

## **An Elective in Papua New Guinea**

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The evangelist had the worst hair I had ever seen – a grey and black comb-over *avec* mullet – an impossible adventure in bad taste. But for \$107 I could not only own a signed copy of his autobiography, but also have the privilege of assisting his ministry in tele- and power-evangelism.

He was followed by the national anthem of Papua New Guinea (PNG), played over shots of the country: the parliament building, parliament in session, girls in traditional dress, and a soldier putting some money in a slot machine, getting nothing out of it and walking away.

The few minutes I spent watching TV in the departure lounge of Jackson International Airport, Port Moresby (the capital), gave me an accurate taste of PNG and the experiences of it I would later have. Even in remote villages I came across books and religious tracts (more often than not about the end times) published in Texas; celebrations of indigenous cultures were numerous; technology worked erratically. That isn't to slight PNG, merely to enumerate some of the disparate aspects of life in this utterly unique country simultaneously buffeted by the newest forms of globalisation and stilled by the ancient customs of its people.

My placement was in Dogura, a small rural mission station sited near the coastal village of Wedau in Milne Bay Province. The site of the first landing and settlement of the Anglican Church in PNG, it is also the location of the cathedral of the diocese of Dogura, the church schools and the St Barnabus Health Centre. St Barnabus is a primary health centre, staffed by two ex-patriate doctors, several nursing staff and community health workers. It is the chief health centre of Rabaraba district, serving a population of 20,000, with in-patient wards for obstetrics, paediatrics, general medicine, and close observation.

Life in Dogura and Wedau are peaceful – something I appreciated even more during my travels around other provinces. Milne Bay Province has the highest literacy rate outside the capital and

the second highest life expectancy in the country.<sup>3</sup> Its prolonged contact with the churches may have something to do with this, as might the province's relative isolation and lack of urbanity.

During my time there I shadowed Drs Griffin and Bettiol at the health centre and on patrol. The patrol was to the village of Gadavisu – a six-hour walk (uphill!) – in the inland mountains that formed a colossal and stunning backdrop to Dogura. In Gadavisu we met Giblin, the Aid Post Orderly who acted as our guide and translator.

The Gadavisu clinic was hectic and cramped, situated in the two-room aid post that served the community. As expected men were seen first, then children, then women. (Incidentally this is the same order in which people receive food at mealtimes and is a reflection of the relative status of each group.) Privacy was minimal with enthusiastic and inquisitive crowds taking the opportunity to see a novel distraction from everyday life. Curious children peeked through every window they could find, watching each consultation in turn. The villagers did not value privacy – something that may derive from a strong community ethos.

The second day of the patrol started with a trek to a second village, Boyaboya, approximately two hours away. Boyaboya, like Gadavisu, was a village full of houses made in the traditional way: wood lattices supported roofs of thatched coconut leaves. This clinic took place on mats laid out for us outside the VBA's house and provided two images that linger in my mind. One was an elderly woman who arrived as the clinic was ending, having struggled to make her way there with a large walking stick, but eager to see the doctors, hoping that they could provide some means by which her eyesight could be restored. (She was complaining of poor vision, being unable to see anything with precision.) A brief examination revealed that she had substantial cataracts in both eyes, which could be removed by a simple operation when the ophthalmic surgeons made their visit to Alotau hospital. However, the fee the surgeons would charge (50 Kina – £13) was far beyond her reach, and the practicalities of a journey to Alotau (which might take a week or more by foot) rendered the operation impossible. She shuffled away sadly.

The other encounter I remember was with a middle-aged man whose complaint was that he had difficulty reading his Bible because of blurred vision. After testing his eyesight Dr Griffin told the man that a pair of glasses would give him back the sight he once had. The man's face crinkled into a smile.

I had the opportunity to go on the Maternal and Child Health (MCH) patrols with the community health workers from St Barnabus. The MCH patrols primarily serve the purpose of surveillance, weighing children and plotting their weights on growth curves. "The road to health" (the minimum acceptable weight-for-age measurements) was actually based on reaching 40% or above of the expected weight for given age. Even then many children fell below the road to health, mainly because of poor dietary protein intake. The effects of this could be seen at the health centre: children (especially those with malaria) were nearly always anaemic. One child I saw had a haemoglobin measurement of 4g/dl!

