risks attributed to tobacco, as assessed in a cohort survey by the American Cancer Society.

When the risk factor is applied to each of the diseases linked to smoking, the result is 2 155 deaths in men and 258 deaths in women thought to be smoking-related, or 2 413 for 19 287 deaths during the same period, i.e. **12.5 % of deaths**, representing a mean crude rate of smoking-related deaths of **65.8 per 100 000**.
The data from metropolitan France showed, in 2000, that 20 % of the total number of male deaths was smoking-related, as was 2 % of female mortality.

The standardised respiratory cancer mortality rate was equal to **42.7 per 100 000**, and the lung cancer rate equal to 38.9.

In New Caledonia, despite a decrease in the daily consumption of tobacco products per person over 15 years of age, as estimated from sales, it is to be feared, as in metropolitan France, that there will be a big increase in lung cancers in the years to come, reflecting tobacco consumption in past decades.

Illicit drugs

Our information comes from seizures by the police, 'gendarmerie' or customs services, which are covered by annual reports to the pharmacy inspectorate.
The main substance concerned in New Caledonia, by far, remains cannabis.
Minor quantities of LSD were seized in 2007.

Small amounts of ecstasy were seized in 2008.
The efforts by the Gendarmerie to combat cannabis use are having visible results in terms of seizures; The majority of seizures concern plants. One plant is equivalent to 200 g of cannabis. In comparison with previous years. The 2008 seizures concern greater quantities of processed product (grass) and fewer plants.
Expressed in terms of total population, these seizures suggest that an economy has sprung up around cannabis.

Seizures (in g)	2000	2001	2002	2003	2004	2005	2006	2007	2008
Cannabis	205 571	110 632	349 201	775 286	3 833 264	2 045 060	3 458 102	3 156 117	1843 062
Cannabis resin	15 631	365	0	439	20	281	2	1	41
Cannabis oil	0	0	0	11 507	0	0	0	0	0
Cocaine	50	0	0	0	0	198	0	3	0
Crack	0	0	0	0	0	0	0	0	0
Heroin	55	0	0	0	0	0	0		0
LSD	0	0	0	0	0	0	0	8 buvards	
MDMA	44.26	1	4	0	4	0	0		
Methamphetamine	0	0	0	0	20	0	0		
Ecstasy									1

Addiction to codeine exists but cannot be accurately assessed. It mostly involves the pharmacy drug Codoliprane® (association of 20 mg of codeine phosphhate and 400mg of paracetamol). Besides the drug addiction aspect as such, the abuse of this medicine is risky because of its paracetamol content. There is a risk of hepatic cytolysis (which can be fatal) due to the ingestion of doses of paracetamol exceeding 10 grams, i.e. two packets of Codoliprane®.

The use of derivatives of N-Benzylpiperazine or BZP, whose effects are close to those of amphetamines, is tolerated in New Zealand and personal importations have been reported. The customs regulations should soon subject imports such as this to DASS-NC control.

Population group approach

Women

As at 01/01/2008, there were **121 188 women** in New Caledonia, 49.6 % aged between 15 and 49 years old (considered of child-bearing age).

Contraception

Contraception-related activity can be estimated from the number of prescriptions issued at provincial medical centres. However, because the data for 2008 are incomplete, these numbers will only be presented for the CCF (family advisory services) in Noumea where contraception activity has increased significantly, due probably to contraceptive promotion campaigns and the involvement of all medical professionals whether in public or private practice.

In 2008, **3 551 packets of contraceptive pills** were dispensed by the CCF physician to schoolchildren and to women in difficulty.
1 193 consultations for contraceptive methods were performed (54.7 % for pill prescription renewals; 16.1 % for first prescriptions; 16.6 % for checking of an intra-uterine device (IUD) or Implanon implant and the rest for the insertion or removal of an IUD or Implanon implant).

Emergency contraception: the CCF has been offering emergency contraception since 1997 with a follow-up appointment 2 weeks later and the initiation of long-term contraception.
In 2008, 52 morning-after pills were issued.

To more realistically assess the contraception use rate in women in New Caledonia, data from contraceptive product sales were used. If the relationship between the number of oral contraception packets sold in a year and the number necessary for a year of contraception is established, this gives an estimate of the number of women for one year.

This calculation is also done for other contraceptive methods such as IM (4 injections per year for the products used in New Caledonia) and for IUD (it is considered that an IUD has an average life of 5 years).

In 2008, the number of women-years of contraception can be estimated as at least 29 645 (other methods of contraception such as condoms and others, are not accounted for), which would represent a coverage of 45.6 % of the women concerned.

Voluntary termination of pregnancy
The methods of voluntary pregnancy termination in New Caledonia were defined by a Resolution dated 22nd September 2000 applied since 1st January 2001.
In 2008, 484 voluntary pregnancy terminations were notified by public hospitals and private clinics and recorded by DASS-NC, which is 7.8 % fewer than in 2007.
The rate per 100 conceptions can be calculated as follows: number of voluntary terminations per 100 conceptions (live births + stillbirths + voluntary terminations); thus assessed more accurately, it is equal to **26.4 per 100 conceptions**.

