

## Working for a healthier Papua New Guinea

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Dr Peter Macdonald migrated to Australia from Scotland in 1972 and conducted a general practice in Manly for 25 years. He entered local politics in 1987 in response to growing concerns about inappropriate development and environmental degradation.

Peter served as local councillor for 16 years as part of a progressive resident action group. In 1991, he was elected as the Independent MP for Manly in the NSW Parliament and retired in 1999. During those two terms, he had a particular interest in issues such as reforming the democratic process; health, in particular mental health; the environment; ethics, or lack of ethics amongst parliamentarians, to name a few.

In 2004 Peter was elected as Mayor of Manly for 4 years and is still a councillor on Manly Council.

Since 1999, Peter has devoted his time to humanitarian medical work in Iran, East Timor and Papua New Guinea; in 2002, he established a new aid organisation called Australian Doctors International, which is currently deploying health personnel and services to the Fly River area of PNG.

Peter is Chairperson of Australian Doctors International.

He currently works as a doctor in remote Aboriginal communities in Northern Territory.

Thank you everybody, and thank you to the National Rural Health Alliance for permitting me to come and share an adventure with you tonight.

I'm now a GP working in remote Aboriginal health in the Northern Territory, but I also dedicate a lot of my time driving this aid organisation called Australian Doctors International.

Tonight I want to tell you about what we do and who we are, and to talk about PNG itself—about its challenges and also the great adventures that await you there if you happen to want to volunteer with ADI as a doctor or a health manager. There are great opportunities in PNG.

ADI is a not-for-profit, non-government aid and development healthcare organisation working to improve the health of people in PNG. It deploys doctors and health workers for up to four months—sometimes up to 12 months—into remote parts of PNG.

ADI was established almost 10 years ago in Sydney and has a small office in Sydney, and only works in remote and rural areas of PNG. I've been there many times myself and also worked for some fairly lengthy stints there. Only recently, we reached an agreement with the provincial government of New Ireland Province to open a second program area there, whereas, at the moment, we are only working in Western Province of PNG.

Essentially what Australian Doctors International does is remote patrols, and to support, at the same time, the national health objectives. You can see there, the map of PNG. Of course, on the western half of the island of New Guinea is West Papua and here is Kiunga, which is in the Western Province, where ADI have been for the last 10 years. Over here is Kavieng, the capital of New Ireland, where we've just opening up a program and will be deploying a doctor and a health manager within probably four to five weeks.

PNG's state of health is in a crisis. All the indicators are appalling, from infant mortality through to maternal mortality. Most of you would be aware maternal mortality rates in Australia are approximately 8.4 women die for every 100,000 live births in Australia, whereas in PNG, the figure is 733. It's just appalling, and many indicators reflect that. Malaria is rife, TB is out of control, particularly multi-drug resistant TB, and also HIV is the highest rate in the Pacific. With severe staff shortages, health centres are closing.

ADI does *Doctor Supervised Integrated Health Patrols*. Our doctors and health managers go out into remote areas for three to four weeks at a time, come back for one week for a rest and go out again. The essence of those patrols is to treat patients, to provide community and school health education, and also to train local staff. Those are the key elements of what we call *Doctor Supervised Integrated Health Patrols*.

This is the Western Province. PNG, as you know, is our closest neighbour. It's very close—only five kilometres from the Torres Strait Islands and, in fact, we are based up here in North Fly. Western Province is divided into three districts: North Fly, Middle Fly, South Fly. ADI operates in North Fly and Middle Fly.

We've chosen not to operate in South Fly because it's so remote—so difficult to operate in, and we can't find a satisfactory partner in South Fly. From the Australian Government's point of view, they should probably be encouraging us to operate in South Fly because at the moment there is no doctor on the mainland there for 60,000 people and, as a result of this, many of the people of South Fly are crossing to access health services in the Torres Strait. We've had no support from the Australian Government, despite the fact that we've met them on a number of occasions.

I just want to talk to you, though, about the logistical challenges. There's very high rainfall—up to eight metres a year in Western Province. There's water everywhere and, of course, that contributes to the high malaria incidence. The Fly River is the major river in Western Province. It's 400 kilometres long and spills out into the Timor Sea and Daru, which is the capital of Western Province. Unfortunately the river—for those of you who know the story of Ok Tedi mine—has been completely contaminated by a gold and coppermine in the North Fly area, and the river is effectively dead. But it's certainly a very important transport route for us to travel through Western Province.

(Photo) The typical weather there is constant rain, which is very difficult to operate in, and you can only go by water and occasionally by air.

(Photo) This is a patrol that's trying to work their way through one of the mud roads into one of the refugee camps. There are about 15,000 West Papua refugees in that border region of Iowara where we operate.