This was a vivid proof to me that much health improvement has little to do with medicine or the action of doctors. Substantial improvements in health could be made by simple alteration of dietary behaviour. Yet impediments to such change exist in deeply ingrained cultural practices. Pigs are of immense cultural value, slaughtered on special occasions, usually to aid celebration. Breeding pigs is not culturally plausible. Chickens don't exist in great numbers and cows and sheep are almost unheard of. In the mountains fish are not a practical option, unless they are tinned and tinned fish is expensive, but for villagers living by the sea there is a plentiful resource easily accessible to them. The MCH patrols demonstrated to me the importance of health education and promotion, and were themselves a great opportunity for such promotion.

I don't wish to present the Papua New Guinean way of life as being entirely harmful to health. The manual labour undertaken by most people ensured that they were in no danger of becoming obese. (In the more developed parts of the country, such as New Ireland, that was not the case and many people were wildly corpulent.) Health educators have also harnessed cultural practice for health improvement. In the Dogura area it is taboo for couples to have intercourse while the female partner is breastfeeding. Spying an opportunity for birth spacing, family planners encourage mothers to breast feed fully for four months, and to breast feed partially for two years. This has a double beneficial effect: to reduce the probability of an immediate successive pregnancy – with all the ensuing physiological and social benefits; and to prolong the benefits of breast feeding for the children – including the maintenance of an acceptable protein intake during the child's crucial early years.

In addition to cultural practice there are other non-medical factors which affect the health of PNG. In his analysis of rural health services Edwards claims that with four, five or even six

sources of funding, effective planning is extremely difficult and budgetary cuts are extremely easy. <sup>14</sup>

During my time at the health centre I saw numerous patients, but I have selected four (their case histories follow) because they illustrate some aspects of PNG life which affect health in some way, or illustrate the effect that health has on people's lives. I deliberately focus on these social aspects of medicine in preference over the biomedical aspects because while the biomedical ones can be comprehended through books, social aspects can only really be experienced through a sojourn in the particular culture.

The island, of which the eastern portion forms the PNG mainland, was divided arbitrarily by European nations in 1882. The Netherlands formalised their long-standing claim to the portion west of 141° longitude in response to Germany's claim to New Guinea (the northern section of the remainder). Britain followed by claiming Papua (the Southern portion). <sup>1</sup> After WWI the League of Nations handed the German territories to Australia, which administered New Guinea as a dependent territory and Papua as a colony until 1942 when the Japanese army invaded. PNG became a major battleground in WWII, with almost the whole island overrun within the year. By September 1942 the allies had halted the Japanese advance and began to counter-attack, expelling them from the mainland by 1945. One of the main results of the war was the fusion of a single country from the separate territories of Papua and New Guinea. The newly formed territory of PNG was administered by the United Nations until 1973 when country became self-governing, with full independence achieved in 1975.

The foreigners who seem to have had the longest-lasting effect on the country are missionaries, the first of whom (Marist Catholics from France) arrived in 1847. They were followed by the London Missionary Society (in 1870), and the Anglican Church (of Australia) which landed in Dogura in 1891. Since then numerous groups have made PNG their mission field and the country has been radically Christianised to an extent probably unparalleled in recent times – even inviting comparisons with Byzantium. Indeed, it is impossible to experience PNG without in some way coming into contact with Christianity: churches run schools and hospitals, every village I visited has a place of worship, national newspapers carry extracts from Bible commentaries <sup>\*</sup> – even the constitution declares PNG to be a Christian country.

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<sup>\*</sup> *The National* carries extracts from *Everyday With Jesus* by Selwyn Hughes on page 2.

"What is wanted here is law, good faith, order, security. Anyone can declaim about these things, but I pin my faith to material interests. Only let the material interests once get a firm footing, and they are bound to impose the conditions on which alone they can continue to exist. That's how your money-making is justified here in the face of lawlessness and disorder. It is justified because the security which it demands must be shared with an oppressed people. A better justice will come afterwards."

