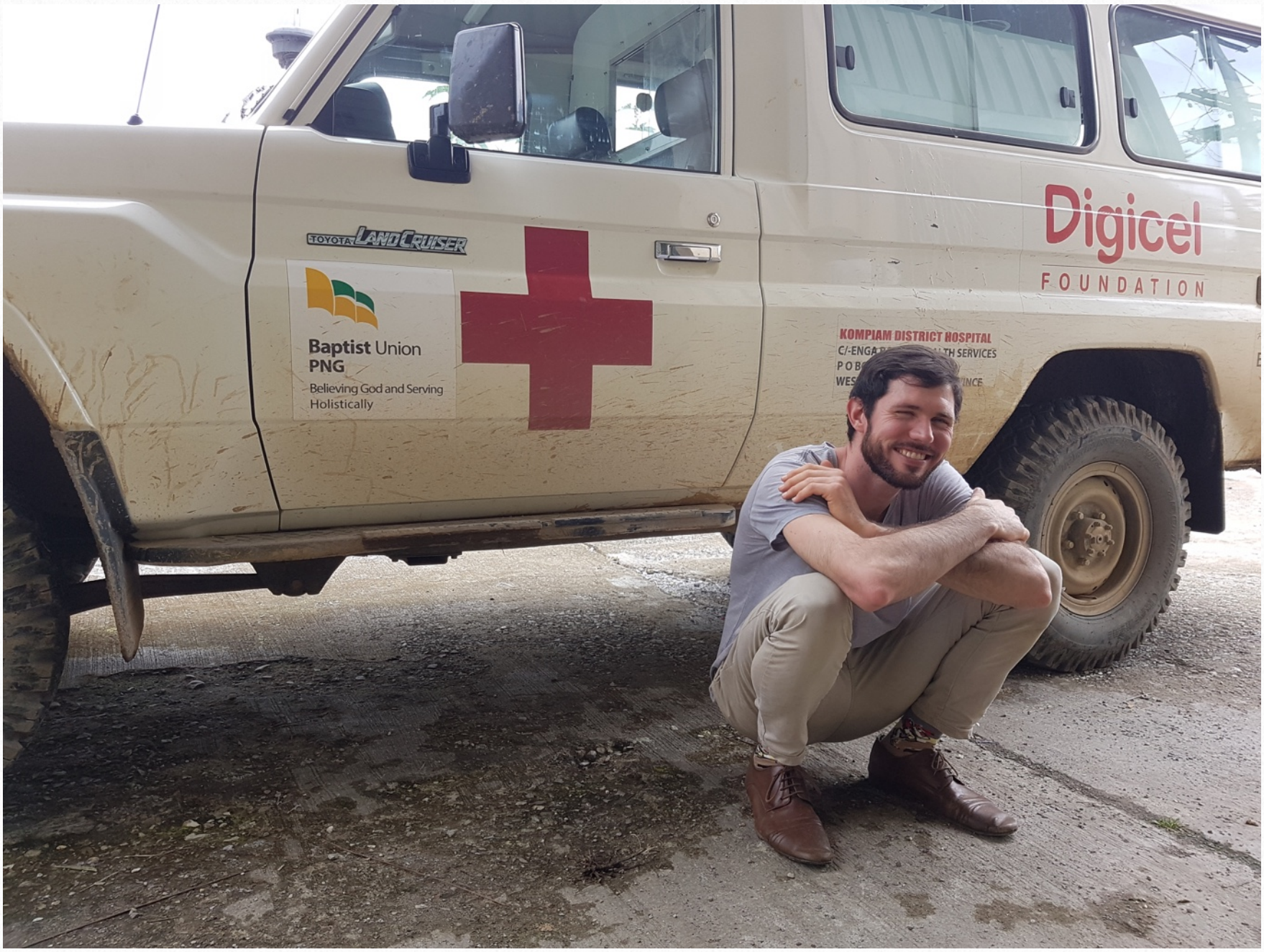