(Photo) This is one of our doctors, Denise Wild, who came back late last year. This is not untypical of the sort of patrol work she had to do: crossing rickety bridges. It's very hard and we expect our volunteers to be prepared to put up with fairly harsh conditions—often living purely on sago, out there for weeks on end. So when you do come and see me tomorrow at booth 45, when I'll be talking about ADI, remember that, having been a boy scout or a girl guide will help and you'll certainly need a high level of fitness.

The infrastructure is failing throughout the country, and Western Province and New Ireland are no different. Appalling conditions, a lack of morale in the health centres, and a lack of funds being directed—much of it is due to corruption at a bureaucratic level, at local, provincial, and national levels of government. Many of the health facilities have got no power, no water, no fridges—so there's no cold chains and staff morale is at rock bottom because, of course, they don't often get paid.

(Photo) This is one of the companions at the health centre—dogs come in and out. The health centres are dirty and poorly attended. That, in the middle of the picture, is a steriliser at one of the clinics, and you can see the patient records scattered around. This was in one of the bigger health centres in New Ireland.

Many of the facilities are only half completed. Many of them are falling down. This is a ward, but it's got no beds. It's got a number of patients, who are waiting patiently for attention.

This is another one. Some of them are very unsafe—they're termite ridden and, in fact, on many occasions you can see there's people under that clinic there—often the consulting is safer under the building than inside the building.

This is one of a small ward in one of the health centres, which is working quite well. They make do. We bring them help. We bring them hope. We bring them advocacy. Having been in the Western Province for almost 10 years, ADI is dedicated to drawing attention to the plight of the people there, and also the plight of the health centres. So we are constantly badgering provincial and national government to bring about an improvement.

There is minimal equipment. Much of it is out of date. The drugs are out of date. I was doing an inspection there last year in one of the clinics in New Ireland. There were major problems with TB and leprosy. When we first arrived, eight or nine years ago in Western Province, we asked the national government in Port Moresby what the incident of leprosy was in Western Province, and they indicated to us that there is no leprosy. Our doctors are finding up to eight cases per patrol of leprosy in the remote parts of the Western Province.

It's bad enough when the statistics are being distorted, but it's very hard to get the chain of supply of crucial drugs, both for leprosy and for TB. You would all know that without a constant regular supply of TB drugs, you get into all sorts of problems with non-compliance and with resistance.

This is one of our doctors—I've got a few slides here of some of our wonderful doctors, many of them—and, in fact, 75 per cent are women. Most of them have experience in the top end or in northern parts of Western Australia and North Queensland and have some general practice background.

This is Deirdre McCormack with a happy group of volunteer health workers.

This is one of our health managers Louise Devereux. She does clinical work and immunisations. It's particularly important that we are now deploying health managers to assist in health management of the clinics. It's all very well having doctors going in and providing clinical support, but what we've noted over the years is the lack of good management in the health centres. If we're going to leave a lasting benefit there, improving the management of the health centres is crucial. So now, on all our patrols, we send a doctor and a health manager.

This is Dr Deirdre again. As I say, it's on the Fly River. Up to 12 hours, some of the trips, down the river to some of the health centres.

This is Dr Denise, who you saw earlier, in a helicopter. We fall upon the grace and favour of the big mining companies in PNG. Many of them have significant logistical support, and this was a helicopter taking Denise into a patrol area in the Star Mountains, which is in the far north of Western Province.

There's Dr Deirdre again on the hike I told you about—the tough walking conditions. And most of our doctors and health workers, who go over there, come back a few kilos lighter, so there's a way of losing a bit of weight everybody.

That's Dr Denise Wild living on sago and banana.

This is Kate Collister, a doctor from Western Australia. She's doing a consultation on the run, and she was just another of the wonderful young doctors that we've had, as I say, particularly women.

This is Peter Bowman, who is currently the GP up in Tiwi Islands in the top end. He's done four deployments for ADI—several with his wife—in Western Province.

This is young Dr Jane—she's currently with the Royal Flying Doctor in Northern Queensland. I think that's probably a TB patient, but I'm not absolutely sure.

That's one of our more recent doctors from New South Wales, Dr Verena Doolabh. She and Louise are doing a joint patrol together which are a critical element of our service provision.

I'm going to show you some of the health challenges, and I must warn you there's one or two pretty confronting pictures coming up here. It actually reflects the ghastly state of affairs and need to talk about it because it's the way we're going to bring about changes—for people to realise just how appalling it is in terms of supply of health services there, and the indifference at government level.

This is a young 14-year-old girl, who was the daughter of our boatman. He had no support from the local health clinic and brought her to us. She had TB and typhoid and she died about a month after this. We couldn't get access to TB drugs, despite the fact that we are an aid agency advocating for such. There were no TB drugs in Kiunga in the Western Province at the time.

