

# **A Study of the Doctor–Patient Relationship in Rural Papua New Guinea**

10th March – 20th April 2001

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## **St. Barnabas Health Centre, Dogura, Milne Bay Province, PNG**

For my medical elective, I spent five weeks at the St. Barnabas Health Centre in Dogura, working under the supervision of the two expatriate doctors recruited by VSO. St. Barnabas is the chief health centre of the Rabaraba district, serving a population of 20,000, with in–patient wards for obstetrics, general medicine and close observation. It is run by the Anglican Health Service, with limited subsidies provided by the PNG government.

## **Dogura Cathedral and St Barnabas Health Centre**

I attended general out–patient clinics, ward rounds and antenatal clinics (where I was asked to conduct an audit of current management of anaemia in pregnant women, and found that all the women attending the antenatal clinic had haemoglobin levels between 6 and 10 g / dl). I also took histories from patients presenting at the health centre, using basic English plus the few words of Wedau I picked up, such as 'kai kai' (food), 'pis pis' (urine), and 'pek pek' (faeces).

St. Barnabas Health Centre is equipped with a basic operating theatre, but due to the lack of daytime electricity, the overhead lamp has to be run from a car battery. Elective surgery is usually started at 6.30 a.m. (soon after sunrise) before the heat and humidity become too oppressive. I assisted with a tubal ligation carried out under local anaesthesia, in which a head–torch was used in order to preserve the car battery. We scrubbed and wore sterile gloves, but there were no gowns, hats, facemasks or theatre shoes.

Tubal ligation is encouraged in grand multiparous women, to avoid the risk of fatal haemorrhage during or after labour in subsequent pregnancies. Due to the lack of facilities in Dogura, tubal ligation is only undertaken in women who are likely to have no complications: slim women with no history of pelvic inflammatory disease or abdominal surgery, and the procedure is preferably carried out postnatally, when the tubes can normally be easily located via a small horizontal subumbilical incision.

Tubal ligation is carried out under local anaesthesia, but ketamine can be used to provide general anaesthesia if the case proves difficult. I saw one conversion to general anaesthesia in a lady who was experiencing significant intraoperative pain due to difficulty locating her fallopian tubes. The amount of local anaesthetic that could be administered was restricted by the woman's low weight. It is particularly important to pay attention to the weight of patients in PNG. Many patients are very light, and reduced drug doses may be required to avoid toxicity. The PNG government–issued standard treatment guide (STG) differentiates between 'small adults' (<50 kg) and 'large adults' (>50 kg). For a woman to weigh less than 40 kg is not at all unusual in PNG. One elderly lady being treated for pneumonia weighed just 23 kg on arrival.

The laboratory at St Barnabas Health Centre is set up to carry out simple but important tests – haemoglobin levels, blood counts, stains for acid fast bacilli, Plasmodia and other bacteria and parasites. The one full time laboratory worker analyses all types of samples: blood, sputum, stool, urine and very occasionally cerebrospinal fluid. She showed me examples of all different stages of the *P. falciparum* life cycle on blood slides from St Barnabas patients, as well as positive sputum tests for acid–fast bacilli.

## **Clinic Patrols**

I accompanied the doctors on a clinic patrol to Rabaraba Health Centre, which is run by two health extension officers (who receive intermediate training between nurses and doctors), and to Menapi. While on patrol, we were well looked after by the locals, with plenty of food, and I was able to sleep under my mosquito net on the veranda of a beautiful bush material house. The sounds of the nearby rainforest were quite something as I went off to sleep, and the sky was full of incredibly bright stars.

In Menapi we conducted a school medical, screening new entrants to the community school (age 7–8) and the school leavers (age 13–14) for splenomegaly caused by recurrent malaria, and for anaemia (clinical assessment alone). A crucial part of each examination was to test for evidence of tuberculosis. We also tested the children's eyesight, ordering glasses if necessary, and examined their ears.

No doctors had been to Menapi for several years, and when it came to seeing adult patients, the crowds gathered around to watch as patients were examined on the pandanus leaf mat under a mango tree for shade. Patients of all ages sat around waiting to be seen, and helped each other by trying to explain each other's complaints in English to the doctors. I had a group of old ladies in fits of laughter while trying to examine their arthritic knees and hips on the hard ground in full view of the crowds.