Of 1000 women between the ages of 15 to 49 years considered to be of childbearing age (average population), the voluntary termination rate in New Caledonia is at least equal to **22.2 per 1 000**. This rather high estimate should be read with as-yet insufficient contraception coverage in New Caledonia, apart from the rate of undesired pregnancies that lead to a birth.

In metropolitan France, the number of abortions per 1 000 women is 14.5.

Screening for cervical cancer
Cervical cancer screening for is one of the 9 priority areas of the prevention plan approved by the Territorial Congress in 1994 (Resolution N° 490 dated 11th August 1994, relating to a health promotion plan). A direct method of evaluating the effects of this screening is to regularly monitor the number of cervical smears done in New Caledonia through laboratory activities.

In 2008, 24 715 cervical smears were done in New Caledonia by two medical laboratories (an increase of 5.2 % in comparison to 2007). 2.8 % of these cervical smears showed pathological lesions according to one of the laboratories.

Maternity
The average age for mothers at first birth is tending to rise, since it went from 25.7 in 1994 to 27 in 2007.

Pregnancies and deliveries
In 2008, the rate of caesarean sections stabilised in the private sector, while showing a tendency to rise in the public sector. The rate for France (mainland) was equal to 19.6 in 2005.

2008	Public sector	Private sector	Total
Number of deliveries	2327	1616	3943
Number of caesareans	344	390	734
% of caesareans / deliveries	14.7	24.1	18.6

Maternal deaths
Maternal death is the death of a woman occurring during pregnancy or within 42 days after delivery, whatever the duration or location of delivery, for any cause determined or aggravated by pregnancy or the care it has required but neither accidental nor occurring by chance. 0 maternal deaths were recorded in 2008 (2 in 2007) a total of 22 cases over the past 18 years. For the period from 1991 to 2008, the average rate was therefore **28.3 per 100 000 live births**.

Because of the low number of cases recorded each year, this rate is influenced by the hazards of small numbers. Caution should therefore be exercised when interpreting it, which does not obviate the need to look closely at the causes of death so to reduce frequency.

Children

New-born children
4 044 births (including stillborn children) were recorded in 2008.
They are recorded in the table by place of birth and characteristics at birth as follows:

Place	Total births	Age of gestat. < 37 sem.	% de gestat. < 37 sem.	Births < 2 500 g	% of births < 2 500 g
Islands Province	nd	nd	nd	nd	nd
Northern Province not including the 2 hospitals	nd	nd	nd	nd	nd
P. Thavoavianon Hospital	248	10	4.0	16	6.4
D. Nebayes Hospital	9	3	33.3	0	0
Southner Province not including hospital and clinics	nd	nd	nd	nd	nd
CHT	2114	318	15	305	14.4
Anse Vata Polyclinic	597	20	3,3	11	1,8
Magnin Clinic	1026	21	2	31	3
TOTAL	4044				
TOTAL ANALYSABLE DATE	**3994**	**372**	**9.3**	**363**	**9.1**

* This figure could not be cross-checked with ISSE, as a population census was in progress. The figure for total borths is there fore provisional.

From these data, the rate of premature babies can be estimated as at least 9.3 % and the rate of light birth weights at 9.1 %. These values are still however higher than those of metropolitan France.

Causes of infant mortality

583 deaths of children less than 1 year of age were recorded between 1991 and 2008.
Perinatal diseases (foetal disorders, neonatal infections, respiratory diseases specific to the neonatal period, etc.) represent the main cause of death with 34.4 % of deaths, then congenital anomalies, with 18 % of deaths (mainly cardiovascular conditions: 34 cases and nervous system: 16 cases) and infectious diseases (13.2 %).
52 cases of sudden infant death syndrome were observed during this period, representing 9.7 % of these deaths.
These figures confirm the need to monitor pregnancies, so as to detect any congenital disease as early as possible, but to also inform mothers about the need to deliver in a medical facility in order to give better care at birth to any child with a perinatal disorder.

Young children

Preventive action related to child care in provincial facilities

The child population under 6 years old concerned by preventive activities is estimated at 24 619 children, or 10.1 % of the total population. One of the purposes of preventive medicine is to make sure that all children are up to date with their vaccinations and vaccinate those who are not.
New Caledonia's regulations provide for all children to have mandatory vaccinations for certain communicable diseases such as diphtheria, tetanus, poliomyelitis, tuberculosis, whooping cough, measles, rubella, mumps, viral Hepatitis B since 1989, haemophilus type b infections since 1994 and pneumococcal infections since 2006.

Regular medical examinations in schools

Medical examinations are mandatory in certain grades through children's schooling.

Since the 'Nouméa Accord', school medical examinations have been a provincial responsibility until primary school and a French government task ('Vice-rectorat': education authority) from secondary school onwards.

In 2008, the Nouméa school medical centre carried out 1 914 pre-school medical examinations, 4 992 primary school ("CP", "CE2", "CM2") médical examinations annd 780 special class ("clis", "IMI/ACH" and "Segpa") médical examinations.