Charles Gould in Joseph Conrad's novel, *Nostramo* <sup>2</sup>

In addition to Christianity, it is essential to grasp two other factors in order to understand PNG. The first is the breakneck pace of Westernisation. Because contact with the West – and its attendant materialism, capitalism and technology – has only been substantial for around 100 years, in the space of a few generations the country has been propelled through millennia of cultural evolution in little more than a century. (Consider that William Blake denounced England's "dark Satanic Mills" around 90 years before PNG experienced sustained European contact.) The last 100 years have witnessed the arrival of plantations, aviation, mass warfare, banks and democracy. Travel literature details accounts of fathers of people alive today seeing aeroplanes for the first time and attempting to shoot them with arrows, believing they were birds. <sup>3</sup>

The rapid societal change, accompanied by religious and political upheaval, has had mixed effects. While it can be argued that some benefit has come from Western contact (in the fields of education and health, for example), the idealism of such as Charles Gould has not been borne out in reality.

Western contact has both damaged and benefited the country. The carrot of first-world wealth has drawn large numbers of people (predominantly young men) to the major cities of Port Moresby and Lae. Such urban drift has not produced a generation of wealthy people – only 15% of qualified people can find paid employment. <sup>4</sup> Instead many young men join gangs, known as *raskols*, and live in squatter camps on city outskirts. Petty and violent crime were the order of the day in the mid-nineties, but travel writers now claim that organised crime and hold-ups are more likely to *raskol* pursuits now.

Unemployment and dispossession are augmented by the Western imports of alcohol and violent films (apparently a Rambo T-shirt is a prized possession among Port Moresby *raskols*), which are

themselves super-imposed on an innately violent society and the *wantok* system (see below), producing immense social problems in the cities. Metal fences topped with barbed wire enclose compounds in Port Moresby and Mt Hagen (I did not visit Lae so cannot comment on it); armies of security guards are employed to protect property.

I hasten to add that while Moresby etc. are not as safe as rural areas, in my opinion they're safer than many ex-patriates led me to believe. Unfamiliarity may breed suspicion, which itself breeds fear. I was given similar warnings concerning my safety before I came to Liverpool, and can appreciate that reputations are often exaggerated.

The *wantok* ("one-talk") system exists because of the cultural diversity of PNG. With around 700 different languages spoken among 5 million people the bonds which a common tongue can give are strong. <sup>4</sup> (This seemed odd to me, until I met a Welshman in Mt Hagen, and realised my affinity to him was far greater than that to the Italians and Germans I met in the same guesthouse.) The *wantok* system is essentially a way of thinking about identity: people think of themselves in terms of their *wantok* before any individual characteristics such as occupation – almost the opposite of the Western individualism. For example, thinking *wantok*, I am an Englishman who happens to study medicine; thinking English I am a medical student from Britain.

The corollaries of *wantok* are fascinating. Reciprocal obligations mean that someone can arrive at a *wantok's* house in another town and reasonably expect food and accommodation. This was one example of the benefits of *wantok* and something that I frequently saw in Dogura: patients would receive material help from *wantoks* living near the health centre. As well as acting as a wealth-sharing mechanism and quasi social security system *wantok* can actually reduce crime in certain circumstances. The truth that one you don't "steal from your own" holds true in PNG even more so than it does in Britain.

The other side of *wantok* is somewhat darker, in my opinion. Because identity is so intimately bound with one's *wantok*, liability, in the common mind, for crimes and accidents rests with the *wantok*, not the responsible individual. Thus if an individual cannot be found or brought to account, a close relative or *wantok* receives the reprisal. In law, I believe, such liability is not regarded as valid. However, as much punishment occurs non-legally, simple accidents or crimes can lead to a cycle of reprisals that can cause immense human suffering. During my stay a

payback feud in the Highlands that had lasted six years and become national news, came to an end. It had, however, claimed scores of lives. \*

Although PNG is economically a middle-ranking country (GDP in 1998 was US\$900),<sup>4</sup> on a variety of social indicators its performance is comparable to many third-world countries: in 2000 the WHO ranked its overall health level as 145<sup>th</sup> in the world.<sup>2</sup> The disease burden varies with geography: malaria, for instance, did not become significant in the Highlands until the 1950's. While in the urban areas an increasing proportion of the morbidity burden comes from non-communicable diseases such as diabetes and cardio-vascular disease, in the rural areas communicable diseases still dominate.<sup>5</sup>

As more than 90% of the population live in rural areas, it is the rural health services that have the greatest role in health service provision in PNG. Because of the extremely low population density (imagine a country four times the size of Britain with only 5 million citizens) a level of service organisation has come into being which is necessary for maximum population coverage.