I also had the opportunity to accompany the nurses and student nurses on two maternal and child health patrols to nearby villages. For one, we travelled by dinghy to Lavora, Aigura and Topura, examining, weighing and immunising children at each village, and offering family planning pills and injections and health education to the mothers. We then walked inland to Yapoa for a further clinic. While we were there, a massive rainstorm started, and on the way back the mud paths had turned to rivers, and I had to use the 1.5 metre-high grasses on either side of the path to help me stay on my feet while climbing up and down the mountains.

Arriving by dinghy was an interesting experience if the sea was rough, as it involved jumping into the water quite far out, to avoid the boat being damaged by the fringing coral reef. Soon after this picture was taken on our arrival at Lavora, the dinghy set off into the ocean, and the boys swam after it to retrieve it.

I also accompanied nurses on a patrol to Waimira, a neighbouring village to Dogura. We walked there, saw each of the children, and then snorkelled back to Dogura along the coast.

## **Patrol**

I spent my sixth week visiting healthcare teams in Alotau, the capital city of Milne Bay Province, and Popondetta, capital of Oro Province. In Alotau I was shown around the hospital by a medical elective student from Edinburgh, and was able to appreciate the superior facilities in this large government-run hospital. In Alotau there is electricity all day, and the Intensive Care Unit is equipped with modern ECG machines and mechanical ventilators. However, the medical student explained how the greater financial resources did not necessarily mean a better service due to poor administration. For example, failure to order even basic inexpensive supplies before they have completely run out meant that a severely ill man with renal failure had no more fluid available for the peritoneal dialysis he was receiving. In Alotau, I also saw the St. Barnabas School of Nursing, which is run by the Anglican Health Service to provide a three-year training course for student nurses. Many of these student nurses carry out their rural attachments in Dogura.

In Popondetta, I stayed with the National Health Secretary of the Anglican Health Service, and was able to meet students at the St. Margaret School of Nursing, which provides a two-year training course for community health workers. By spending a day in the Anglican Health Service office, I was also able to grasp a little of what is involved in the management of the various Anglican health centres and training schools around PNG. I also visited Popondetta General hospital, a large government-run hospital with reasonably good facilities. One of the nurses teaching at the St. Margaret School of Nursing kindly showed me around the laboratory, radiography department, theatre and wards.

## **Medical Conditions seen in PNG**

### **Malaria**

Malaria is a major problem in lowland PNG (below 1800m). *Plasmodium falciparum* is the main culprit, but *P. vivax* and *P. malariae* also cause disease. One aspect of the malaria problem that I had failed to anticipate was that it regularly affected the nurses and other staff working at the health centre, so on any particular day, there would typically be one, two or more of the staff off sick with 'hot body'. (The expression 'hot body', meaning 'fever', tends to be used interchangeably with the word malaria.) The Standard Treatment Guide states that all patients presenting with fever with or without other symptoms should be commenced on a treatment course of antimalarials – chloroquine daily for three days plus a single dose of primaquine. Primaquine serves to arrest the *Plasmodium* life cycle by preventing transmission back to mosquitoes. Patients with severe malaria, or those who have developed malaria whilst on chloroquine prophylaxis (e.g. pregnant or breast-feeding mothers) are given intramuscular quinine three times daily followed by three days of oral quinine once an improvement is seen. Fansidar (sulphadoxine with pyrimethamine) is given on the last day of quinine treatment, with a dose of primaquine.

## **Malaria Prophylaxis**

According to the STG, prophylaxis should be given to all pregnant women, patients with tropical splenomegaly syndrome and highlanders or expatriates coming to a malarious area. There is some debate as to whether it is beneficial to offer malaria prophylaxis to patients living far from an aid post or health centre equipped with quinine. This is because any patient developing malaria whilst on chloroquine prophylaxis may not be able to reach a source of quinine. Health care workers are discouraged from giving out medicines without first seeing the patients, but a three-day walk to an aid post may be impractical for someone suffering the fever, headache and vomiting of malaria. Without treatment, the patient is at risk of severe cerebral malaria, which may be fatal.

