Since independence in 1975, things have changed mightily in PNG. To begin with, PNG has grown from just over 2 million people (1970 census) to nearly 8 million today. This rapid population growth (over 3% pa) has contributed to all sorts of health problems and issues. It is nearly impossible for any government to keep up with infrastructure and service provision when the population growth rate is so rapid. Last year, over 250,000 babies were born in PNG, but only 40% of women were able to reach a health facility and access any kind of professional midwifery support for the birth. The main result of this statistic is that PNG has one of the highest rates of maternal death in the world (MMR of 733: PNG DHS 2006). And, unfortunately, village birth assistance is not useful in the PNG context because no matter how skilled the attendant is, if something significant goes wrong with mother or baby during the birthing process there is nothing much one can do on the floor in a village house. In such circumstances, by the time the woman can be moved from her village to a health facility it is usually too late.

For this reason the recent refurbishment and expansion of the Anglican Church’s St Margaret’s hospital at Oro Bay in the Northern Province of PNG has been very important in helping women access labour and delivery care close to
their homes. From St Margaret’s it is possible to refer a woman to the provincial hospital at Popondetta in less than an hour if a caesarean is required or she or her baby require secondary hospital care. In fact, church agency health services (including the Anglican Church) now provide for a significant part of the health services for the rural areas of PNG and, because of the perception that people get more sympathetic (client focused) care in church agency health facilities, they are usually better patronized than the government rural facilities.

Rapid population growth also means that more than 50% of the population of PNG is under the age of 18 years. This has serious implications for the education system. Class sizes are too big for effective teaching and quality teaching suffers. In addition, in the 1980s and 1990s many health worker training schools closed down, such that now the only community health worker (CHW) training schools still operational are church agency ones. St Margaret’s CHW training school trains health workers for both Northern and Milne Bay provinces and St Barnabas Nursing school in Alotau likewise trains nurses for all the south east provinces of PNG. Both these schools are very challenged in terms of training materials and books for the students. In most schools the library has very few books and students do not have any books of their own. A recent AusAid-sponsored project supplied neonatal resuscitation equipment and maternal and newborn care text books to all the CHW training schools, but this was a once off and further support of this kind is always welcome.

Because rural health facilities in some areas of PNG are in such poor condition, women seeking birthing care bypass the rural facilities and head straight for town. This has led to severe overcrowding in many provincial hospitals. At Port Moresby General Hospital labour ward now we supervise more than 50 births a day and because of lack of bed space some women unfortunately are forced to deliver on the floor.

One of the most cost effective ways of helping women survive and cope is to provide family planning. Many women travel long distances to obtain family planning, or make a really big effort to travel to the provincial HQ of their province to have ‘the last baby’ and obtain a tubal ligation. In PNG we have recently introduced the contraceptive implant and this is fast becoming the most popular temporary method of family planning. Women really appreciate the fact that they do not need to keep coming back for more supplies.

Lastly, the very large number of babies born each year challenges our ability to register births and record birth outcomes. Indeed at the moment only about 2% of PNG births are registered each year.

---

**Development of the Anglican Health Service**

*Aileen and Martin Gardham reflect on the development of AHS:*

“From the earliest days of the Anglican Mission in Papua New Guinea, there was a recognition of the threefold ministry of preaching, teaching and healing. The first trained nurse to volunteer for work with the mission appears to have been Florence Agnes Thomson, who joined the mission in 1896 and worked at Dogura and Samarai until her resignation in 1904. The first St Barnabas Hospital at Dogura was completed in 1915. After World War I the Anglican Mission started work in new areas and began the process of training Melanesians...”
to take over from expatriates. One important area of expansion was the Mambare River in what is now Oro Province, where Fr Romney Gill set up a mission station at Duvira in 1922. Fr Gill had received some medical training in England, and his station provided medical advice and care over a period of thirty years. His brother Dr Cecil Gill set up a bush-materials hospital at Gona in 1926.