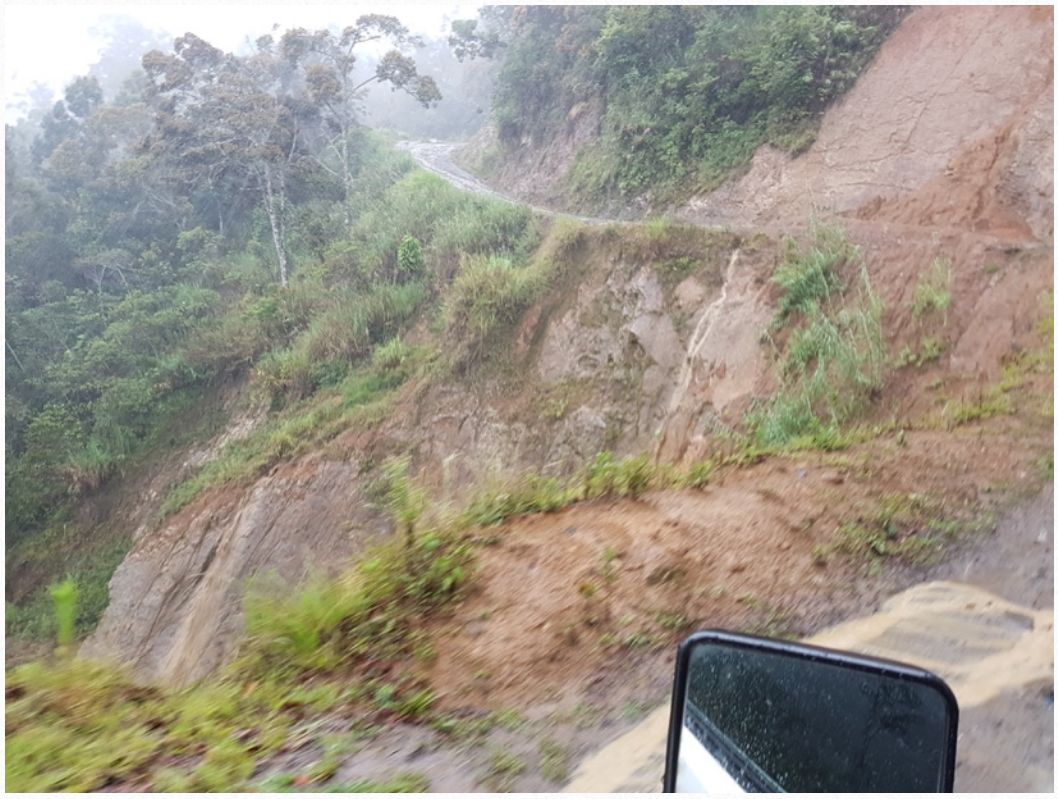
1