Malaria is a common cause of premature labour and perinatal mortality in coastal PNG. There is also a high rate of fatality in women developing malaria during pregnancy. Any pregnant woman developing fever should be given a full course of antimalarials, beginning with IM quinine if she is already in labour. During my time at Dogura, one lady presented at term with malaria. With treatment, her fever soon resolved, but her child was still-born.

When we conducted a school medical at the remote coastal village of Menapi, where the aid post has been closed for over a year due to recurrent vandalism, about a third of the children examined had significant splenomegaly (3 cm or more below the costal margin). The debate arose as to whether it was advisable to start these children on weekly chloroquine after their initial three-day treatment course to eradicate existing infection. The risk to children with splenomegaly is that violent play may lead to splenic rupture, which would be likely to be fatal in a remote village. However, starting a child on weekly chloroquine renders him quinine-dependent should he develop malaria. The issue is complicated by the fact that it is the school that acts as the children's guardian in this matter, and parents are not involved in the decision-making process.

However, if the child is not at school when fever develops, it may be the parent who has to take the child on the trek to find quinine. The system also depends on accurate communication with parents and conveyance of the importance that the child must receive quinine rather than chloroquine if he develops malaria. It was decided that the children should be given the weekly chloroquine, but should be checked every three months, and chloroquine should be ceased once the spleen had reduced in size to within the acceptable range.

One aspect I had not appreciated was that PNG nationals living in the Highlands are actually at greater risk than 'dim dims' (white skins) like myself of contracting severe malaria if they move to endemic areas. This is because ex-patriates travelling to an endemic malarious area are usually well informed about the risks of malaria, and almost all take malaria prophylaxis, such that any breakthrough attacks that occur tend to be mild. On the other hand, much less fuss is made about nationals moving around the country for work placements or to visit relatives. There is no malaria exposure during childhood in the Highlands, and primary attacks in adulthood tend to be severe.

## **Pneumonia**

Streptococcal pneumonia is very prevalent in coastal PNG, particularly in smokers, and may be very severe. Unfortunately, during my time in Dogura, I witnessed the death of a mother-of-four in her forties, who had pneumonia complicated by dehydration (due to diarrhoea) and severe anaemia (most likely due to a combination of hookworm infection, recurrent malaria and poor diet). She suffered a cardiac arrest just hours after her arrival at the health centre. She had presented to her village aid post with fever and cough one week earlier, but had been treated for malaria alone, as no diagnosis of pneumonia was made. As her condition deteriorated, she was carried to the health centre by her relatives, and on arrival she was tachycardic (128 b.p.m), anaemic (haemoglobin 6 g / dl) with an axillary temperature of 38.50C. There was markedly reduced air entry in her right lower zone and she was severely dehydrated. She was commenced on chloramphenicol and IV fluids, but developed high output cardiac failure and suffered a cardiac arrest. Initial attempts at resuscitation were successful in regaining cardiac output, but in the absence of blood transfusions to correct her anaemia and mechanical ventilation (spontaneous respiration had ceased and bag and mask ventilation could not be continued indefinitely), there was little to offer this woman. The generator had been turned on early to provide light to facilitate resuscitation, but there was no other equipment available, and after her cardiac output was lost for the third time, attempts to resuscitate her were ceased.

## **The Doctor – Patient Relationship in PNG**

During my time in PNG, I undertook a qualitative study to explore aspects of the doctor – patient relationship, drawing comparisons against current medical practice in the UK. My study involved the evaluation of twenty-one consultations by the ex-patriate doctors working at St. Barnabas, some of which took place in Dogura and others at Rabaraba or Menapi during the clinic patrols. The consultations evaluated involved a typical sample of patients (9 male, 12 female; 6 children, 15 adults), and particular note was made regarding the following four areas of the doctor–patient relationship:

- Communication skills employed to improve patient understanding and compliance
- Patient involvement in decision making regarding therapeutic options
- Informed consent for medical and surgical interventions
- Patient dignity, privacy and confidentiality

Some of the most interesting findings within each of these categories are discussed below.