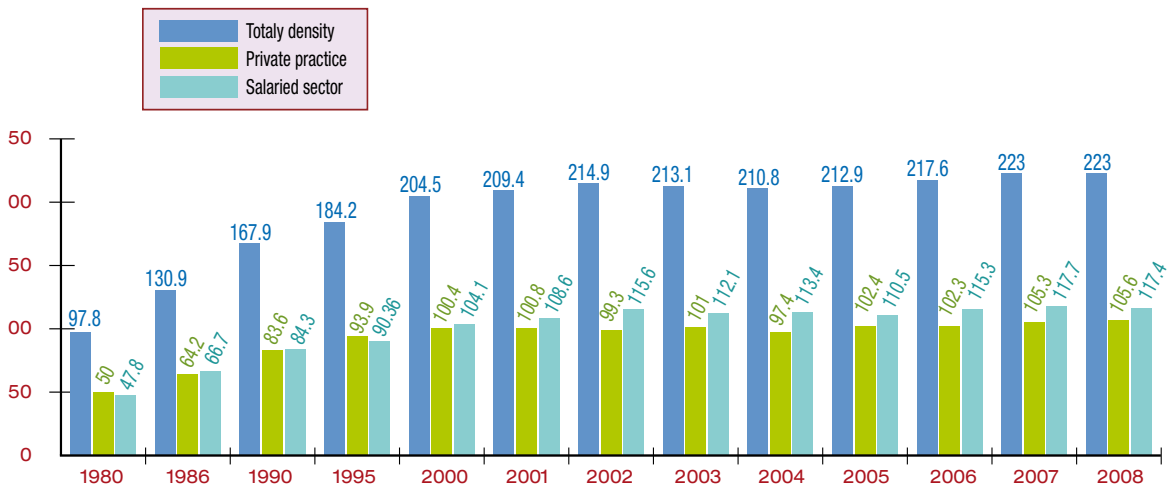
1 926 children were examined in the Southern Province CMS and 725 in the Islands Province. The Northern Province did not supply any data.

A total of 36 796 chhildren (public and private {church} education sectors) were enrolled in primary schools in 2008.

Physicians

The results obtained come from the 'ADELI' records administered by the Health Inspectorate at DASS - NC. For 2008, the figures were established as at 1st September.
This group includes private practice physicians whether or not bound by contract to the public health scheme, public health physicians and salaried physicians in the private sector.
Physicians doing a replacement, interns, physicians awaiting a practice or seeking employment, physicians who are technical aid volunteers and those practicing at the 'Direction Inter Armée des Services de Santé' are not included.
In the ADELI listing, a physician is considered as a specialist if he is practicing his specialty.
The nomenclature used is therefore related to the year concerned.

545 physicians were practising in 2008 (258 in private practice and 287 salaried), an increase of 1.68 % in comparison to 2007. In 2008, an increase (1.9 %) in private practice physicians and an increase of 1.4 % in salaried physician numbers were observed. The number of physicians in private practice is controlled because of the freeze in new contracts with the social protection agencies.
In 2008, the density was 223 physicians per 100 000 population.



Density disparities are observed between provinces, with the lowest in the Loyalty Islands and the highest in the Southern Province, in Nouméa in particular because of the presence of hospitals and clinics where most of the specialists and many GPs practice.
In the Northern Province, the figure falls between that of the Loyalty Islands and that of the Southern Province.
These densities are as follows:

- Loyalty Islands: 79.8
- Northern Province: 96.3
- Southern Province: 274.2

255 (44.8 %) of active physicians are general practitioners, a density equal to **104.3** for New Caledonia as a whole, which is lower than for metropolitan France which was equal to **135 general practitioners for 100 000 population** (estimate by DREES as at 1st January 2008). **89.7 %** of Southern Province general practitioners were working in the Nouméa or Greater Nouméa area, a density equal to **116.6** for this zone as against **109.6** for the other Southern Province communes taken together.

290 specialist physicians were active, representing a density of **118.7** specialists per 100 000 population in New Caledonia. The density is higher in the Southern Province and in Nouméa in particular, because of the presence of the main hospitals and technical facilities.

The densities by group of specialists by province are as follows:

Speciality	Density per 100 000 habitants		
	Nothern Province	Southern Province	New Caledonia
Medical	6.56	88.57	64.7
Surgical	6,56	36.33	27.8
Psychiatry and Child Psychiatry	2.19	10.78	8.2
Biology	2.19	4.54	3.7
Public health	0	4.54	3.3
Occuptional	2.19	7.95	6.1
Total density	**21.88**	**158.4**	**118.7**

Other health professionals

The numbers in each profession and distribution by area of activity come from the ADELI records, employer records and CAFAT data for 2008.

In New Caledonia, the density of dental surgeons is **51.1 per 100 000** population. The breakdown between the salaried sector and the private sector is respectively 36 % and 64 %.
The density of dental surgeons in private practice is **32.7 per 100 000** population.
In metropolitan France, the average density was a little higher and equal to 68 per 100 000 as at 01/01/2008.
The density of midwives in New Caledonia was **163.2 per 100 000** women aged 15 to 49 years (N = 106) in 2008. In metropolitan France, the density was 125 per 100 000 women aged 15 to 49 years (as at 01/01/2008).
The density of pharmacists, all categories combined, was **57.7 per 100 000** (N = 141) in New Caledonia in 2008. In metropolitan France, this density was higher and equal to 118 as at 01/01/2008.
The density of nurses – general, specialised and supervisors – was **449.2 per 100 000** in New Caledonia in 2008. In metropolitan France, the density was 780 as at 01/01/2008.
The total density of physiotherapists in New Caledonia was **47.5 per 100 000**; the density of private sector physiotherapists was **40.5 per 100 000**. In metropolitan France, the density was 105 as at 01/01/2007.