Pacific Health Fund Report

Evan McRobb
University of Melbourne



Elective placement, Kompiam District Hospital July 2018



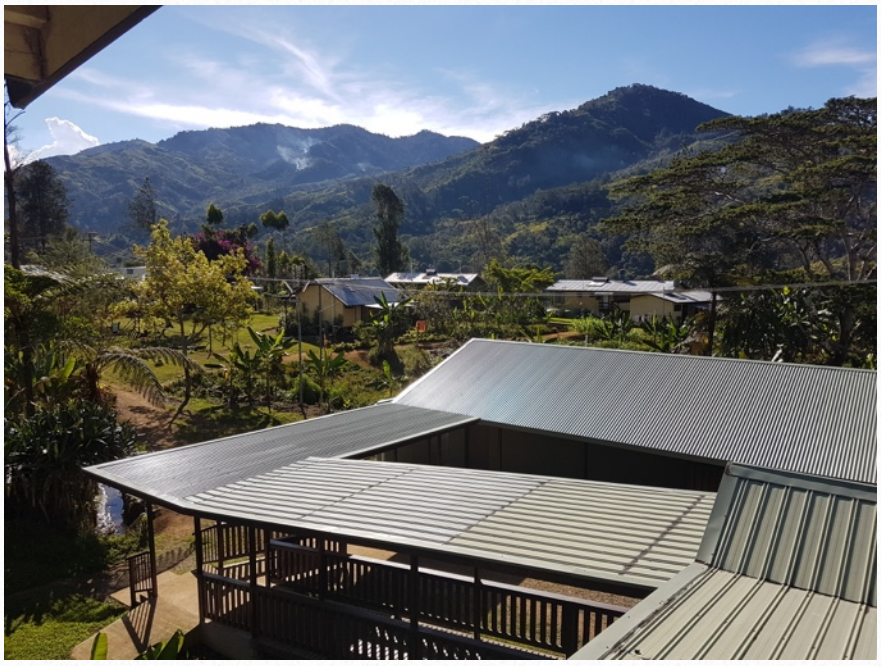
Picture 1.

Papua New Guinea has been high on my list of destinations, being a place many of my mentors have lived and worked over the years in the medical field. A fellow medical student, Harley, and myself had arranged a two-week placement in Kompiam district hospital, Enga province, PNG. This placement was made possible by the Andrew Dent Pacific Scholarship Fund, a bursary for health students to carry out placements in the pacific region. Aerial Google image shots didn't give much idea of the health centre. Having a few boxes of basic medical supplies, kindly provided free by the Melbourne University Health Initiative (MUHI), we boarded our flight. I had many burning questions surrounding what a health service looks like in rural PNG, how the local people were integrated into the service, and what kind of medical problems arise.

We had an overnight stay in Mt. Hagen, the closest commercial airport to our destination; around 5 hours drive from Kompiam hospital. Two wide grinned men met us at the airport, shouting through the fence. We shared stories and got a small insight into what life is like in the highlands, and changes going on in the area. The road to Kompiam was picturesque, traversing a mountain range with a wide valley beneath (Picture 1). We drove past fifty men beating drums and marching, apparently a type of victory parade for a recent tribal fight. The men

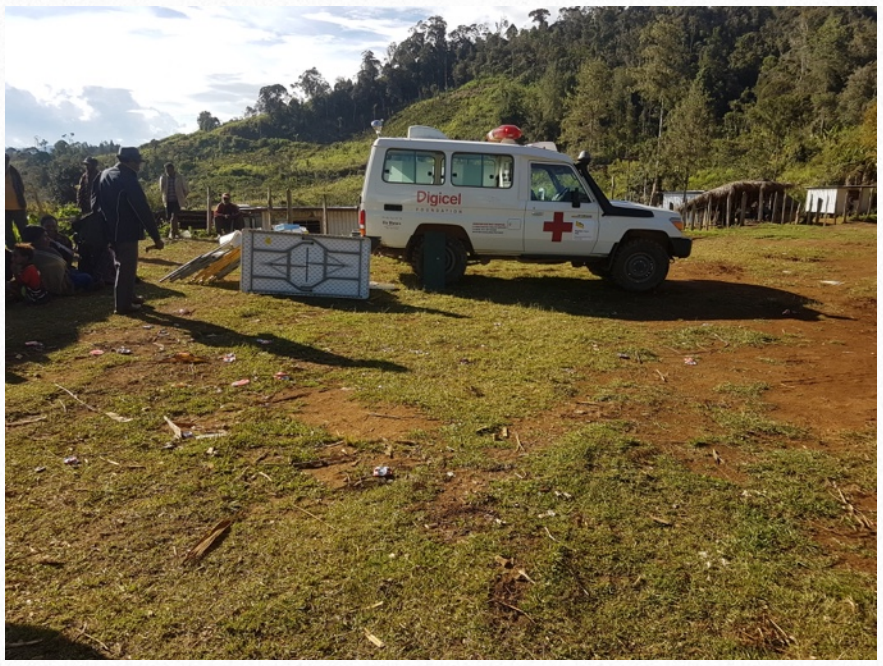
were decorated in colourful feathers and paint up front, with a mixture of casually dressed men following up.

