

Papua New Guinea Church-Government Wholistic Health Promotion
Medical Ambassadors International
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The growing realization that a large “gap” exists between the average Papua New Guinean villager’s world view and the western medical model is finally being addressed. That gap has not been bridged by traditional health intervention approaches, and earlier attempts to address it had not been widely received. In 1984, during the 8 year period of time when I (Dr. Bieber) worked with the Papua New Guinea Department of Health, first in medical training and then provincial health administration, we identified a need for a village level health volunteer. At that time we started a “village level worker” school to train pastors and others in a wide variety of health education, development, and improved agricultural methods, along with spiritual teaching. This lasted a few years, but there was little ‘buy-in’ from the national health administration, and it finally evolved into a vocational training school.

However, the Lord’s timing and purposes prevailed. In 2001, Medical Ambassadors International asked if my wife and I would go to Papua New Guinea for a survey trip to see if health promotions was a priority on the agenda of the health department, and if MAI could have some input in that. Indeed, we found that they had just launched the new 10 year plan, 2001-2010, and that health promotions was the number one priority. This plan talks about the need for cooperation with their strong partners, like the churches, in order to get health education to the village level, and to train village level worker volunteers. The plan also states the need for communities to take responsibility for their own health needs, recognizing the limited resources of the government. The timing couldn’t have been better or the need more obvious.

Another factor in the timing of introducing the program was the World Health Organization initiative adopted by all the west Pacific Islands including Papua New Guinea, called “Healthy Islands Initiative”. In this document, health is defined as “physical, spiritual, social and mental well being, not just the absence of disease.” The inclusion of the spiritual component gives the islands, which were largely animistic but adopted Christianity when early missionaries introduced them to the faith, the mandate to include Christian teaching as part of health training. While they had this on paper, and various aid programs are helping with the other aspects of health teaching, there were no organizations able to integrate spiritual teaching in a ‘seamless’ way as part of a wholistic health program.

Because of our previous time spent in the country, we were well known and trusted by the health administration leadership, many of whom were former students and colleagues, and many are committed to seeing spiritual change as a major part of the solution to their nation’s problems. So it didn’t take much for all of us to realize that the ideas we were talking about fit with Medical Ambassadors’ main tenants-- prevention, an integrated wholistic approach, community ownership, the need to multiply the training of village health volunteers (already categorized as VHV’s by the health promotions office) throughout the country.

It was suggested that we work province by province, starting with Eastern Highlands Province where we had worked before. They were very receptive, and after having all the health centre officers-in-charge discuss the program, they passed a motion to use the MAI wholistic strategy to address the health promotion initiative of the National Health Plan. So in Sept. 2001 we did a Vision Seminar with leaders of all the churches in the province,

followed by the first level of the Training of Trainers with around 30 trainers who had been identified by their churches. Many were already health workers, some retired, and several were pastors. One young pastor later told us of his fear to come to such a course, knowing he had limited medical knowledge, but in that he had never before been invited to something by the health office, he felt he should come. Afterwards, having been told that they as pastors hold the key to the health of their village communities, he said he went home and “jumped up and down with excitement!” He truly caught the vision and has been influential in the changes in his community and surrounding areas.

After that first Training, it was obvious to the provincial health administrators that the concept would spread rapidly, and that they needed to appoint someone to coordinate the programs. Sister Julie Mosinakave was appointed. She was a nursing sister with many years of experience in community health, and is now fully dedicated to seeing the Community Health programs of the province move ahead and to supporting the trainers, all of whom are volunteer. This kind of cooperation from the Provincial health department has been very significant, as they continue the salary of Sr. Julie and also pay for the costs of the training programs. There have been several three to five day training courses conducted over the past 2 years, so that now there are at least 2 or 3 trainers in each of the 8 districts of the province.

Another significant factor in the cooperation that has been evident, is that there already exists in PNG a contractual arrangement with churches which are involved in health care, and they are all part of what is called Church Health Services. Since decentralization of health care to the provinces and district levels, the Provincial Health Office works closely with Church Health Services to manage all primary health care programs. As a countrywide average, 51% of health services are delivered by the churches, and in some provinces it is as high as 80% or more. This existing positive relationship between the government and churches in the area of health has been a major contributing factor to the success the Community Health Evangelism programs are experiencing.

The ingredients for cooperation are all in place: 1) the realization of the need to address the issue of the “gap” between the government health services and the willingness to access them by the people, 2) the mandate given by the WHO Healthy Islands Initiative and the National Health Plan to bring training in a wholistic manner, and 3) the additional mandate that the churches have through the Church Health Services to meet those objectives as they also fulfill the Great Commission by addressing the total needs of whole communities.