Essentially the aim is to ensure that as many people as possible have access to some form of health care; while recognising that certain practicalities (geographical and financial) prevent a medical centre, staffed by doctors, from being within easy reach of the entire population. The mechanism that has been used is the creation of layers of health care *below* primary care (if we may think in that way), with primary and secondary care retained. Health sub-centres are small health centres staffed by nursing officers with capacity to refer to health centres.

In addition, three inventions are critical to this strategy. Aid Posts exist in most villages of any size and are staffed by Aid Post Orderlies (APOs) – health care workers trained to deal with minor complaints and injuries, with the capacity to refer to health centres or sub-centres. Examples of conditions an APO can manage are simple diarrhoeal conditions and recurrent malaria.

Further down the chain of referral two further health care workers exist at village level. These are Village Health Attendants (VHAs) and Village Birth Attendants (VBAs). VHAs are villagers given basic training in recognising conditions requiring referral, skills such as bandaging, and also health promotion, encouraging healthy practice in cooking, sanitation etc. VBAs are also villagers, exclusively women, trained to supervise low-risk deliveries in village settings. They

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\* I cannot be precise about the story, but believe it to be true, having heard reports on Radio Milne Bay.

also are trained to recognise patients who need to be referred to health centres for observation, delivery and post-natal contraception. As 90% of high-risk pregnancies in PNG can be diagnosed through history taking alone, advanced examination skills are not necessary. <sup>6</sup> Before the introduction of VBAs the maternal mortality rate had remained constant in PNG; <sup>7</sup> in 1990 it was estimated that over 80% of deaths in women aged 15–44 years in PNG arise from village deliveries. <sup>8</sup> Thus tackling this prominent cause of mortality is a priority of any government. There is evidence that the VBA system has been highly successful in reducing mortality and morbidity, at low cost, using personnel known to the village who can not only communicate with villagers in their own language, but also encourage good medical practice in a culturally sensitive way. <sup>9</sup> This is of desperate importance in a country such as Papua New Guinea where traditions that originated before European contact are still highly regarded. <sup>10</sup> It is even more remarkable when the fact that many VBAs are illiterate and trained using pictures only.

## Case Histories

The first case history, that of patient B – a teenage boy with nephrotic syndrome – demonstrates the effects of chronic (or relapsing) illness in a developing country. Patient B has spent seven months away from school in the past year and a half – something that is common in PNG where for financial reasons many children miss years of schooling – potentially harmful to his life chances. Compounding the problems is the mother's absence from the rest of her family during this time. (Patient B's mother stayed with him in the health centre during his stay as an in-patient.) Women are critically important to families in PNG, not only in educating and raising children, but also in the labour of subsistence agriculture.

Patient N – a man in his twenties exhibiting florid psychosis – provided fascinating distraction from everyday life in Dogura. Papua New Guineans are fairly conservative in their attitudes towards sex, so patient N's streak through the village was extremely inappropriate and shocking. The village was also disturbed by his shouting and shrieking.

Papua New Guinea is a country awash with animistic beliefs – spirits, both ancestral and malign, are a permanent part of its collective imagery. Some types of spiritual thinking easily find validation in Christianity, with reports of exorcism in the gospels. Spirits are blamed for many things in some cultures and thus it was not surprising when stories began to circulate that spirits caused N's condition. The explanation I came across most frequently played N as a pastor who attempted to expel demons from a boy, only to become possessed by them himself. Thus the only way of curing N was to exorcise the demons: medication would not work.

Mental health facilities are scarce to non-existent in PNG and so responsibility for long-term care for N would fall on his family. The stigma that would attach to them would be immense, an insult added to the injury of the condition. When I left Dogura the doctors were attempting to find the ideal dose of chlorpromazine which would control his symptoms but leave him capable of some sort of normal life. After walking two days to bring N to the health centre, the family stayed with him for three weeks and was exhausted. Their situation was tragic.