### **Communication skills employed to improve patient understanding and Compliance**

Most patients in PNG have a very limited understanding of biology and they would be unlikely to request or desire much information about the way that medicines work. Therefore, it was often a case of using simple communication skills to convince a patient of the importance of taking a particular medicine, and explaining how the medicine should be taken. Many of the patients seen in PNG had infectious diseases such as tuberculosis, pneumonia and malaria. In the case of an infectious disease, the necessity for medications is very evident to the patient and his family. On the contrary, the failure to treat many conditions seen in the UK has less immediate consequences, as symptoms may not appear until the condition has been present for many years e.g. hypertension.

In the case of malnourished children, simple communication skills were used to inform the parents how best to feed their children with nutritious foods. Rather than going into details about the nutritional composition of all the different foods, the doctors would provide parents with three simple instructions. They were told to feed the child five times per day:

early morning, lunch time, and evening with the rest of the family, but also additional meals mid morning and afternoon. This practical explanation allowed the parents to easily visualise the required meal times and put them into practice. They were also instructed to give plenty of the nutritious foods that were readily available in that particular village –

for example a handful of beans or crushed peanuts every day to provide protein where fresh fish could not be obtained. The final instruction was to add coconut cream to every meal, to provide additional calories.

St Barnabas Health Centre has a nutrition garden which has been set up to teach parents how to grow nutritious foods, so that the children will continue to gain weight after their return to their home village, rather than losing weight again as tends to happen if education is not offered.

However, this excellent idea is proving difficult to put into practice as staff already find themselves pressed for time in meeting the more immediate needs of in-patients. Making up a baby's feed and handing it to the mother to administer takes much less time than showing her how to grow the foods and prepare them.

Patients were very understanding about problems regarding the availability of medications, most likely because they are so accustomed to going without when foods and supplies are not available. There were no complaints heard when medicines or vaccinations could not be provided due to difficulties with maintaining supplies caused by lack of financial resources, ceased production or problems with transportation. They would be willing to accept an alternative treatment, wait several days until supplies arrived, or simply to trek back to the health centre another time. This was in stark contrast to the system in the UK, where health services are expected to stock everything and be able to provide it immediately.

One area of communication that caused much amusement was that of talking about family planning and sexual activity. Women tended to be very shy and just giggle if asked about their use of family planning methods. Similarly, frank discussion could be difficult with the men. One patient requested treatment for grille. The doctor went to great lengths to explain that griseofulvin could only be supplied to treat the man's skin condition if his wife first attended the clinic to receive family planning, due to the teratogenicity of the medication. The man seemed quietly amused, but failed to speak up until after much further questioning, when we determined that he was actually 60 years old, as was his wife, and that teratogenicity would really not be an issue. The man appeared to be in his early forties, but did not know his age. When presented with this difficulty in determining age, the easiest method was to ask whether the man was alive, and if so, what school grade he was in at the time of World War II.

One case in which perhaps communication skills could have been better used during the first consultation in order to prevent a family misunderstanding was that of a seventeen-year-old girl who had presented with a urinary tract infection (UTI). Questioning by the doctors about any sexual activity which could have made a UTI more likely had led the girl's father to believe that she had been seeing a secret boyfriend without his permission.

The girl had given a urine sample, which had shown her to have a simple UTI, which may have had nothing to do with any sexual activity. However, the father was under the impression that the doctors had suspected a sexually-transmitted disease, and he had beaten the girl and left the family home in anger. The girl arrived for a follow-up consultation, to be told that antibiotics had effectively eradicated the UTI. She was accompanied by her uncle, who had come to gain a clearer understanding of the situation, so he could report back to the girl's family and represent her case to them, and so the father would return to the family home.

### **Patient involvement in decision making regarding therapeutic options.**

Due to language difficulties, any relative or friend, or even the next patient in line may be asked to be present at a consultation in order to translate. It is a great help to the doctors that a 'stand-in' translator can almost always be found when necessary. However, there is a tendency for the translator to take a more active part in the consultation, answering some of the questions on the patient's behalf, and the doctor has to remain alert to ensure that the right person is being asked and answering the questions to obtain an accurate history. Where the translator is the patient's husband, it can be particularly difficult to insist on all questions being relayed to the patients, and hard to know if her replies are being relayed back unchanged. There is a tendency for the patient to become excluded from the discussion about treatment, such that the doctor and husband negotiate the management plan, which is then translated to the wife, who is asked if she is in agreement. By this stage, the doctor and husband have already decided on the best course of action, and the wife would be very unlikely to refuse to go along with the plan.