Facilities

Hospital beds and places (as at 31 December 2007)

Short-stay

Medicine: The 220 beds at CHT Gaston Bourret include the 8 beds in the call-in service.

Surgery: The 133 beds in the surgery unit of CHT Gaston Bourret include the Orthopaedic Surgery, Intestinal Surgery and Surgical Speciality Service beds (ENT, Ophthalmology, Stomatology).

Obstetrics: The 63 Obstetric Department beds at the CHT Gaston Bourret include 13 beds for surgery patients, 37 post-maternity beds and 13 beds for risky pregnancies.

Critical care unit: there are 61 hospital beds altogether for this unit, including 40 at CHT Gaston Bourret, with 8 constant cardiological surveillance beds and 8 neonatal resuscitation beds.

Sector	Short-stay hospitalisation services				
Private	Medicine	Surgery	Obstetrics	Intensive care	Total
Anse Vata Clinic	26	1	7	0	34
Baie des Citrons Clinic	21	32	0	9	62
Magnin Clinic	16	40	19	7	82
TOTAL secteur priv	**63**	**73**	**26**	**16**	**178**
PUBLIC	Medicine	Surgery	Obstetrics	Intensive care	Total
CHT G. Bourret	220	133	64	40	457
P.Thavoavianon Hospital	17	13	9	3	42
D. Nebayes Hospital	14	2	6	2	24
TOTAL public sector	**254**	**148**	**79**	**45**	**523**
OVERALL TOTAL	**314**	**221**	**105**	**61**	**701**

In total: short-stay units represent 680 beds.

Psychiatry

At the end of 2007, the number of beds available and monitored was **108 in-patient beds** (adult psychiatry) and **79 partial hospitalisation beds**, 25 of which were for adult day hospitalization, 20 places in rehabilitation centres and therapeutic workshops, but also for child psychiatry, 15 for day hospitalization and 10 in 'CATP'.

Medium-term stay

Medium-duration hospitalisation concerns essentially the beds available at the Col de la Pirogue sanatorium.

There are 34 beds: 20 geriatric readaptation beds at the CHS and 14 multi-purpose care and readaptation beds at Poindimié CHN (Northern Province Hospital).

Long-term stay

Long-term hospitalisation is available through 81 beds, 25 at the Raoul Follereau Centre and 56 beds at the Elderly Persons Unit at CHS Albert Bousquet.

Multi-purpose local hospitalisation facilities

These are the beds in the medico-social centres managed by the provincial health and social affairs departments in the rural areas and the islands. They number 26 with a total of 42 beds, broken down as follows:

- 5 medico-social districts in the Islands Province totalling 31 beds;
- 14 medico-social districts in the Northern Province totalling 2 beds;
- 7 medico-social districts in the Southern Province totalling 9 beds.

All these health facilities operate with a constant medical and para-medical presence (weekdays and holidays). These are local facilities whose main task is to meet the needs of the community in the curative, emergency and prevention areas.

Para-public facilities (2006)

The Société Le Nickel, with the 'Mutuelle SLN' (SLN mutual insurance system) includes:

- The SLN medical centre at Doniambo, in Nouméa, with 2 ophthalmologists and 3 dental surgeons.
- 2 optical centres, one in Quartier Latin and one in Doniambo, where 1 optician spectacle-makers practice.
- 2 dental surgeries, in Thio and Kouaoua; one dental surgeon covers these two locations.

In 2007, 11 154 ophthalmological consultations and 10 905 dental consultations were performed.

'Mutuelle des Fonctionnaires' (public servants' mutual insurance scheme)
- in Nouméa: 1 physician, 6 dental surgeons, 1 physiotherapist , 2 pharmacists ;
- in Boulari (Mont-Dore): 1 general practitioner, 2 dental surgeons,
- in Pouembout: 1 dental surgeon, 1 pharmacist.

In 2007, 3 859 dental consultations and 8 204 medical consultations were performed.

CAFAT : (New Caledonia social security system)
In Noumea, there are 2 socio-medical centres, one at Receiving and one at Rivière Salée, where the following doctors practice:
- 9 general practitioners,
- 4 dental surgeons,
- 1 radiologist,
- Cardiologists, paediatricians and ENT specialists working as consultants.

In 2007, 22 324 general medical consultations, 1 681 specialised medical consultations and 2 101 dental consultations were performed.