Patient M, a pregnant lady with suspected malaria, was at great risk. While she displayed malarial symptoms and signs her malarial blood slide was negative. This does not mean, however, that she did not have malaria (blood slides are used for confirmation, not refutation, of diagnosis). The

dangerous aspect of her condition was her anaemia, which required swift transfusion before a miscarriage or stillbirth occurred, or even an ante-partum haemorrhage which she would have had little chance of surviving.

The dinghy used to transfer patients to Alotau hospital would have been an inappropriate form of transport. Seas are often rough and a two-hour sea journey would be torturous for M. Instead she was booked on a flight to Alotau. While this was far better than a journey by boat it might still have presented her with great discomfort: the planes flying out of Wedau were small and propeller-powered, vulnerable to turbulence, and landed on uneven grass runways.

Patient J had a ten-month history of tuberculosis, and had already been treated with some success during that period. Her return to St Barnabus was saddening, and her decline tragic to watch. Her 4-year old daughter was a picture of joy, enlivening the health centre and providing us with many laughs. J had four other children waiting for her in their village while her husband stayed with her in the health centre. (They had been there so long they had taken over a room on one of the wards and made it their own.)

I met J's brother on the beach during one of my walks and chatted with him. The extent of his despair is difficult to communicate but imaginable for anyone who has had a relative in danger of dying prematurely. He said, "We hope and we pray that she won't die. We pray every night. Every night. And she just gets worse."

After two months of medication (second course) and no improvement, concerns arose that J might have HIV – a growing problem in PNG.<sup>11 12</sup> The first ever HIV test on a St Barnabus patient was sent to Alotau and came back negative, leading the doctors to the conclusion that J had treatment-resistant TB and would soon die. (When I left she weighed 25 kg.) It was only by chance at the end of July that one of the nurses happened to overhear J's husband telling someone that J vomited her tablets after taking them and had done so for the last four months. Neither J nor her husband realised this was the likely reason for the disease's obstinacy and didn't tell nursing staff out of embarrassment. The mixture of frustration and relief the doctors felt on being told this was incredible: J might yet be cured, but was on the verge of dying because of a misunderstanding!

Communication between doctors and patients was a continual problem. While some patients spoke English and other staff and patients could act as interpreters, many consultations were

extremely difficult to conduct. Further to that, communication was rendered even more problematic by vast cultural differences. To overcome these Drs Griffin and Bettiol developed ways, using indigenous words (e.g. "sou-sou" meant breast milk, "long-long" meant crazy) and local expressions (N's psychosis was "restlessness", and health was "strength"). The six weeks in Dogura were an extended lesson in communications skills and demonstrated the necessity for their development.

## Case History: Teenage Boy with Nephrotic Syndrome

**Patient B:** teenager with nephrotic syndrome

**Age:** 14 years. **Sex:** Male

**Village:** Boianai, Rabaraba District, Milne Bay Province.

**Religion:** Assemblies of God

**Previous admissions** (all for nephrotic syndrome):

18/12/98 to 08/03/99

04/09/99 to 03/10/99

15/04/00 to 31/7/00

**Initial presentation:** 18/12/98: referred to Health Centre by MCH patrol

Puffy face, oedema in legs, distended abdomen and testicles

Malaise for 3 weeks

**Past Medical History:** treated for TB in 1997 – completed whole course of treatment

**Family History:** a strong history of TB

**Social History:** schoolboy, grade 4 at time of admission

**Nursing officer's examination findings:**

Pulse: 80/min, BP: 110/70mmHg, temp: 35.5°C, weight: 40kg.

No signs other than those already reported.

**Nursing officer's management:**

Chloroquine tds for 3 days (given to all patients on admission)

Albendazole 2 stat (given to all patients on admission)

Observe for 24 hours until doctor reviews

**Doctor's examination findings:**

Shifting dullness in abdomen; no abdominal tenderness.

**Doctor's management:**

Prednisolone 20mg tds

Amoxil 250mg tds

Daily urine dipstick, weight and BP measurement

No salt in the diet

Pat B responded to steroid treatment and was discharged

15/4/00 – **Examination findings:**

Afebrile, weight: 41kg, pulse: 80/min, BP: 90/60

Pitting oedema to mid thigh of both legs

Chest clear on auscultation

**Management plan:** prednisolone 40mg bd

Chloroquine tds for 3 days

Amoxil 250mg tds

Isoniazid 3 tabs md

Daily urine dipstick, weight, BP and pulse measurement

17/4/00: proteinuria +++; weight 40kg

By 31/7/00 on advice of consultant paediatrician in Alotau, Pat B began being weaned from steroids to **indocid** (an NSAID).