The Primary distinctives which Medical Ambassadors seeks to preserve in all their projects have fit very well in the context of the goals and objectives of health promotion in Papua New Guinea. These are, in summary:

1. Concentration on meeting priority needs keenly felt by the village in simple community projects---designed to teach the people to do as much as possible on their own. The attempt is to begin at the ability level of the people in relation to their leadership, initiative, and self-reliance.
2. An aggressive initiative of going to the people, with a vision to reach the most people possible, rather than expecting them to come to our or others' programs.

3. Integration of preventive medicine, along with spiritual, emotional and social components into a truly wholistic program. The emphasis is on prevention and education, with expected results in changed lifestyles, living conditions and revitalized churches.
4. A program of instruction which shows the people how they can participate in their own development.
5. A commitment to delegate most of the tasks to local church leaders, community leaders, and then to village volunteers, who can best generate local support and commitment for the program.
6. An understanding that the content of the training must be kept as simple as possible in order for it to be transferable and multipliable.
7. A commitment that readily available local resources should be used as much as possible.
8. Provision for good cooperation with the national and local government health initiatives, and particularly the nearest available health centre, for necessary obstetrical, surgical and medical care of severely ill patients.
9. Participate in DOH mass immunization programs for measles, BCG, DPT, polio and HIV/AIDS programs.
10. An underlying principle of community ownership, where right from the beginning projects are initiated by and owned by the community rather than by outsiders.

After the first Training of Trainers in 2001, when the participants formed teams based on the districts where they currently lived and worked, some community awareness began. The second level of Training, about 6 months later, increased their understanding and motivation. They conducted more community awareness sessions in their villages, helped with the selection of a health committee in each area, and did 3 day training sessions with the committees, who were representative of community leadership. We began to see amazing changes after that process, even before the Village Health Volunteer selection and training had begun. Fencing out the pigs which before had run loose around and inside the village homes making kitchen gardens impossible, eating out of their cooking pots, and contributing to the skin diseases and intestinal disorders of the children, became a high priority. The villages we visited even a few months after the program started were proud to show us their new walkways, flower and vegetable gardens, dish drying racks with gleaming clean pots, and new pit latrines. When asked what they liked best about their improvements, several commented, "the air smells so nice now!" In one village, their rivals in the village upstream were consistently cutting the water line so there was no water piped to their village. We asked what they were planning to do about that, to which the committee chairman smiled. "We will wait until they come and ask us what we've done to change and if we could teach them to do the same. Then we'll go and teach them. After that there will be no more problem with the water." This is heart change, not just physical "window dressing." These same people told us that "nobody is telling us to change.... It is the Spirit of God within us making us want to change." The sense of pride and joy in their accomplishments was exhilarating to witness.

In 2002, we visited Mengino census area of the Lufa district, a remote area accessible only when the roads are dry. The district administrator and others had informed us that only 3% of people had pit latrines throughout the district of about 30,000 population. They added that just the Christians had latrines! When we asked why, they explained that the fear of sorcery and evil spirits lurking in small dark places was so strong that even though the health people had urged them to build latrines, they refused. However, now in Mengino, the most backward area of their district, we were told that every household has their own pit latrine. In spite of the mountainous terrain and slippery slopes we had been warned of, we had to see for ourselves. Walking for a total of about 10 hours through 14 villages, we were amazed to find every single household with a fenced and cleanly swept courtyard, many lovely flowers and walkways with steps down those slippery slopes, separate latrines for each family, many with attached wash stands, dish drying racks, not a pig in sight, clean healthy looking children, and some new kitchen houses being built to get the smoke out of the sleeping area. The local community health worker, who is one of our trainers, has noted that already after 9 months the visits to his aid post from those villages has decreased and that the children appear in better health. The committee members gathered with us to ask what they could do next, and indicated their willingness to collect a bag of coffee to sell from each household to help with putting in a water system. This kind of initiative will not go unnoticed by the local district administrator, who has already decided this will be a good area to introduce training for some integrated farming techniques, and other projects such as mushroom growing. The three churches in the area are working well together, with each of the pastors as part of the committees, and using the church buildings as focal points for the trainings. While we didn't get any specifics about church attendance in this area, in other areas we have been told that churches before almost empty are now full. This is indicative of the hunger that exists for spiritual teaching that is integrated with their real world and relevant to the needs of their lives.

No formal evaluation has been done to this point, however there is constant community feedback, more requests for training than can be met, and reporting of all activity to the government health authorities for funding accountability. Regular meetings of Church Health Services and Health Department representatives also take place. The gathering of statistics and objective reporting is a difficult exercise in a culture that has been largely oral and story-oriented. Until there has been a lot more training on reporting techniques, any statistics gathered are largely unreliable.