In common with other activities of the Anglican Mission, its medical work was heavily influenced by two formative events, World War II and the eruption of Mt Lamington in 1951. Two of the twelve members of the Mission who were killed during the war, May Hayman and Margery Brenchley, were nurses. The publicity which their stories gave to the medical work of the Mission led to a renewed interest in that work overseas.

After World War II a diocesan medical committee was established, which decided to set up two nurse-training schools, St Barnabas’ at Dogura for the eastern region and St Margaret’s at Eroro for the northern region and the highlands. Work was resumed in New Britain, where it had started in 1928, but the most significant expansion of Anglican activity came with Bishop David Hand’s outreach to the Highlands in the late 1950’s and early 1960’s.

An important step towards co-ordinating the medical services of the various churches and missions working in Papua New Guinea was taken in 1965, when representatives from a number of churches were invited to attend the Anglican Diocese’s annual medical conference at Dogura. This led to the establishment in 1968 of the Combined Churches’ Medical Council, which in 1972 became the Churches’ Medical Council, an effective and influential body that after Independence became the main channel of communication between the churches and the PNG Government.

From 1891 to 1969 the medical work of the Anglican Mission had been controlled directly by the Bishop, but in 1969 Bp David Hand asked Dr Blanche Biggs, then based at St Luke’s Hospital, Embi (near Popondetta), to assume the new role of Medical Coordinator, which she held until just before Independence in 1975. She then handed over her responsibilities to Helen Roberts, who had joined the Mission in 1947 and been posted to Wanigela, in the Collingwood Bay area of Oro Province. One of Sister Helen’s main tasks was that of bringing the training and qualifications of the Anglican medical workers into line with those of the new PNG Government.

Though she did not die until 1992, Helen Roberts ‘retired’ in 1985, and was succeeded as Medical Co-ordinator by Nancy Vesperman (now Garland) and Aileen Lawrence (now Gardham). In 1993 the then Provincial Secretary, Peter Shepherd, invited Dr James Harper to come to PNG from the UK to carry out a review of the organization of the Education and Medical Divisions. The review of the Medical Division recommended a new structure, with the Medical Co-ordinator being replaced by a National Health Secretary. The first holder of this position, Fr Bill Crossman, started work in Lae at the beginning of 1995.”
Being a VSO Doctor in PNG

Dr Alex Sohal, together with partner, Dr Hiran DeSilva, spent 13 months working as a VSO Medical Officer within the Anglican Health Service. Here she writes about her experience and the impact on her subsequent career.

“I was based at Koinambe Health Centre, on an isolated Anglican mission station in the Lower Jimi Valley. The entire Jimi Valley had a population of 33,000, reliant on subsistence farming of sweet potatoes, cassava, taro and greens. The people in this community, which also had a church and school, were materially poor but extremely welcoming and supportive. Mission Aviation Fellowship provided a weekly flight and helped with occasional emergency medical evacuations to hospital in Mt Hagen, some 30 minutes away. For the locals, this was a two-day journey walking on a dirt-track road often impassable due to heavy rains and landslides.

Koinambe Health Centre had an outpatient department, an inpatient ward, a delivery room and a postnatal ward. Patients were seen every day in the outpatient department, with family planning and immunisation available. There were no real diagnostic facilities, apart from a simple WHO blood test and urine dipsticks, so we relied solely on our histories and examinations – rather like UK primary care where I now work as a GP.

In Koinambe, my priorities were:

- to improve the quality, effectiveness and access to rural health services, especially maternal and child health
- to help build the capacity and confidence of the health centre staff and isolated health workers
- to raise awareness of preventative health measures, particularly HIV/AIDS

Hence, I always worked alongside local staff (nurses and community health workers), whether in Koinambe Health Centre, visiting the two sub-health centres or patrolling to the twelve remote clinic points, to ensure staff received relevant practical training. The week-long patrols on foot to the more remote areas involved immunising children, reviewing pregnant women, distributing free mosquito nets and treating patients. The commonest illnesses were malaria, pneumonia and malnutrition.