At his mother's request Pat B was discharged, to be reviewed by paediatrician during his patrol on 18/9/00. Community health workers are to supervise the weaning.

## Case History: Man with Florid Psychosis

### **Patient N**

**Sex:** Male. **Age:** 27years. Unmarried.

**Village:** Davudavu

Brought to health centre by family

13/07/00

### **Presenting complaint:**

1 week history of shouting out, swearing at himself, insomnia and removing clothes

Examples of cries: "I am no good", "Throw me off the cliff"

Talks to objects (real and imaginary) when alone, then "quiet as an old man"

No violence against self or others

No recent drug-taking – smoked cannabis three years ago

### **Past Medical History**

Admitted to health centre for somatic complaint in 01/00, absconded without explanation.

### **Doctor's examination:**

Staring – at person talking to him

Spitting – not directed at people

Speech – gabbled, loud

Mood – laughing occasionally

Orientation – aware of place and name

Cranial nerve tests – no apparent disorders

Reflexes/ Tone – no apparent disorders, no difference between sides

Tests: Hb: 11.5 g/dl WCC: 11000 ESR: 28

**Diagnosis:** florid psychosis with persecutory delusions

**Management:** Chlorpromazine 50mg IM prn until settles down

24/7/00

Tolerating Chlorpromazine

Continuing negative thoughts

Claims people in the distance are making fun of him and trying to control him – these are the same people who were present during his previous hospitalisation in 01/00 Makes eye contact, co-operates with conversation.

Management: drug regime trial and error: initially too low, then too high

Now: chlorpromazine 200mg tablet bd, 300mg tablet nocte, and 25–50mg IM prn

3/8/00

No insight into his condition

Becomes agitated as chlorpromazine wears off.

Signs of religious grandiosity

## Case History: Pregnant Lady with Suspected Malaria

### **Patient M**

**Age:** 25 years    **Sex:** Female    Married

**Village:** Qwabunaki, Rabaraba District

**Religion:** Church of Christ (Pentecostal)

Self-referred

28/06/00

**Presenting complaint:** pregnant, with fever

LMP: mid 01/00

Foetal movements felt in 04/00

Weakness, fatigue, joint pains, non-productive cough, decreased appetite

### **Obstetric and medical history:**

Gravida: 4    Parity: 1

22/7/93: Male born, full term, vaginal delivery (unassisted). Child alive and well.

1995: miscarriage at ?12 weeks

1998: miscarriage at ?12 weeks

Previous history of fits (further details not obtainable because of language difficulties)

### **Doctor's examination:**

Pitting oedema at ankles

Febrile, temperature of 39°C

Weight: 4.7kg

BP: 100/60.    Pulse: 112/min

Fundal height: 28cm

Foetal heart beat: 136/min

Position – early pregnancy, therefore womb only just palpable

Splenomegaly

**Medication:** chloroquine given by Aid Post Orderly

### **Investigations:**

Hb: 4g/dl

WCC: 7500.

Malarial blood slide: negative

**Management:** monitor temperature 6 hourly

Eight hourly 5% dextrose IV

Quinine 7.5ml IM tds

Albendazole 2 tabs stat

Refer to Alotau Hospital for blood transfusion.

Likely to find dinghy journey difficult, therefore plane transport needed.

Need to sort out transport for husband to Alotau, too.

## Case History: Lady with Tuberculosis

### **Patient J**

**Age:** 30 years **Sex:** Female **Married**

**Village:** Boyaboya, Rabaraba District

**Religion:** Anglican

### **Previous stays in hospital:**

- 1) 23/9/99 to 13/12/99 (TB)
- 2) 1/3/00 to 5/5/00 (TB – transferred to Alotau)
- 3) 27/5/00 to present

*24/9/99*

### **Presenting complaint:**

Cough (productive), night sweats, weight loss – all for last two months.  
Some chest pain on coughing.