The communities within the hospital compound were vibrant, laughing children played at the basketball court across from the main hospital buildings, and well-maintained gardens sprung out from every house lining the grass streets. The hospital buildings themselves seemed new, with wood decking and coloured steel and solar panels covering most rooftops, not unlike health services in Australia. (Picture 2).



Picture 2.

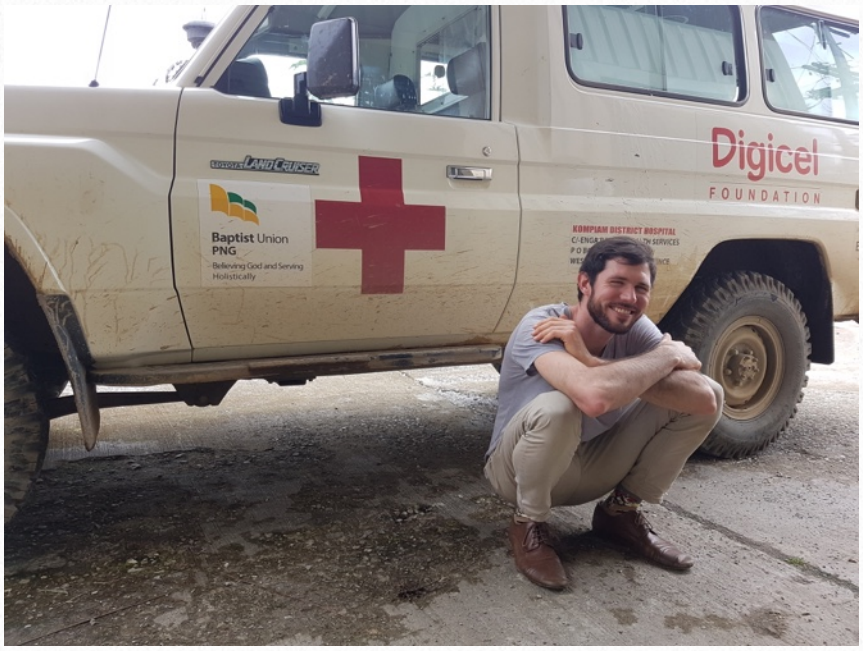
When first stepping foot in the hospital, there were much less people around than expected for a developing world practice, the reason being that many patients fled from the health service the day before following the previous week's shooting of a vehicle just outside the health centre. I tried to put this event in context, speaking to the nursing and other heath staff at the Kompiam Hospital who grew up in the highlands. They described the constant and fluctuating nature of fighting, which they accept as part of life. Those who grew up in the coastal areas were relatively unsettled by the current flare in fighting, for which some staff left and returned home. During the weeks following the flare up in violence, we ran mobile clinics at a nearby village locked in by the fighting (Picture 3, 4).