Armed forces health centres

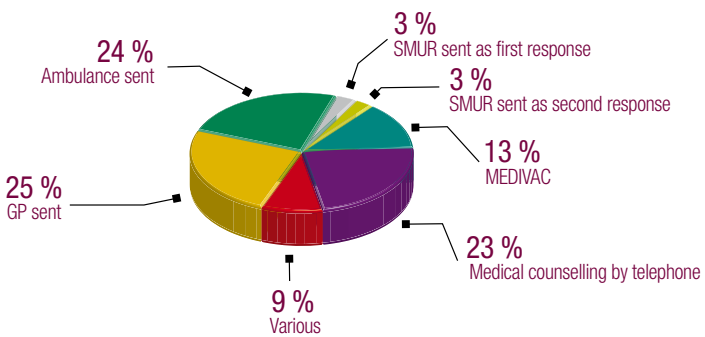
Infirmeries	Beds	Personnel		Number of days	Number of consultations
		Physicians	Nurses		
'Centre de consultations interarmées', Nouméa	12	4	6	139	5 144
Marine infantry regiment for the Pacific (RIMAP) in Plum	9	3	4	347	2 595
RIMP Detachament in Nandaï - Bourail	7	1	1	25	1 798
Tontouta naval air base	4	1	3	1	847
Special military service group in Koumac	0	1	1	0	1 102
TOTAL	32	10	15	512	11 486

For army health care outpatient consultations, army families can got to the 'Centre de consultations interarmées' in Nouméa.

Emergency units

The SAMU's essential mission is to provide or obtain appropriate emergency health care to sick persons, persons with injuries and parturients, wherever they are located in New Caledonia, on a constant basis. The emergency unit's mission is to cater at any time for all patients coming to Gaston Bourret Hospital for immediate care and for whom care was not scheduled, whether in the event of an emergency or a perceived emergency.

In 2008, the 2 emergency units at Gaston Bourret and Magenta recorded 43 605 patients as against 41 988 in 2007, an increase of 4 % (+2 % at the Magenta Hospital and +5 % at the G. Bourret hospital). 22.2 % of these cases required hospitalisation: 39 % at Gaston Bourret and 12.7 % at Magenta.
SAMU - SMUR results: the centre: the 15 emergency call centre received 29 529 calls producing a medical response in 2008, which is 8 % more than in 2007. These calls were processed as follows:



Blood transfusions

2008 was characterised by an increase in overall activity (6 407 884 B), -3.1 % over 2007. A decrease in the number of blood donations was recorded in comparison to 2007 (-3.6 %). These donations have been the only therapeutic source of platelets since August 2004 and make it possible to ensure constant local supply of this product, for which the need is urgent and unpredictable. The quantities of blood given for auto-transfusion are stable and the practice is infrequent.

Medical biology

In the public sector, there are biochemical and haemostasis laboratories at 'Centre Hospitalier Territorial Gaston Bourret' and there is a laboratory at the Thavoavianon Hospital in Koumac.
Institut Pasteur, mostly performing serology, haematology, and microbiology, as well as having an anatamo-cytopathological function, is a private foundation recognised as being of public usefulness with the task of contributing to disease prevention and treatment through public health activities, research and training.
The medical testing laboratory of the CAFAT Medico-social Centre is located in the Receiving area and performs chemical, haematological and microbiological testing.
11 medical testing laboratories are registered in the private sector, 6 in Noumea, 1 in Dumbea, 1 in Mont-Dore, 1 in Koné, 1 in Paita and 1 in Bourail.

Medical imaging

At the Noumea CHT, radiology is split into 2 units, one in-house in rue Paul Doumer that includes the Scanner and RMI Unit (since November 2005) and one at the Magenta Annex which basically does woman and child radiology and echography. It should be noted that an agreement between the public and private sectors gives private practice patients access to the CHT Scanner and MRI unit.
The P. Thavoavianon and D. Nebayes hospitals as well as the Cafat Medico-social Centre at Receiving all have radiology units.
In the private sector, there are 5 private radiology practices.

Pharmacies

57 pharmacies are registered and open to the public: 54 in the private sector and 3 mutual insurance pharmacies.
These 57 pharmacies are distributed as follows:

- Nouméa : 21 pharmacies + 2 mutual insurance pharmacies ;
- The other communes of the Greater Noumea area: 14 pharmacies ;
- Outside Greater Nouméa : 19 pharmacies + 1 mutual insurance pharmacy ;

Seven dispensing physicians practice outside the greater Nouméa area.

Pharmacies within a healthcare facility

Elever pharmacies within healthcare facilities have been authorized : ATIR-NC, at 'CHT Gaston Bourret', 'CHS Albert Bousquet', 'P. Thavoaviannon Hospital', 'D. Nebayes Hospital', 'Magnin Clinic', 'Anse-Vata Clinic' and 'Baie des Citrons Clinic' ; Islands Province, Northern Province, Southern Province.

Pharmaceutical wholesalers

There are 4 wholesale pharmaceutical distributors in New Caledonia, with the main ones being 'Office Calédonien de Distribution Pharmaceutique' (OCDP) and 'Groupement de Pharmaciens de Nouvelle-Calédonie' (GPNC).

Medicine depots

There are 25 medicine depots operated by non-pharmacist traders. This number of businesses conducting this activity in practice is not accurately known and the situation needs to be reassessed.