### **Examination:**

Palpable ride-sided lymph nodes: axillary and supraclavicular  
Audible crepitations in Right Upper Lobe on auscultation

### **Investigations:**

Initial sputum test not possible because reagent had run out.  
CXR: white patches in right chest field

**Diagnosis:** Tuberculosis

### **Management:**

Rifampin 3 tablets daily  
INAH 3 tablets daily  
Pyrazinamide 2 tablets daily  
Ethambutol 2 tablets daily

*13/12/99*

Discharged because of symptomatic improvement and completion of treatment course

*1/3/00*

Re-admitted with same symptoms as 09/99

*31/7/00*

Situation worsening. Weight: 25kg

Utterly cachexic and lethargic

HIV test: negative

Transpires that patient has been vomiting tablets after taking them every morning.

### **Management:**

Ensure patient takes tablets with warm tea on every occasion.

Monitor vomiting and note it on vomit chart.

Continue regime decided in 09/99

## Epilogue

"We conceal from ourselves the unpleasant knowledge of the values by which we live. We conceal from ourselves the similarity of our society to those we execrate."

T S Eliot <sup>13</sup>

"It is unfortunately the case that youths fail to comprehend that the sacrifice of one's life is, in a large number of such instances, possibly the easiest option, and that to sacrifice, for example, five or six years of one's youth—inflamed life on difficult, laborious study? is quite often almost entirely beyond many of them."

Fyodor Dostoyevsky, *The Brothers Karamazov* <sup>14</sup>

Papua New Guinea is an extraordinary country and I am extremely grateful to those who helped me before and during my stay, and those who let me share a little in the life of their communities. It is far from easy to present any conclusions concisely. What I can say, however, is that I saw a great amount of beauty in the country – I hope that some of it remains lodged in my mind for a long time yet. I was deeply impressed with the community life of the people of Dogura and Wedau: the way they lived together, sharing in celebration and sorrow. The extent to which people were prepared to help one another when they fell into difficulty (the dedication relatives showed in caring for patients and keeping them company at the health centre, for example) is also something I greatly admire. I hope my worldview has altered such that I can emulate such beauty in my own life.

There was also ugliness. For example, the treatment of women in many parts of PNG was appalling – their lot was little more than that of donkeys. Greer's comments are apposite: "The universal 'division' of labour' between the sexes was in fact the apportioning of daily drudgery to the female, so that the male could indulge his appetite for sport, play, dreaming, ritual, religion and artistic expression." <sup>15</sup> I have never seen work so unequally apportioned. Even more appalling was the fact that in Mt Hagen I witnessed a man beating his wife in public with a crowd watching him, doing nothing to halt the battering – something which sickened me then and sickens me still. Sometimes at night in Liverpool I can hear cats mewling in the alley my bedroom overlooks and am reminded of that woman's wails, emanating from her bloody mouth.

That 70% of married women in a country professing to be Christian could report having been beaten by their husbands <sup>16</sup> – reportedly the second highest rate in the world <sup>7</sup> – deeply saddens me. What happened to the apostle's command, "Husbands, love your wives, as Christ loved the church and gave himself up for her"? <sup>17</sup>

It is easy to criticise another country, forgetting my own country's shortcoming: ignoring the log in my own eye while condemning the speck in my brother's. <sup>18</sup> Eliot was right: we *do* conceal the unpleasant knowledge of the values by which we live, and our similarity to those whom we execrate. Women are treated badly in Britain, too – maybe just in subtler ways.

As a man, as a potential husband and father, I need to have these lessons drilled into me. Actions have consequences and must be considered. I have been challenged to behave well and have been given examples to follow. This trip was deeply moral.

I read Dostoyevsky's last novel while I was in Dogura and was struck by his indictment of Russian youth. His words posed me a second challenge: to finish the five or six years of "difficult, laborious study" and be useful.

There is much to learn, and much to be done in my life and in the world.

Stephen Ford  
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September 2000

**Note:** edited for publishing on the internet (some great pictures removed for size reasons, fig.1 removed and some repaging). Many thanks to Stephen Ford.

## References

- <sup>1</sup> Lipscomb A, KcKinnon R, Murray J. *Papua New Guinea*. Hawthorn, Victoria: Lonely Planet, 1998.
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