Protein energy malnutrition was particularly prevalent in the Jimi, with people being recognisably smaller in stature than in neighbouring valleys. I tried a variety of strategies to tackle this complicated and challenging problem. The majority of pregnant Jimi women never received antenatal care and had unsupervised deliveries in the bush. I encouraged attendance at antenatal clinic, with admissions for confinement and the occasional transfer of high-risk pregnancies to Mt Hagen hospital. Throughout, supported by the local Anglican priest, Fr Nicholas Kaam, I talked with lots of people and groups about HIV/AIDS. Condoms and mosquito nets were distributed after Sunday church services.

The clinical experience I gained in PNG proved invaluable and influential in a number of ways. I had a one-shot chance in assessing multiple children rapidly in a busy OPD on market days and on patrol to determine illness and treatment, appreciating they were unlikely to see another health worker for many months. This experience repeatedly highlighted the importance of going back to basics ie ensuring that a global assessment accompanied accurate basic observations of heart- and respiratory-rate. This robust experience has helped me deal effectively with the many children I see successively in ten-minute appointments in my morning UK general practice list.
I came to realise that the biggest risk factor for morbidity and mortality in women of childbearing age, both in PNG and globally, is domestic violence and abuse (DVA). Tackling this requires a coordinated community response involving local non-abusive men, and recognition of the direct and indirect harm caused to men, children and women. I tried to develop this approach when the whole community was affected by a Koinambe woman being killed in an axe-attack by her husband, with predictable violent repercussions before a peace agreement was reached.

This experience, together with the associated accident leading to the premature death of local man, Tobi Apoi, (see ‘Tobi’s Story’ below) had a profound effect on my career. On returning to the UK, I completed my MSc in Primary Care, focussing on identifying DVA in general practice. I then did a MD(Res) considering the healthcare response to DVA, before becoming a Royal College of General Practitioners’ Clinical Champion against DVA.

Subsequently, supporting Tobi in his own home, 3km up the mountain from Koinambe and the Health Centre, proved too isolated and difficult. Thanks to the doctors’ intervention, a trip to Lae for Tobi provided wheelchairs, foot-brace and crutches so that he could get around the station and continue his strengthening exercises. In the meantime, the Parish Priest, the doctors and some local boys constructed an easily accessible house for Tobi and his family in Koinambe. He was happily installed in it before the doctors had to return to England.

This was the start of another happy, positive period for Tobi and his family about which he wrote to his doctor friends, “In Koinambe, I am free to talk and move around easily with Momb and Alistair. I am taking Sunday School every Sunday, playing the guitar and singing with children, sharing Bible verses, etc.. In 2005, again because of shortage of teachers, I taught the 44 students in Grade 1. At night, I work on a computer donated by two former doctors (Chris & Tony Rolles) and keep doing my exercises on parallel bars made from bush-materials. When I do these things I forget about my disabilities.”

Sadly, Tobi died recently, just 35 but having touched the lives of many around him.

I am now a Clinical Lecturer in Primary Care, with a healthcare response to DVA research interest; also Principal Investigator leading a Department of Health-funded team evaluating a DVA training and referral programme for GPs.

When setting off as a VSO volunteer with AHS, I just could not have predicted the many ways this greatest adventure of my life in PNG would go on to impact my own life.”

---

**Tobi’s Story**

A Koinambe boy, Toby had his schooling in the village and at Mt Hagen Secondary School, before returning home again in 1997. In 2002, because of a teacher shortage, he taught Grade 1 in the local school, getting married at the end of the year. He wrote: “My wife, Momb, and I made (food) gardens, built a house and had a baby son, Alastair. It was a happy time.”