Health sector accounts

General

Resolution N° 490 dated 11 August 1994, as amended, relating to a health promotion and health expenditure control plan on the Territory of New Caledonia provides for annual 'health accounts' to be prepared. In this document, they are presented for a series of three financial years (2004 to 2006). Health accounts make it possible to assess the cost of health care and analyse its evolution. They also make it possible to identify the source of the financial resources allocated to this expenditure and the distribution of financial effort between health insurance agencies, supplementary insurance policies and public bodies.

Definition

The cost of health care can be approached through two standardised combined concepts:

- Total medical consumption;
- Recurrent health costs.

Total medical consumption

Total medical consumption is equivalent to the value of the medical goods and services used in New Caledonia in direct response to individual health needs. It is expressed in terms of overall financial volumes arising from curative care and individual preventive medicine services offered over the year.

Health care consumption comprises inpatient and outpatient healthcare benefits delivered by hospitals, private practices, district medical facilities, provincial health centres and social welfare agencies. To health care proper should be added the **consumption of medicines and other medical goods** (optical items, prostheses, small supplies and dressings).

Medical care and goods are grouped into the following categories: hospitalisations, out-patient care, medical evacuations, physicians' fees and the costs stemming from their prescriptions: medical auxiliaries, drugs, tests, prostheses medical transport, etc., plus dental care.

The expenditure relating to individual preventive medicine comprises the cost of vaccinations, testing and medical surveillance, as well as the expenditure incurred in industrial medicine services.

Recurrent health expenditure

Recurrent health expenditure is equivalent to the overall effort expended on health in the course of a year by the population and institutions in New Caledonia; It amounts to the total expenditure committed by the funders of the health system: Cafat, the provinces of New Caledonia under medical aid, the supplementary cover organisations (mutual insurance companies, insurance companies, provident institutions) and households themselves.

To the total medical consumption defined above, should be added the daily allowances, research, health professionals' training, health system management costs and collective prevention outlay (public awareness and health education campaigns).

Precautions

The following data are estimated where household and private insurance outlays are concerned, as the private insurers did not communicate any information. Expenditure is assessed through a comparison with the revenue received by hospitals and, as an overall figure estimate, where municipal health care expenditure is concerned (SANESCO basis = 5 % upward adjustment).
Similarly, the data communicated by certain bodies or public administrations were incomplete and a footnote states which data are estimates.

Trends from 2004 to 2006

Between 2004 and 2006, total medical consumption increased, overall, by 21 % and recurrent health expenditure by 18 %. The rising trend in health expenditure began to slow between 2005 and 2006 after a steep increase in 2004.

Year	Total medical consumption in millions of CFP francs	% N-1	Recurrent health expenditure	% N-1
2004	47 339.17	+3.6 %	52 951.79	+4.8 %
2005	54 303.63	+14. 7 %	58 596.49	+10 %
2006	57 461.71	+5.8 %	62 563.88	+6.7 %

The development of the supply side in the health sector, improved general socio-economic circumstances and the extension of the social protection system have contributed to an improvement in the overall health status of the community but have been accompanied by an uncontrolled structural increase in health expenditure.

This major growth in health-related expenditure prompted the Congress in late 2005 to adopt a second health expenditure control plan after the initial one adopted in 1994 that made it possible to contain health expenditure for a number of years. The first effects of this new plan were felt in 2006, notably in reduced hospital expenditure.

Comparison

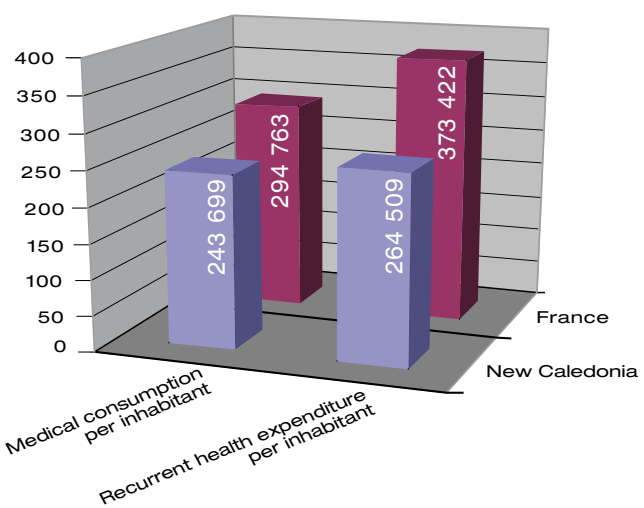
The use of standardised aggregates makes comparisons possible, with mainland France in particular, by expressing:

- Total medical consumption and recurrent health expenditure per inhabitant;
- Total medical consumption and recurrent health expenditure per inhabitant in relation to GDP.