### **Informed consent for medical and surgical interventions**

The issue of consent for any particular medical intervention is complicated in rural Papua New Guinea by the fact that any patient travelling miles by foot or dinghy to consult a doctor has implicitly consented to concurring with any advice or treatment that may be offered, unless the proposed management is so different from what he or she had hoped for that he actively objects to it. Most patients coming from any distance would first have consulted family members, and perhaps the village witch doctor or aid-post worker, if one were available. Therefore the decision to travel to see a doctor indicates a desire to seek that doctor's advice, and as medications are provided at no cost from St Barnabas Health centre, there would be no reason to refuse the proposed treatment.

There were very few occasions when a patient would express a desire to go against the advice of the doctor. On one occasion, an elderly lady suffering from malaria refused to take her prescribed quinine, as she didn't want to subject herself to its side effects of nausea and vomiting. Her fear of taking quinine also caused her to refuse to take any of her other prescribed medications, and since she was recovering well without medications, she was discharged back to her village. The only other expression of discontentment occurred when patients wanted to leave the health centre against the doctors' advice as either they had run out of food and felt unable to ask relatives to bring more for them, or in the case of some younger patients, they were simply bored with staying at the health centre and wanted to return home to get back to normal life.

The weekly family planning clinic was a time when the issue of consent was raised, not regarding adequate explanation to the woman of the benefits and potential complications associated with each of the three available options (oral contraceptive pill, three-monthly depot injection or tubal ligation), but rather regarding whose consent was required – that of the woman or that of her husband. One woman asked the nurse not to write down the time of her appointment for her next depot injection, as if it was written down her husband might find it, beat her and prevent her from attending. Daily pills were also problematic for the same reason – if a woman was found taking the pills, she may be beaten and the pills may be destroyed. At least the injection offered the possibility for the woman to follow family spacing advice to safeguard her own health, without the husband's knowledge where necessary. No outward sign would be present to indicate to the husband that the woman had disobeyed him.

In the case of tubal ligation, however, the operation could not go ahead without the written permission of the woman's husband, in addition to the written consent of the woman herself. Vasectomy is a very rare procedure in PNG, as family planning is considered to be women's business, and if vasectomy were to be carried out, it would certainly not require the written consent of the man's wife! This discrepancy is due to the risk of violent reprisals when the man discovered that doctors had carried out an essentially irreversible procedure that would prevent him from fathering more children. The abdominal scar from tubal ligation

would be very obvious to the husband, and as this procedure could not be kept secret from the husband, it was necessary to first seek his consent.

### **Patient dignity, privacy and confidentiality**

All women presenting for antenatal clinic on a particular morning, including respected professional ladies, in-patients on the antenatal ward, and women who had walked several miles from surrounding villages for their routine check-up would all be asked to sit on the bench outside the consultation room. The nurse would then work her way along the line, weighing each woman in front of the others, and taking her blood pressure, then writing each lady's weight in kilograms and blood pressure on her hand in red biro, so it could be copied into her maternal health book when she arrived in the consultation room for her examination. This set-up did not seem at all inappropriate in rural PNG, but provided amusement when one considered application of a similar method in the UK, where women would certainly object to being weighed in public, and to having their hands used as notepaper.

### **Betel Nut Chewing and Smoking in PNG**

The higher prevalence of oral cancers in PNG compared to the UK has been attributed to the widespread habit of chewing 'bouai' (betel nut). The majority of PNG adults, and many children (sometimes from the age of five or six) chew betel nut. When mixed with 'mustard' (a green stick of plant material) and 'lime' (powdered coral limestone), the betel nut causes the production of copious amounts of bright red saliva, and gives the person a 'high'. Although chewing is not good for the health, it does provide a substitute for smoking tobacco, and as such, may save more lives than it costs. However, many villagers also grow tobacco, and a high proportion of men (but few women) smoke. The cigarettes are carefully rolled with newspaper, and the smoker will typically light the cigarette and take a few puffs, then snuff it out and keep it behind his ear until he lights it up again later on. Although this is almost certainly for economical rather than health reasons, the reduced intake of tobacco over the course of each day must make the habit less damaging.