This also highlights the need for a trained national country coordinator who has a good understanding of the program and who can go around to each project in each of the currently 4 provinces which have started the program. Funding for this would likely have to come from outside the country initially, as each province has their own separate health budget. The model of support by the Eastern Highlands Province through allocating one of their health officers to oversee the programs would be an ideal in each of the provinces involved. One problem we see in rapid expansion is that of trained provincial training teams who are able to mentor others. While the desire is to grow rapidly in order to outrun the looming AIDS crisis, which is said to be 3-5 years away from another "Africa", we realize that sustaining the enthusiasm of trainers, committees and volunteers takes time and personnel at the coordination level. As government infrastructure and funding levels deteriorate, again there may be increasing need for outside aid for the support of national supervisory personnel. This is not ideal, as it goes against the self reliance distinctives, but may be necessary at the initial stages.

In summary, the Community Health Evangelism/ Village Health Volunteer program that is being implemented in Papua New Guinea meets health department initiatives for health promotions in a wholistic context. It could become, we believe, a model for other developing countries where health authorities and churches are willing to cooperate to see the lifestyles of their people improve. We see the timing right now as being significant, as World Health Organization and governments recognize the validity of the wholistic approach. As Christians, we understand what this truly means from a Biblical perspective, and that this really is the solution modeled by the ministry of Christ. The opportunity is unprecedented, as the mandate is being held out to us. In a pessimistic world, we have a model which can bring wholeness and hope for a brighter future to the poor of this generation, a desire that we know emanates right from the heart of God.

APPENDIX "A"

Memorandum of Understanding between Ministry of Health in Papua New Guinea and Medical Ambassadors International:

Whereas the Ministry of Health of Papua New Guinea is charged with the total health care for the nation and whereas a major component of their plan is providing health promotion which emphasis the prevention of disease and the promotion of good health:

Whereas about 40 to 60% of all health care is provided by church-related institutions coordinated by Church Health Services, which has a desire to deal with the whole person's physical, spiritual, emotional and social health:

Whereas Medical Ambassadors International has 15 years experience in developing and implementing wholistic community-based programs in 56 countries of the world and is continually refining the strategy to make it more useable in different cultures, ethnic, political and religious situations, and pulls together many different disciplines such as public health, agriculture, management, community development and mobilization for effective community-based health:

It is to the benefit of the three named organizations to enter into this Memorandum of Understanding to accomplish the goal of equipping individuals to take more responsibility for their own lives, in such a way that it will be multiplied throughout each community and then from community to community throughout a province thereby transforming the nation's wholistic health from the inside out. The program is to be called Church Health Services/Village Health Volunteer (CHS/VHS) program.

The program will be implemented one province at a time down through selected districts in the target province to individual wards until potentially all provinces are involved.

Each organization agrees to do the following:

MEDICAL AMBASSADORS INTERNATIONAL

1. MAI will provide continual updating on strategy, research and development, multiple models, modifications, materials and expertise to assist partners in implementation of CHS/VHV throughout the organization without any fees or charges.

2. Provide a Field Director to coordinate the CHS/VHV program at the national and provincial level. Their role is to equip the province and district coordinators to become trainers of trainers.

3. Provide training materials and lesson plans for translation and use.

4. MAI Field Director will visit selected CHS/VHV projects for consultation as agreed upon between both parties and be available for troubleshooting in regard to such projects.

DEPARTMENT OF HEALTH

1. Will provide and pay for a provincial CHS/VHV Coordinator who will be chosen by CHS and approved by the Provincial Health Advisor. This person will coordinate all CHS/VHS work in the province.

2. The intent is to have a CHS/VHV coordinator in each district to train and coordinate work of local ward/village training teams and act as their mentor in implementation of village programs. The district coordinator will be paid, supervised and accountable to the provincial ministry of health office.

3. There will be local ward/village training teams that will be equipping local villagers to be CHS/VHV's. These local training teams will be volunteers provided by the churches involved with CHS. These CHS/VHS will function under the direct control of village committees. In addition to doing health education they will assist the community in implementing community improvement projects.