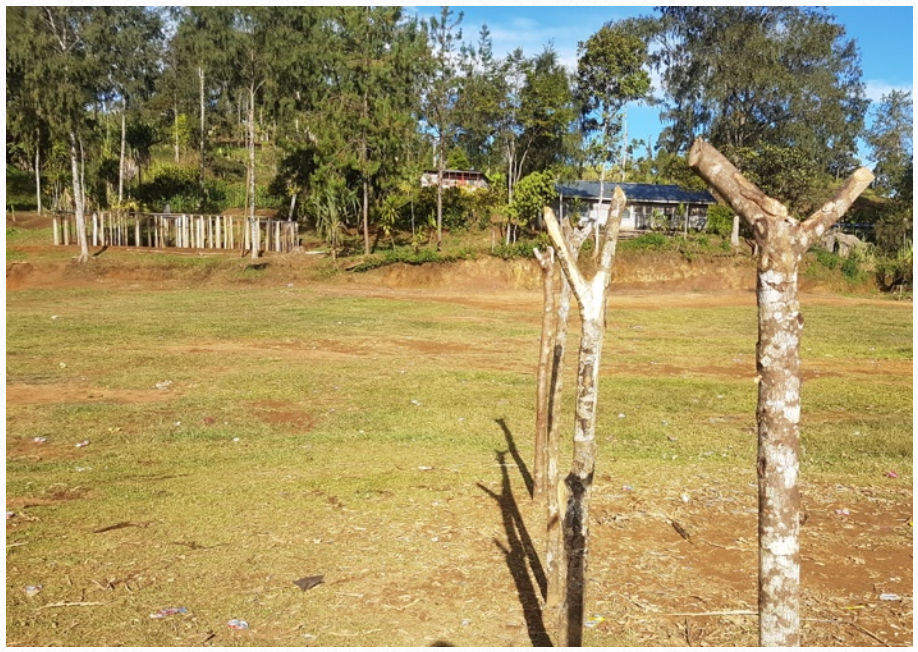
Picture 3.

Solemn reminders of the lives lost during these conflicts were in the football field in the village we visited for mobile clinic. Four wooden poles stood side by side, being

symbolic of the four young men who died in the recent vehicle attack nearby to Kompiam (Picture 5). During the three days, we saw around 250 patients, travelling from surrounding areas, and unable to access Kompiam for at least the next few weeks. During the hour commute to this clinic from Kompiam, we passed through other villages tied up in the conflict, where one afternoon around two hundred men sat in a number of groups blocking the road, all attentive to a police chief, standing in the centre of the village, shouting at the men and silenced while we noisily drove by in the troop carrier. I guessed this was a peacekeeping exercise of some sort.



Picture 4.

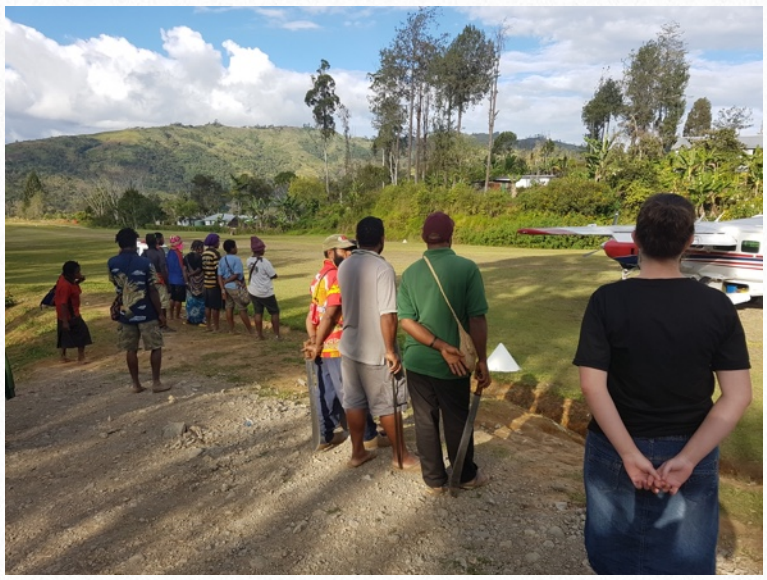


Picture 5.

