

## LEPROSY AND PRIMARY HEALTH CARE WORKERS IN PAPUA NEW GUINEA

Sir,

The 3 major components of the leprosy control programme in Papua New Guinea are: rural para-medical workers, an integrated leprosy service subject to central control, and a standard management for the disease. The difficult terrain of Papua New Guinea, combined with a multilingual and geographically isolated population offers a peculiar challenge to health administrators. The village Aid Post Orderly (APO) has limited primary education, and his medical training is directed at the recognition of symptoms and their treatment, and the supervision of village health and hygiene. Above the APO, but still a primary health worker is the Health Extension Officer (HEO). HEOs have 10 years of schooling followed by 3 years of paramedical training. HEOs work in and from rural health centres but an essential component of their work is the supervision of the work of APOs in their district. The APO works usually in the village of his birth, while HEOs cover a larger population of 5 to 10 thousand people, and 5 to 10 or more APOs. The average HEO seems more at ease dealing with individual clinical problems in the health centre, and least happy in dealing with broader community related problems, including the supervision of APOs. The HEO is often not indigenous to the area he is working in, and may find himself at a cultural disadvantage in dealing with his subordinates.

The origins of leprosy in Papua New Guinea are uncertain. Early attempts at control through establishment of leprosaria and the enactment of restrictive laws proved ineffective. After the Second World War a separate leprosy service was born which was successfully integrated into the general health services in 1974. However the professional and technical aspects of the leprosy programme are still subject to central direction and control.

The third component of the programme has been the concept of the standard management of common diseases. Standard management rationalizes drug treatments, and thereby the pharmaceutical services. The standard management of tuberculosis and leprosy has been described by Kennedy.<sup>1</sup> In principle medical officers are expected to use standard managements, for the sake of unity and as an example to paramedical and other workers. In practice medical officers have usually received insufficient indoctrination into the importance of standard managements: or they complain of restrictions of their clinical freedoms: or they may feel that standard managements are not the optimal form of treatment for individual patients. In consequence the management of leprosy by medical officers, but not by primary health workers, is often bewilderingly varied.

APOs cannot initiate treatment for leprosy, but HEOs may if: there is a characteristic, anaesthetic, skin lesion: AFB are found in skin smears: there are thickened nerves. In practice HEOs are urged to obtain a second opinion from a superior before starting treat-

ment. Treatment is in two stages: in the first phase the patient is given daily supervised treatment, either as an out- or in-patient in hospital or rural health centre, depending on social, geographical and physical factors. During this phase the patient receives treatment, and health education and contact tracing are instituted. In the second phase treatment is contained with either daily self-administered dapsone, or twice weekly supervised dapsone. These treatments are given by or through village aid posts or rural health centres. APOs are instructed in giving treatments according to the standard programmes, recognizing if things are going wrong with the patient's progress, and keeping records of attendance. If treatment is being given through an aid post it is the duty of the supervising HEO to check that treatment is in fact being given correctly. Equally it is the function of medical officers in district hospitals to supervise the work of the HEOs. This also is an area where deficiencies occur. The majority of medical officers are clinically orientated, more at home in a hospital. Equally, the majority of medical officers in Papua New Guinea are still expatriates, most of whom have had little training or experience in the administration of public health programmes, or of the management of leprosy. The indigenous medical officers, trained at the Medical Faculty of the University of Papua New Guinea have received extensive training in community medicine, the importance of aid posts and rural health centres, and spend part of their residency programme working in isolated health centres. Despite this, these medical officers are not interested in Primary Health Care. The reasons for this are not always apparent. However, the University always has difficulty in filling the places available in the medical faculty. For those who do choose medicine, the rewards are to be found in well appointed urban hospitals. This attitude has been reinforced by some expatriate medical teachers who have emphasized the importance of hospital based treatment, and denigrated the role of rural health workers.

In terms of the management of leprosy, the present system has many advantages: it is inexpensive, making use of facilities which already exist: it serves the rural population where leprosy is found: it is spread across the whole country. The important constraints are: because of the success of the earlier vertical programme there is still widespread lack of enthusiasm for the integrated programme among all levels of health workers, many health workers have had little experience in the management of leprosy, and a new patient can generate considerable anxiety, and traditional attitudes to health are still widespread. Health is seen as being in the right relationship with the community and the environment, physical and spiritual; ill health is necessarily the result of a wrongful relationship and this can only be righted by traditional medicine, payment of compensation, magic or sorcery, pig-sacrifice or a combination of these. It is evidently impossible for a health worker who still clings to some of the old values to put his trust entirely on a handful of pills. A useful synthesis of traditional and western, though often accepted in principle, has not yet occurred.

The evidence in Papua New Guinea is that where there is enthusiasm the programme works well. The on-going education of all levels of health workers seems to be the basis for a successful programme, and will have to underpin the programme in the future. If sufficient enthusiasm and knowledge can be generated then most leprosy patients can look forward to a rosier future.

MYRA KENNEDY

H RÉE

*Hospital for Tropical Diseases*  
4 St Pancras Way  
London NW1 0PE

#### Reference

- <sup>1</sup> Kennedy M. *Standard Management of Tuberculosis and Leprosy in Papua New Guinea*. Port Moresby: Public Health Department, 1979.