REPORT

WORKSHOP ON PRIMARY HEALTH CARE

Kavieng, New Ireland, Papua New Guinea
25-30 April 1983

Manila, Philippines
June 1983
REPORT

WORKSHOP ON PRIMARY HEALTH CARE

Convened by the

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Kavieng, New Ireland, Papua New Guinea

25-30 April 1983

Not for Sale

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NOTE

The views expressed in this report are those of the participants in the Workshop and do not necessarily reflect the policy of the World Health Organization.

This report was prepared by the World Health Organization Regional Office for the Western Pacific for Governments of Member States in the Region and for participants in the Workshop on Primary Health Care, held in Kavieng, New Ireland, Papua New Guinea, from 25 to 30 April 1983.
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1. SUMMARY

A workshop on primary health care was convened by the WHO Regional Office for the Western Pacific at Kavieng, New Ireland Province, Papua New Guinea from 25 to 30 April 1983. A total of sixteen participants attended the workshop, the majority of whom were from island countries, Papua New Guinea and Indonesia as well as an observer from Australia. The participants reviewed primary health care development in their own countries and described the situation in their country reports. Primary health care development in the context of the island countries differs significantly from that of the larger countries because of the geographical situation and the number of population.

The papers presented by the speakers provided an appropriate background for the discussions. The field visit to the villages around Kavieng provided participants with a better illustration of the constraints as well as of the achievements in the development of primary health care.

The group discussions focused on practical issues and constraints in primary health care development, and provided participants with the opportunity to exchange their experiences extensively, and to describe what they had learnt from these experiences.

It was the consensus of the participants that primary health care is "a total development, a broad strategy covering all human needs and using as far as possible community resources. The responsibility for and control of primary health care lies with the people, with cooperation from outside the community."

The participants noted that, for the future development of primary health care, more attention should be paid to the following: strengthening of existing structures and utilization of resources within the communities such as the churches, and other nongovernmental organizations, and village or community resources; education of decision makers to ensure that primary health care is not regarded as inferior health care but is active and growing individual and community participants in improving village life in all its aspects.

Finally the participants considered that the workshop had been quite a useful experience although more time should have been available for discussions on topics like training and utilization of peripheral health workers and components of primary health care.

2. INTRODUCTION

The workshop was organized by WHO and funded by ADAB. Participants were invited from nine countries or areas to discuss primary health care development. Kavieng in Papua New Guinea was selected as the site of the workshop for the purpose of sharing field experiences. The workshop was conducted in English.
3. OBJECTIVES

The objectives of the workshop were:

(1) to exchange experiences in the development of alternative approaches in the health care delivery system through primary health care, with emphasis on the development of training and utilization of peripheral health care workers;

(2) to identify strategies for the application of the principles of the primary health care approach.

4. ORGANIZATION

The workshop met in plenary session for the opening ceremony in the course of which addresses were delivered by the Regional Director, WHO Regional Office for the Western Pacific, the Premier of New Ireland Province, and the representatives of the Ministry of Health and ADAB. These was followed by the election of the Chairman, Vice-Chairman and Rapporteur. An overview was presented of primary health care development in the Region, describing the various stages of development among the Member States. Country reports on primary health care were also presented and summarized. The plenary session closed with an introduction to the field visit by the Provincial Health Officer of New Ireland Province.

The second day of the workshop was devoted to a field visit to villages around Kavieng.

The third day started with a plenary session during which three speakers presented background papers: Primary health care in Papua New Guinea, the Malalaua Project, and Health services research in Papua New Guinea, findings and recommendations. These was followed by a group discussion on sharing of experiences and insights in primary health care development.

The group discussion was continued on the fourth day. The participants were given a situation whereby they had to outline a presentation to higher or senior health officials explaining what primary health care projects were trying to achieve and how these would contribute to solving health problems.

At the end of the day, the group work was presented to the workshop in the plenary session. Subsequently, the participants were given a second exercise on how to deal with issues or constraints.
The group discussion was continued on the fifth day. The participants were given a situation in which they had to assemble a team to implement primary health care and identify the major issues and constraints. They had to outline a plan of action to their senior health staff and describe what should be done to handle the constraints and issues, and what resources and support would be required.

The group work was presented at the plenary session. In the afternoon the participants were requested to prepare an individual plan of action to be implemented when they returned home to their own area of responsibility.

On the final day, the participants presented their individual plan of action, followed by a presentation on the future development of primary health care. This was a summary of the issues and constraints identified in the course of the workshop which had to be addressed. Particular emphasis was laid on the strengthening and support of existing structures and resources, intersectoral coordination, better utilization of resources within the community, i.e. churches and other nongovernmental organizations, educating the decision makers, trainers and the community to ensure that primary health care did not translate as poor health care but as active and growing individual and community participation in improving village life in all its aspects. The issue of the increasing urbanization effect of socio-economic development and social change was also discussed.

The workshop was formally closed by the WHO Representative and Programme Coordinator, Port Moresby.

On the last day, the participants were invited by the Provincial Government of New Ireland to attend the official opening of an aid post where the participants enjoyed the hospitality and cultural activities offered by the local people and the Provincial Government.

Throughout the workshop, a steering committee consisting of the Chairman, Vice-Chairman, Rapporteur, the chairmen of the groups, the temporary adviser, and the secretariat met to discuss the conduct and progress of the workshop and to ensure the achievement of the objectives set for the workshop.

The workshop expressed its gratitude to the Government of Papua New Guinea for acting as host to the meeting. It also acknowledged with thanks the hospitality of the Provincial Government of New Ireland Province, its provincial health staff and many others, which had helped to make this workshop a success.