During these days I learnt that these types of conflict constantly exist and fluctuate, and regardless of a person's involvement, their safety is always linked to the current relations of their tribe. This was evident when the local drivers would not drive in certain areas around the district, for fears of being attacked by rival tribes, regardless of the fact they held full time employment working for a neutral hospital service, and had no interest in taking part in any conflict. I found this fact difficult to comprehend when hearing this from the hospital's head nurse, Tania, a Papuan women who teaches all nurses, and performs most procedures in the absence of doctors at the health service. Tania had two children and a husband within the compound, however could not join us on the mobile clinics because of the risk of

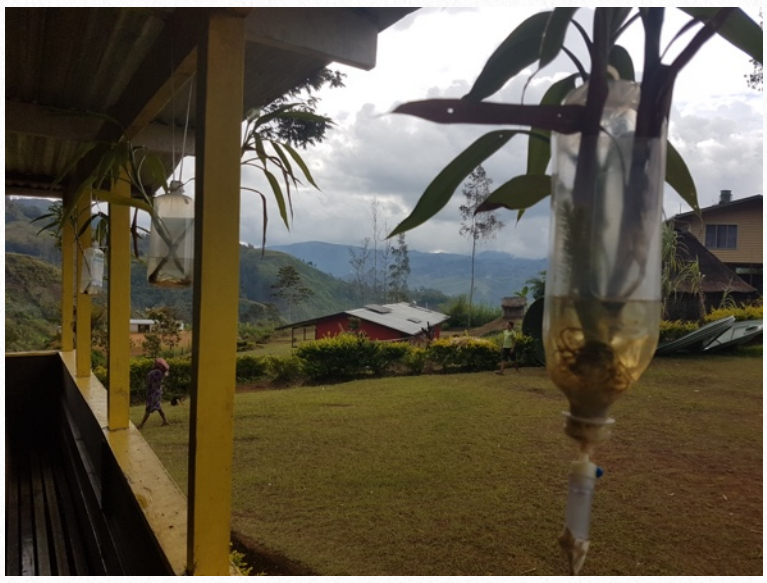
being attacked, however she did make the journey one of the days. Kompiam is a high functioning health facility, however the main resource is the healthcare workers. I wondered what would happen to the health system losing a member such as Tania, I couldn't imagine it would recover for a significant period of time.

The hospital received a few interesting cases during July, a women arrived by plane in the first week, having a machete injury penetrating her nose, and cut through each cheek, the injury almost breaching the roof of her mouth (Picture 6). Tania casually placed in sutures to hold the women's face in tact until repair took place a number of days later. Her husband's second wife attacked the woman, polygamy being a common practice in Papua New Guinea. In any form of domestic violence, the person being treated in hospital is required to pay a 150 Kina domestic violence fee, where I struggle to see how this arbitrary fee serves as a deterrent, especially charged to the victim. Perhaps the fee is a simple way of expressing the health service's frustrations, however there may be cultural elements surrounding this fee that I am not aware of.