That's a nasty case of breast cancer. Access to any sort of secondary healthcare is almost impossible.

A population of 200,000 live in the Western Province and there is no functioning government hospital in the whole province. There is one mining hospital in Tabubil which, of course, is excellent.

This is not untypical—a lot of desquamating fungal infections of the skin due to hygiene issues and the high moisture and rainfall.

Burns, of course, are common in all these types of communities where they rely on kerosene for heating and for cooking. In this case, this young girl will have a shocking contracture. There's nothing we can do. We are dedicated to primary health care. Others may well organise for her to, perhaps, be flown back to Australia to give her some chance to use that right arm again.

That was a fairly nasty burn that we saw at one of our clinics. That will be okay. That will be managed and you can see it's a fairly reasonable facility there.

This next case was an interesting one. I saw this little boy in Namatanai, in August last year, in the southern part of New Ireland, and as you can see, he's got nephrotic syndrome. He spent five months in a clinic—they didn't know what it was, but we managed to identify that. When I say we, I was travelling, at that point, with a PNG paediatrician, and he helped with his management and he was put on medication and he is probably going to be all right.

This, of course, is a fairly advanced case of leprosy and nothing that one can do there in terms of the neurological complications — xxxxxxxxx

This is an earlier case of leprosy. We have major problems in getting drugs for leprosy. Our doctors and health workers see leprosy in children as young as five, but we can't get access to drugs.

That is a case of cerebral malaria. This child had been brought in to the clinic. (I am in the picture at the front and at the back, in the blue, is a paediatrician from Kavieng in New Ireland.) We were visiting the clinic and this child was in a back room and we asked, "Well, what's happening?" They said, "Well, the child has come in fitting." The child had been well in the morning and was now fitting—that's how quickly malaria hits young children. She was given quinine and rectal valium and transferred up to the hospital, and that child was fine. We followed up in a couple of days with a phone call and she was okay. But she was lucky she was diagnosed and treated quickly. For every one of those, there must be dozens that aren't and they die.

This next child is an appalling case I saw in Kiunga on the border with West Papua. This child is from Irian Jaya, nine or 10 years old, had untreated TB and within three months got TB meningitis. So the child, of course, is beyond any hope and died shortly after.

So with malaria, bed net distribution is absolutely crucial. After a short time that ADI was in Western Province, we thought, "How can we really get a good bang for our buck and really make a big difference in terms of health outcomes?" Of course, the answer is malaria bed nets. We were the first to distribute them in very large numbers, and we've distributed 51,000 in the Western Province. And through education—as crucial as you can see here in this picture—there's been a dramatic drop in malaria in those areas where the bed net distribution has happened. The UN, through the Global Fund, has now taken over the distribution in PNG and is spending \$37 million on the distribution of bed nets, and I commend them for that. It's an enormous logistical difficulty distributing nets in remote communities, but it makes an enormous difference.

That is a bed net in use with one of our workers. We distribute them often on the rivers, and that's one of our boats which we use for distributing bed nets.

This is lymphatic filariasis—a shocking picture—that boy died a week later. He's had that lymphatic blockage—which is elephantiasis—for three months. We brought him into the clinic and he died within a week.

One of the treatments for filariasis is mass drug administration, using DEC and albendazole. That's a program that we've introduced there and this individual, who was part of the welcoming ceremony when the doctors arrived in the village, is receiving his drugs.

As I said, education is very important to the schools and the community. It's got to be provided as part of an integrated health service.

And we do in-clinic training—that's one of our doctors teaching some first aid.

We are now being invited up here into New Ireland. You couldn't compare it to Western Province, which is difficult, remote, hostile and very wet. New Ireland is a bit like Fiji probably 50 years ago. It's a dream. It's a beautiful place, but has got no doctors doing remote work.

I've just signed an agreement with Sir Julius Chan, who is the Governor of New Ireland and former Prime Minister of PNG, to provide health services to all their 62 clinics. As part of the beautiful scenery of New Ireland, I think we'll have plenty of doctors and health managers volunteering to go into New Ireland. The population is 160,000 and there are only 10 doctors, all based at one of two hospitals and none dedicated to primary health care.

I know I'm running out of time. But this is where the health system is failing: TB failing, there's no family planning, malaria is worst in PNG.

So this is what we do best: *Doctor Supervised Integrated Health Patrols*. And I leave you with that message. I'd like you to look at our [www.adi.org.au](http://www.adi.org.au). It's a good website and it tells you more about ADI.

So I hope to see some of you tomorrow at booth 45. Meanwhile, thank you.