### **Location and History of Papua New Guinea**

The mainland of Papua New Guinea is located just north of the northern tip of Queensland, Australia, and is bordered by Irian Jaya, which forms the western part of the island. Many far-flung islands also form part of Papua New Guinea's territory.

Papua New Guinea was formed by the fusion of Papua (whose name is derived from the Malay word 'papuwah' which means 'fuzzy hair') and New Guinea, following the end of the Second World War. The new territory was administered by the United Nations until 1973 when the country became self-governing. Full independence was achieved in 1975.

### **Points to consider in deciding if a placement in PNG is right for you.**

I chose rural Papua New Guinea as an ideal location to experience tropical medicine in an environment totally different from my own. I was fascinated by the cultural diversity of PNG (over 700 languages are spoken by a population of less than 5 million). The landscape is spectacular, with mountains rolling into the ocean, vast expanses of tropical rainforest and countless species of animal, bird and other wildlife.

I am seriously considering long-term overseas medical work in a developing country and felt it was important to experience a taste of this kind of work before qualification, to clarify future plans in my mind, enabling me to maximise the benefit I derive from the rest of my studies and postgraduate trainee posts.

Elective placements with the Anglican Health Service are intended for Christian medical students, as you are expected to participate in the life of the village community, which involves attending church and living according to Christian principles. It is not a place for those who are looking for exciting night life, as the generator is only on for four hours in the evening, so all lights go off at 10 p.m. It is also not a place for people who like their comfort. The water supply is temperamental (although there is usually plenty of rainwater in the tanks) and there will be toads and snails in the shower room. You have to take a fairly liberal attitude towards sharing your bedroom with geckos, cockroaches, spiders and whatever else fancies living there.

Food is pretty basic – you can buy scones (complete with baked-in beetles!), bananas, coconuts, peanuts and all sorts of vegetables very cheaply at the market, but the rice and tinned meat and fish in the trade

store are at UK prices or more, due to high freight costs. You can get by comfortably on a couple of pounds a day, but it's more fun to buy lots of food and invite lots of people round to help you eat it (a good way of getting to know people!)

Malaria is a real risk in coastal PNG. Doxycycline is recommended due to high levels of chloroquine resistance, but weekly chloroquine plus daily paludrine is also thought to be effective. The heat can be intense and you have to be careful about sunburn, especially if you're swimming or travelling on a dinghy on the open sea. The humidity can make you feel very uncomfortable during the day, but evenings are cooler after impressive afternoon rainstorms.

Snorkelling is a must if you go to Dogura. Take your own snorkel, mask and fins, as to get there and find there were none available to borrow would be a real shame. There is nowhere to buy snorkelling gear near Dogura, and the angelfish, butterflyfish, anemone fish, massive blue starfish and countless other species are too good to be missed. The locals catch fish by diving and spearing them with a spear attached to a long pole by elastic, which works like a catapult. I met a large moray eel defending its territory on the outer edge of the reef and sharks are certainly present in the water (in some coastal areas of PNG, the locals catch them and bludgeon them to death in their tiny canoes), so you have to keep a constant look-out, and not go too far from the shore.

Due to the small size of St. Barnabas Health Centre, and limited number of patients, I would not recommend that more than one medical student be placed there at the same time. The doctors' main priority is to train national health care workers and nurses, and whereas it is fine for one UK medical student to be present, two or more may shift the focus away from training the health centre's own staff. There are plenty of very friendly national staff to befriend and spend time with, chatting, swimming, playing cards etc, so there is no need to worry that you would be lonely going to St. Barnabas on your own. However, one disadvantage of a placement in PNG is that it is not entirely safe to travel around the country on your own, particularly for a female student. I encountered no problems travelling through the country alone to reach Dogura, but did not feel it was a good idea to go touring round for any length of time to other parts of the country. Although most people are very friendly and hospitable, white skinned people are very conspicuous and may become targets if there are trouble-makers around. In practice, this seems to work in reverse, as white people are presumed to have contacts in high places, and so even attacks on nationals may be averted by the presence of a 'dim dim', as the perpetrator would be afraid of being reported and traced.