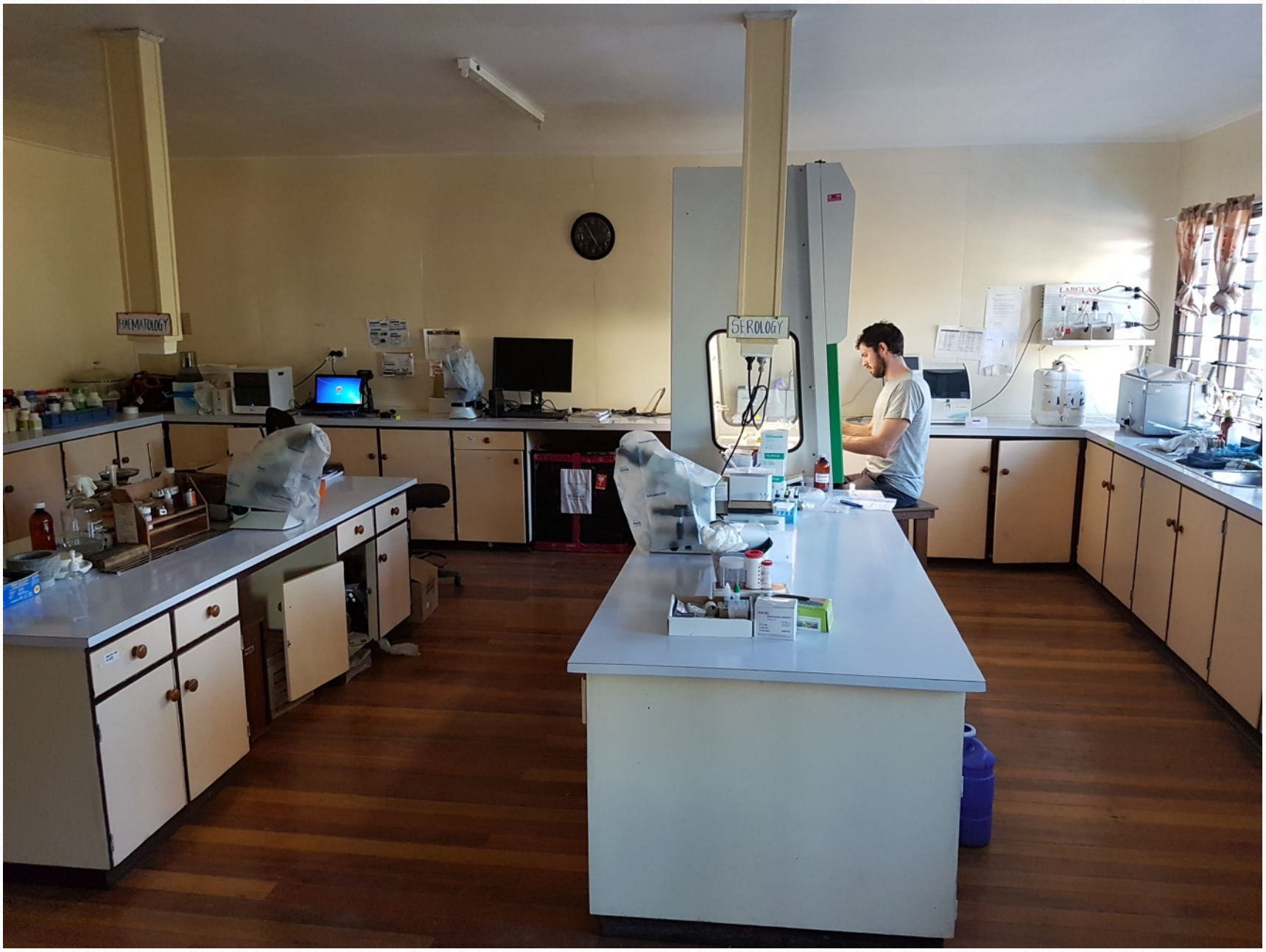


Picture 6.

Aside from bush knife injuries, abbreviated as BKI in medical notation, many Papuans live in dwellings often filled with smoke from indoor fires, mostly for cooking and warmth. Most people therefore had COPD-like illnesses. The nurses were using innovative ways to treat patients, one example being the use of plastic Intravenous fluid bottles as makeshift spacers to deliver inhaled asthma medications, brilliant! The fluid bottles were also used as smart decorations at a rural clinic (Picture 7).



Picture 7.



Picture 8.

While not running clinics, our time was spend helping the TB control programme, which consisted of a couple of hand held tablet computers, and a decade of dusty patient files in a storeroom. It was a privilege to attend the TB control planning taking place within Kompiam district, where patients were encouraged to stay in hospital during the first months of treatment, and discharged with medications, various barriers to treatment completion were not dissimilar to other developing regions. Seeing these issues tackled at a local level was fascinating. Communication issues between staff to ensure TB patients are documented and treated appropriately was also on the forefront of discussion. The coordination of this TB control work, and laboratory facilities were something I didn't expect from a remote hospital situated nearby to scarcely contacted tribes and rugged terrain (Picture 8).

Overall my placement in Papua New Guinea was enriching and enjoyable. I now have a basic understanding of this region, and local connections to foster an ongoing link into the future. I once again thank St Vincent's hospital, and the Pacific Health Fund committee for their support.