Life for Tobi and his family changed dramatically in the middle of 2003 when a local woman was beheaded by her husband after an argument. “The woman’s relatives heard the bad and sad news. The next morning they came to my village with bush-knives, bows and arrows, spears and guns to attack us. They burnt down all our houses, killed our pigs with great destruction everywhere. A peace agreement was reached by both sides a week later. Our village leaders said that each man should contribute K200 (£50) and a pig as compensation payment.”

Not having the money, Tobi was one of a group of men that decided to go off to camp by the river to dig for gold, to sell to meet their community obligation. A huge tunnel was dug by the river, yielding a lot of gold. Tobi was inside the tunnel when it collapsed on him, breaking his back and paralysing the bottom half of his body. A bush stretcher was made to carry him to Koinambe Health Centre, from whence a MAF medivac flight took him to Mt Hagen Hospital. He stayed there for 16 weeks before being flown back to spend three months in Koinambe Health Centre being cared for by his wife, the staff and the two English VSO doctors.

Subsequently, supporting Tobi in his own home, 3km up the mountain from Koinambe and the Health Centre, proved too isolated and difficult. Thanks to the doctors’ intervention, a trip to Lae for Tobi provided wheelchairs, foot-brace and crutches so that he could get around the station and continue his strengthening exercises. In the meantime, the Parish Priest, the doctors and some local boys constructed an easily accessible house for Tobi and his family in Koinambe. He was happily installed in it before the doctors had to return to England.

This was the start of another happy, positive period for Tobi and his family about which he wrote to his doctor friends, “In Koinambe, I am free to talk and move around easily with Momb and Alistair. I am taking Sunday School every Sunday, playing the guitar and singing with children, sharing Bible verses, etc.. In 2005, again because of shortage of teachers, I taught the 44 students in Grade 1. At night, I work on a computer donated by two former doctors (Chris & Tony Rolles) and keep doing my exercises on parallel bars made from bush-materials. When I do these things I forget about my disabilities.”

Sadly, Tobi died recently, just 35 but having touched the lives of many around him.
Being a Community Health Worker in an isolated Aid Post

The Aid Post on Kumbun Island, off the South Coast of West New Britain, must be one of the most isolated health facilities run by the Anglican Health Service in PNG. This piece results from a collaboration with Simon Kamong, NGI Diocesan Secretary in Kimbe, retired-Bishop James Ayong, the Community Health Worker (CHW) and two ‘postie’ boatmen on Kumbun.

Early missionaries established Kumbun Aid Post before WWII. In those days, this health service was funded and run by the Anglican Church. An Aid Post Orderly (APO) would typically receive a small allowance and subsidised food rations on a monthly basis. Some time after PNG Independence in 1975, all Church-run health services were integrated under the National Health Department, who assumed responsibility for paying staff salaries within nationally-agreed salary scales and conditions of service, through a grant to the Churches Medical Council. Although CMC is now called the Christian Health Services, it still deposits funds directly into diocesan health-workers’ salary accounts.

Kumbun’s present APO (or CHW as they are now called) is Paul Gubare, aged 55. He has been there for seven years now. Paul comes from Agaun, an inland village in Dogura Diocese. He attended Agaun Community School and Martyrs’ Memorial School before training as an APO at St Margaret’s School of Nursing, Oro Bay, a full week’s walk from his home village. In his 28 years’ service as APO, now CHW, Paul has served in two Health Centres (with an Officer-in-Charge and Nursing Officers) and four Aid Posts. Throughout his service, without any further training, Paul has had to rely on the training he received at St Margaret’s, together with the knowledge and practical skills he has acquired on the job.

The current equipment Paul has at Kumbun Aid Post comprises: thermometer; stethoscope; fetascope; artery-forceps; tooth-forceps and scissors. Drugs usually available are associated with the treatment of malaria, asthma, respiratory and antenatal conditions, plus dressings and family planning materials. Shortage of drugs and the delay in obtaining supplies is a problem which can result in him having to travel to the Provincial capital, Kimbe, when transport is available.