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CHURCH HEALTH SERVICES

1. The CHS, recognizing that the government's first priority of the 2010 Health Plan is health promotion, will encourage their member organizations to participate in the CHS/VHV program Training of Trainers seminars at the province and district levels as agreed upon

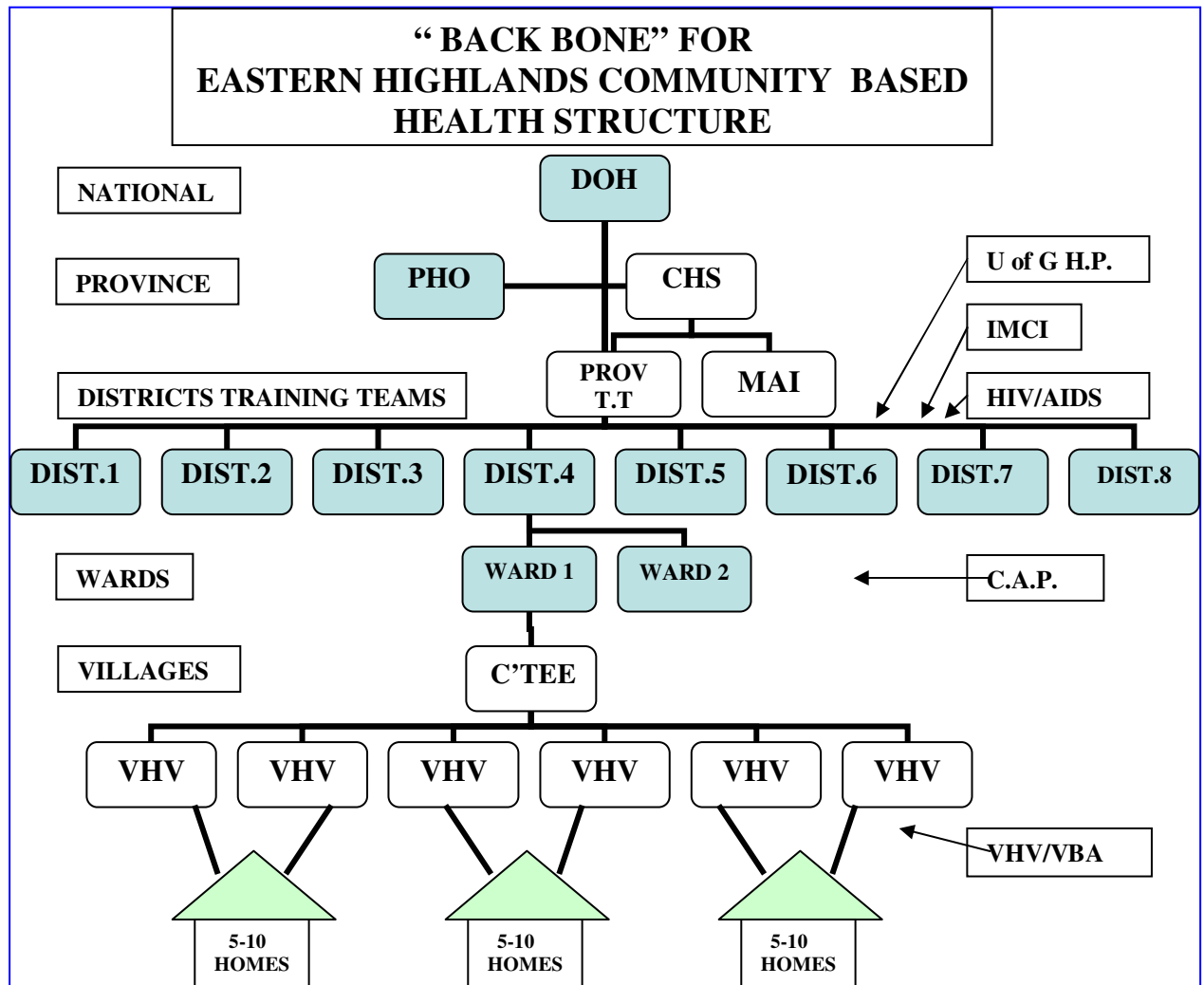
2. Will implement the CHS/VHV training at the village level

3. CHS will provide committed church people to be the provincial and district Coordinators for the CHS/VHV program.

4. Will provide committed people from local churches to be trained as local trainers for the CHS/VHS village programs.

APPENDIX “B”: HEALTH PROMOTION ACTIVITIES IN EHP

In April 2001, the EHP adopted this wholistic approach to be coordinated through their strongest partner in health care delivery, **Church Health Services**



Advantages of a coordinated approach which directs all health promotion activities through the above “back bone”:

1. Achieving policy directives of National Health Plan 2001-2010 in health promotion, following the WHO “Healthy Islands” Initiative
2. Wholistic approach, through Church Health Services
3. Strengthening the partnership with Church Health Services, currently providing 51% of health care service throughout PNG
4. Home-based, therefore affecting greatest behavioral changes with family members
5. Cost-effective, using internally motivated volunteers and fostering self reliance

6. Multiplication affect of training, from the Provincial Training Team through District T.T.'s to volunteers who teach in the homes
7. Vehicle for all awareness programs, including HIV/AIDS, DOTS, Malaria control, IMCI, VBA/VHV, to the home level