A- Trends in total medical consumption per inhabitant and recurrent health expenditure per inhabitant

Year	2004	2005	2006
Population of NC (ITSEE data)	227 878	232 258	236 528
Total medical consumption per inhabitant in NC	207 773 F CFP	233 807 F CFP	243 699 F CFP
Health expenditure per inhabitant in NC	232 369 F CFP	252 290 F CFP	264 509 F CFP

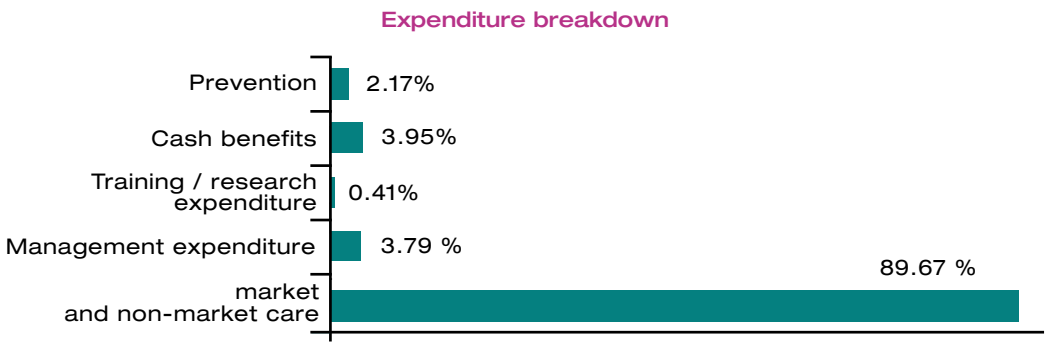
Comparison



The lower figures for medical consumption per inhabitant in New Caledonia can be explained in particular by the younger age structure of the New Caledonian population, as young people consume less health care. The average amount spent on health care for persons aged over 60 years is 3 times higher than for the 20-49 year-old age group. 37 % of the population is under 20 years of age in New Caledonia, whereas this age group only accounts for 25 % of the population in metropolitan France.

The over-64-year-old group represents 16.2 % of the population in France while they only account for 6.4 % of the New Caledonian population. However, this age group is expanding slightly while birth numbers are decreasing, suggesting that the average age will climb over time.

To this lower medical consumption per inhabitant should be added training and research expenditure which is much lower in New Caledonia than in mainland France, producing recurrent health expenditure that is also relatively lower.



B - Trends in recurrent health expenditure in relation to GDP

The moderation of the weight of health in national wealth creation is however partly linked to GDP growth over the past three years (mean annual growth rate of 4.1 %)*.

In %	2004	2005	2006
New Caledonia GDP (in billions of CFP francs)	565.5	599.5	647
Medical consumption in terms of GDP	8.37	9.05	8.88
Recurrent health expenditure in terms of GDP	9.36	9.77	9.66

National health expenditure in OECD countries

The OECD uses a slightly different concept to enable comparisons between its members: national health expenditure, which is assessed from recurrent health expenditure by deducting daily cash benefits and research and medical training expenditure and adding the crude initial fixed capital value of the public hospital sector.

In New Caledonia, this corresponds to investment in the territorial public hospitals (CHT/CHN/CHS), amounting in 2005 to 536.3 million francs and in 2006 to 970 million francs.
The construction of a new hospital in Koutio, to supersede the current Gaston Bourret CHT, accounts for a major share of this investment. National health expenditure calculated for New Caledonia in 2005 was 8.47 % of GDP, while for France the figure is 10.6 % of GDP.

In 2006, 62.56 billion CFP francs were spent in total on health care in New Caledonia, an average of 264 509 CFP francs per inhabitant.
Within this figure, 57.46 billion were directly spent on the consumption of medical care and goods, i.e. 243 699 francs per inhabitant.
New Caledonia has health expenditure figures equivalent to the average health expenditure of developed countries.

* ISEE data

The environment

Health is the result of a group of determining factors, in particular, the physical and social environment, lifestyles and health care systems. Health protection and promotion policies should be designed to encompass all of these determinants.

Climatology

Significant features of 2008

- Annual rainfall was substantially higher than normal, mostly due to the exceptionally high figures recorded in the early part of the year (La Nina phase) and late in the year. March and April were particulary rainy months, beating many previous records.
- The mean annual temperature was notably higher than normal, especially from July onwards (an exceptionally hot month).
- Insolation and solar radiation were below average on the whole.
- Potential evapo-transpiration was high during the warm and wet season, with 2008 featuring heavy early-year and late-year rainfall ; the potential annual water balance is in a surplus situation overall
- Average wind speeds are slightlly lower than normal

Water

The Government of New Caledonia mainly exercises jurisdiction over water through health and hygiene regulations. The Provinces have jurisdiction over environmental matters, particularly regulations on classified facilities (water treatment plants, for example).

According to the 'Commune Code' (the 'commune' is the smallest administrative subdivision in France), communes have jurisdiction over hygiene matters and are responsible for preventing disease outbreaks. In this regard, they must implement quality control measures for their water supply systems and ensure the quality of bathing water and sanitation facilities.

In New Caledonia, mean annual water production is **39** million cubic meters, about **27,1** million cu. m. of which was for the Greater Nouméa area in 2008. This amounts to some 424 litres per day per inhabitant.
In Noumea, the public water supply service has been contracted to 'Calédoniennne des Eaux'. Noumea's water supply comes from the water reservoir above the Dumbea Dam, the 'Aqueduct' pumping facilities at Tontouta and several pumping stations spread out along the Dumbea River.

Mean consumption for Noumea is about **42 200 cu. m/day** with peaks of **60 000 cu. m.**

Bathing water

Only the City of Noumea carries out quality control inspections of bathing water.
The Municipal Hygiene Department takes and tests water samples on a regular basis.