Paul works alone at Kumbun, where the Aid Post is under Sagsag Health Centre for supervision, reporting directly to the Provincial Health Authority in Kimbe. Minor cases are dealt with on Kumbun, even when requiring frequent visits or treatment. More serious accidents and illnesses are transferred to the Sagsag Health Centre; to the Roman Catholic Health Centre on another island; or in the most serious cases, to the Provincial base-hospital in Kimbe. As Kumbun is such a small island, transfer of cases is done by dinghy with an outboard-engine, usually accompanied by Paul. The cost of such an arrangement is paid for by the sick patient’s relatives. Because of his reputation and experience, Paul also finds himself travelling to deal with requests for help from nearby villages on other islands and the NGI mainland.

Paul’s three wishes? Firstly, to receive further training to update his knowledge and competencies. Secondly, because of the growing number of patients from the six scattered island and mainland communities of 3,500 people, to see the Kumbun Aid Post upgraded to a Sub-Health Centre. Lastly, because Kumbun is the first posting he has had outside his own diocese, a next posting nearer home.
Port Moresby General Hospital and a front-line fight for better health

Now retired as Bishop of Port Moresby and back in the UK, +Peter Ramsden writes:

“One of the more challenging aspects of being Bishop of Port Moresby was being asked by the Minister of Health to represent the Churches as a member of the Port Moresby General Hospital (PMGH) Board.

PMGH is the major referral and teaching hospital in PNG but a few years ago had suffered years of administrative and financial neglect and consequently the service offered to the public was in serious decline. The government’s somewhat controversial solution was to appoint a new board with some very senior managerial experience from private sector companies, including Exxon Mobil and Digicel, under the chairmanship of Sir Theo Constantinou of Hebou Construction.

The hospital was familiar to me from pastoral visits but only when I joined the board did I fully realise the state of the place - wards were dirty, sinks were blocked, fire doors locked, maintenance almost non-existent, inappropriate donated equipment lay unused, many squatters lived on the premises, "ghost" workers claimed pay every fortnight, and worst of all the morgue was full of unclaimed bodies. I was asked to lead the Patient Care Committee, which had terms of reference but hadn't actually had a meeting for four years!

Many challenges remain but the new Australian CEO Grant Muddle, major investment from the chairman’s charitable foundation, a number of new staff and an increase in staff morale have all made a big difference. Have a look at their website: www.pomgen.gov.pg

PMGH has to keep improving, for the demands for basic health care (not least maternal health) from a rapidly increasing population are huge, but people are right to expect the best from a country which boasts of its huge revenues from mining and natural resources. The challenge remains to avoid waste and corruption and use wisely every Kina raised - government, churches, NGOs all have to learn to do that.”

Malaria in PNG

For a decade from 1963, Dr Pene Key worked in a variety of roles in Anglican health services in PNG, in St Margarets - Eroro; St Lukes – Embi; St Barnabas School of Nursing – Dogura; Mt Hagen; Kundiawa; Movi; and Port Moresby – in four out of the five dioceses in present-day ACPNG. These experiences and other aspects of a varied career are recorded in her book: ‘Pushing the Boundaries – Memoirs of a Traveled Doctor’. Now retired, she retains an active interest in ACPNG and PNGCP, is involved with the WHO South-East Asia Regional Office and a Trustee of Malaria Consortium UK.