As domestic flights are very expensive, nationals who you meet are very unlikely to be able to travel around with you if you wish to see some of PNG. Because of this, I felt it would have been nice to have another UK student with me, so I could have travelled a little more. As the Anglican Health Service increases the number of doctors placed in the various mission hospitals around the country, the opportunity will hopefully arise for two or more medical students to travel to PNG together, work in different hospitals and then meet up to travel round the country together, which would be an ideal arrangement. If you do decide to travel around PNG, some general advice would be to find the name of a specific person or group to visit in each village or area, so that when you arrive you will be identified with someone within the community, which will offer you immediate protection. Also, I'd recommend travelling at the end of your stay rather than the beginning, as by the end you should have much more idea about how the country operates, and should be more aware of cultural practices.

## **Travel Arrangements**

I booked my flights through Tokyo, Cairns and Port Moresby to Popondetta with Boomerang (see 'contacts'). Peter Rookes can book your flight with Milne Bay Air from Popondetta through to Wedau airstrip (a short walk from Dogura).

When I arrived in Milne Bay, the airstrip at Wedau was closed due to long grass and lack of an administrator, so I got out at the previous stop, Rabaraba, then travelled by dinghy to Dogura, with the dolphins and flying fish jumping around on either side of the boat.

## Contacts

### Applications for elective with PNG Anglican Health Service

Mr Peter Rookes  
National Health Secretary, Anglican Health Service  
PO Box 245, Popondetta, Oro Province, PNG  
email: ahspop@global.net.pg

### Advice from the UK

Mrs Chris Luxton  
PNG Church Partnership, UK  
157 Waterloo Road, London, SE1 8XA  
tel: 0207 937 5794  
email: pngcpluxton@aol.com

### Visa Information

Ms. Jwan Ramdoyal  
Consular Assistant, Papua New Guinea High Commission,  
14 Waterloo Place, London, SW1Y 4AR  
tel: 020 7930 0922

(You can acquire a 3-month medical exemption visa for £7 plus the cost of recorded delivery for return of your passport.)

### Flights

Boomerang – specialists in value travel to Australasia  
Boomerang House, 1st Floor, 182 Cranbrook Road, Ilford, Essex IG1 4LX  
tel: 0800 428 787, www.australian.co.uk, sales@australian.co.uk

### Budget

Travel	£1063
London – Tokyo – Cairns – Port Moresby – Popondetta return flights (Japanese Airlines, Qantas, Air Niugini)	£ 856
Popondetta –Wedau Airstrip, Dogura (Milne Bay Air)	£ 137
Internal travel (contribution towards dinghy fuel costs etc.)	£ 40
UK internal travel	£ 30
Insurance (Banner Insurance Group)	£ 64
Insurance to cover medical work in PNG – free of charge through MDU	
Medical expenses	£ 47
Anti-malarials, insect repellent, antibiotics, first aid kit, sunscreen, sun hat etc. (obtained at reduced price through Addenbrookes' Occupational Health)	
Accommodation	£ 70
Provided free of charge while staying in Dogura and Popondetta Overnight accommodation required in Port Moresby and Alotau.	
Daily expenses (Food, telephone, fax etc.)	£ 256
Visa for entry to Papua New Guinea	£ 10
Photography	£ 40
Miscellaneous (Replacement clothes and toiletries due to delayed baggage)	
	£ 20
<b>Total cost</b>	<b>£1,570</b>

Sources of Funding	
Queens' College Travel Grant	£ 450
The Worshipful Company of Haberdashers	£ 300
Medical Missionary Association Healthserve	£ 250
Cambridge Vineyard Church	£ 100
Personal Friends	£ 100

**Total funding raised**

**£1,200**

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PNG government publication

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PNG government publication

Lonely Planet: Papua New Guinea  
A. Lipscomb, R. McKinnon, J. Murray, 1998, ISBN 0 – 86442 – 402 – 7

## **Acknowledgements**

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