Sanitation

Poor maintenance or lack (in most cases) of sanitation systems lead to a noticeable decrease in the bacteriological quality of water.

For that reason, water in New Caledonia is, on the whole, of inadequate bacteriological quality.
It is characterised by excessive amounts of faecal germs from both humans and cattle. This presence deteriorates drinking water if it is not treated but also impinges on contact uses such as swimming, bathing, etc.

The most alarming situation is the contamination of the water lens in the Loyalty Islands, the population's only source of drinking water.

Air
The 'Association de Surveillance Calédonienne de la Qualité de l'Air (**Scal-Air**: http://www.scalair.nc) provides surveillance of air quality in New Caledonia and raises public awareness on this issue.
Scal-Air takes samples and analyses **in real time** the pollutants present in the ambient air.

Four pollutants are kept under surveillance: fine particles; sulphur dioxide; nitrogen dioxide; ozone. Concentrations of each of these pollutants are classified on a scale from 1: 'very good' to 10: 'very bad'. The highest of these four sub-indices gives the **'ATMO' index** for the day.
Real-time mapping data can be used to accompany the index figure.

Fires
All levels of government and the communes are responsible for **fire protection**. The French Government, as part of civil security, has a share in the responsibility for managing the resources to fight large-scale fires. The high level of involvement by the Armed Forces in fires that exceed the communes' resources should be noted.

Altogether, **297** fires destroyed 1 734 hectares during the 2007-2008 season, from 1st October 2007 to 31st January 2008 (in 206: 428 fires and 9 239 hectares burnt).

Food
The Animal Health Office at the Department of Animal Health, Food and Rural Affairs is responsible for monitoring food products of animal origin. This office also monitors catering facilities in collaboration with provincial or municipal hygiene services.

The veterinary service has a laboratory capable of carrying out microbiological testing of food items. It also has data on the in-house inspections carried out by facilities that prepare ready-to-eat cooked dishes.

The Economic Affairs Department conducts quality control of food in retailing networks as part of its fraud control work.

Waste
Household refuse generation is steadily increasing due to the growing population and increased use of manufactured and factory-packaged goods.

Certain **specific types of waste**, e.g. purged substances or liquids, used oil, tyres, toxic waste (pyralene, lead batteries) undergo specific processing. Up to now, **potentially infectious health system waste material** has been destroyed by incineration.
A new process will soon be put into place that uses a disinfection process.

A wide ranges of actions designed to heighten **public awareness** about cleanliness have been carried out and are still extremely vital for New Caledonia.

Economic and social data (ISEE)

World-wide growth maintained a fairly high GDP rate in 2007 despite the American financial crisis and the surge in raw material prices recorded late in the year.

New Caledonian economy: sustained activity

Despite greater vulnerability in the world context, in 2007 New Caledonia's economy, mirroring the trend of recent years, experienced strongly sustained economic activity, broadly stimulated by the nickel sector, with growth promising to be stronger than in 2006 and inflation kept down to 1.8 %.

Mining and metallurgy

The price of nickel, after spectacular growth of some 157.5 % in 2006, continued its spectacular climb in early 2007 (+51 %).
But from June the average nickel price collapsed over the second half of the year, losing 50.2 % of its value in December 2007.

Fisheries and agriculture

A difficult year, in particular:
- a decrease in exports of seafood, shrimp and venison;
- slightly offset by an increase in fruit and vegetable production.

Construction

Sustained construction and public works activity allowed an increase of +8.5 % in salaries in the construction sector and a marked increase of +15.8 % in housing loans. An increase in the overall cost of construction of +3.5 % was noted.

Energy

A very slight increase in overall electricity production was recorded in 2007: +2.8 % over 2006.
The breakdown by source shows that 77.8 % of energy is generated by power stations, 20 % by hydro-electric schemes and 2.2 % by wind farms.

Tourism and travel by New Caledonians

A total of 224 756 visitors (103 363 tourists + 121 393 cruise ship passengers) came to New Caledonia in 2007. An analysis by nationality of these cruise ship passengers shows a majority of Australians, with 81.5 % of the total. New Zealanders account for 7.6 %, British 3.0 %, Americans 1.8 % and other nationalities 3.6 %.
A total of 106 377 trips were taken by New Caledonians in 2007, an increase of 6.2 % in one year. Australia remained the preferred destination: 37 744 travellers in 2007; then came France with 31 571 travellers. New Zealand accounted for some 11 000 travellers.

Consumer prices

In December 2007, the consumer price index stood at 127.5 (as against 125.2 in 2006), showing an increase of 1.8 % in one year. Inflation was highest on food products (+4.5 %), followed at a relative distance by services (+1.2 %).
The figure for manufactured products came in last place with +0.4 % over the past twelve months.

Public finances

With revenue expanding faster than expenditure, the New Caledonia budget surplus increased.
It stood at 15.8 billion CFP francs in 2007.
Initial provisional data on public finance in the Provinces show relatively stable budgets in the Southern and Northern Provinces.
The Islands Province budget was not available.

DASS
Nouvelle Calédonie

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