Historically, malaria, including cerebral malaria, has been recognized as one of the major causes of death in PNG, with reports of increasing resistance to treatment and prevalence at greater altitude in the Highlands. Following her contribution to the PNGCP Day Conference in September 2015, Dr. Key has provided the following comment:

“The battle with malaria is being won! Since 2000 the number of people dying from this disease in the world has halved. In PNG there has been dramatic success. Five years ago, 1 in 5 people had malaria parasites in their blood; today only 2 in 100 have malaria in their blood! 50% of the population has access to insecticide-impregnated mosquito nets. The Director General of the World Health Organisation says nobody should be complacent about improvements but that the avoidance of mosquito bites between dusk and dawn is the first line of defence against this disease. Nets cut the incidence of malaria cases by half so all development programmes should include the distribution of insecticide-treated bed-nets.”
PNGCP, ACPNG & PNG News

- PNGCP Committee member, Kola Akinola, has resigned to take up a VSO posting in Nigeria, anticipating “a tough challenge trying to help the development and delivery of projects in my own country!” Previously, Kola worked as a volunteer with ACPNG for two years, helping develop the Church’s HIV & AIDS work. Part of his legacy to PNGCP was the creation of the agency’s excellent new website: www.pngcp.org.uk

- Anglican Missions Board – New Zealand has recruited two key mission volunteers to work with ACPNG. One, Maori accountant John Tapiata, is paying regular visits to the Anglican National Office, Lae to help bring ACPNG’s accounts up to date. The other, Margaret Poynton, is working with Archbishop Clyde Igara in his newly-established Port Moresby office. Part of her role will be the distribution and oversight of overseas funds coming to ACPNG. (At a recent briefing meeting with her in New Zealand, Margaret shared how impressed she was with the new PNGCP website, “The video has been excellent for my deputation work and I really liked the ‘Imagine…’ section, it is perfect as the basis of an eight-minute talk.” – Editor)

- Newton Theological College lecturer, Fr Spencer Kombega, is currently on a scholarship studying for a Master’s degree at St John’s College, Auckland.

- On 19th September, the 40th Anniversary of PNG Independence was celebrated at a lively gathering in Leeds. It included the retiring High Commissioner, Winnie Kiap, and her Deputy; many of the Papua New Guineans in the UK and Expats with PNG connections. Needless to say, pig was on the menu and entertainment was provided by Trobriand Islanders, before the evening concluded with dancing to PNG rhythms.

- In January, Archbishop Clyde Igara will be in the UK to attend a Primates’ Meeting called by the Archbishop of Canterbury. The following month, the Bishop of Dogura, Tennyson Bogar, will be attending the annual Canterbury course for new Anglican bishops. It is hoped that both will be available to visit and meet with some of PNGCP’s supporters during this time.

- At the end of October, many around the world were saddened to learn of the death of Brother Brian Harley SSF. Aged 90 and in the 57th year of the profession of his vows as a Franciscan, Br Brian was a well-known and much-loved figure from his religious service in England, Papua New Guinea, Australia and New Zealand. In PNG in 1964, after three years in Port Moresby, Br Brian was sent to head up the new St Francis evangelist training college at Haruro, near Popondetta. He then moved next door to become the guardian of the Friary and chaplain to the adjacent indigenous community of Sisters, before leaving in 1976 to set up a noviciate in the Solomon Islands. He subsequently was elected Minister Provincial of the new Australia-New Zealand Province, becoming Minister General (worldwide leader of the Anglican Franciscan Friars) in 1991. In 1993, Br Brian gave a memorable homily at PNGCP’s Day Conference. Some 200 people, including five NZ bishops, attended the funeral of this unassuming holy man in St Peter’s Cathedral, Hamilton.

With grateful thanks to the following for their contributions and help in compiling this Newsletter: Prof. Glen Mola; Dr. Alex Sohal; Bishop Peter Ramsden; Aileen & Martin Gardham; Dr. Pene Key; Simon Kamong, retired Bishop James Ayong; Paul Gubare; Peter Milburn; Lloyd Ashton; Jasper & Della Rea. Any comments, queries or ideas to the Editor, John Rea johndellarea@yahoo.co.uk

Papua New Guinea Church Partnership

PNGCP, St Andrew’s House, 16 Tavistock Crescent, London W11 1AP
Email: pngcpoffice@gmail.com Web: www.pngcp.org.uk Tel: 0207 313 3918