The workshop also acknowledged with gratitude the assistance of ADAB in financing this meeting and of the people of New Ireland and particularly of the villages around Kavieng who had shared their experiences in the development of primary health care.
5. FINDINGS AND CONCLUSIONS

5.1 Concept of primary health care

The participants noted that different countries have concentrated on particular aspects of primary health care depending on their special circumstances. The participants felt that it would facilitate the discussions if a workshop would define the concept of primary health care.

Primary health care was defined as being a total development, a broad strategy covering all human needs and using as far as possible community resources. The responsibility for and control of primary health care lies with the people, with cooperation from outside the community.

5.2 Planning

The participants reviewed the process to establish primary health care and agreed upon the following steps:

- selection/nomination of primary health care project officer/coordinator;
- establishment of political, departmental or agency support and commitment of resources and advisory services through workshops and publicity;
- establishment of community support and participation through workshops; this includes nongovernmental organizations such as church groups, women's groups and youth leaders;
- outlining of criteria for the choice of villages, e.g. good leadership, the level of socioeconomic development, suitability for technical and administrative supervision;
  - identification of basic community needs and priorities;
  - joint planning with the community of action programmes;
  - identification of resources, from both within and without the community, with emphasis on self-reliance;
  - regular evaluation of progress for improvement and solving of constraints and problems.

5.3 Community involvement

The workshop considered the role of the community crucial in the development and implementation of primary health care. Community involvement should be seen to be necessary not only in the implementation stage but from the planning stage onwards. Thus the community must have the right to establish or change the direction of primary health care.
In order to ensure full community participation, it is necessary to help organize the community. Through community leaders and the community organization, a better division of labour in implementing primary health care activities will be established, traditional health activities will be incorporated, and intersectoral coordination at the community level will be ensured. Through the community organization, needs and priorities will be identified and decided by the communities.

It is also important to clarify the roles of the communities and outsiders such as health staff so that a true partnership may be developed among those involved in primary health care. Wherever possible, primary health care must become part of the traditional way of life. New and old ways must be seen to be complementary and not in conflict. The traditional authority structure must be respected and capitalized on to promote community participation.

5.4 Resources

The participants realized that the stimulus to introduce primary health care may come from outside the community, and that resources such as technical and financial assistance will be necessary. However external contributions should be seen as support only to the community. Such external resources must be coordinated at each level to avoid unnecessary duplication and confusion for the community.

The participants stressed the need for a free flow of information on developmental activities and frequent communication within communities, between external sectors, and between communities and external agencies. Frequent consultation between the participating agencies and the communities and reporting of progress to the higher authorities, including politicians, will enhance the development of primary health care. There is a need for continuous promotion of primary health care at all levels of the administration and among the countries in the Region.

5.5 Village health workers

Participants expressed great interest in the concept of the village health worker. The question of payment was discussed and it was agreed that it was for the community to decide whether payment should be paid in kind or on a fixed salary or voluntary basis.

The knowledge of the health workers may need to be upgraded for reasons of self-sufficiency and efficiency and also to meet certain qualification requirements. The development of curricula for the training of the health workers should be practical and related to problems faced by health workers. The motivation of health workers should be promoted through closer supervision. The participants expressed the need to strengthen the training programmes for all levels involved in primary health care.
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Allow me first of all, to say that, while I am unable to be personally present today, you may rest assured that I shall follow the proceedings of this meeting with the keenest interest. I would like to express my gratitude to the Government of Papua New Guinea for serving as host country to the workshop. I also wish to thank ADAB for its contribution in funding this workshop.

It is now more than seven years since resolution WHA28.88 was adopted, urging Member States to develop and implement plans of action in the area of primary health care and calling for an international conference, which was to materialize as the Alma-Ata Conference of 1978. Since that time, countries have proceeded to implement different phases of primary health care, the emphasis and entry points in each varying according to local circumstances and individual conditions.

There is, however, one theme which is common to all these efforts, and that is the need felt and the intention to integrate at the community level all the elements necessary to make an impact upon the health status of the people, as evidenced by epidemiological data on health and disease as well as by relevant information concerning the environment and lifestyle. In following this orientation, the health care system needs to re-interpret the concept of health and to broaden the scope of its mission to include the development of the people's capabilities for leading a socially and economically productive life, in this way achieving community self-reliance in health. This is the ultimate goal of health for all by the year 2000.

For too long, health has been regarded mainly as a physical condition of the individual, and health care a private affair between the patient and the doctor. Recently, we have witnessed a welcome shift in this perspective. Health is now viewed from the standpoint of the individual's total well-being and includes not only the state of his body but also his environment.

The concept of the environment is in itself broad, for it includes both the physical environment and the social environment. This new perspective has necessarily resulted in a more comprehensive concept of health care. The individual is no longer an isolated unit of the community to which he belongs, and thus, concern about the health of the individual automatically implies concern for the well-being of his community as well. This new dynamism is characterized by a new thrust towards community participation and organization at the grassroots level in villages and municipalities.
Annex 2

I am convinced that the implementation of primary health care requires more than just a political commitment by countries. It is precisely for this reason that we are gathered here in Kavieng to discuss problems and constraints, sharing our experiences in the implementation of primary health care. The Kavieng primary health care activities will serve both as an example of how the provincial government of New Ireland has been able to implement primary health care as well as an illustration of the problems and constraints encountered in the implementation of primary health care. I am happy to note that this meeting will go far beyond reviewing these problems and constraints, and will give more time to discussing the necessary action to be taken to implement primary health care.

The success of the workshop will depend largely on your own initiative and participation and in the final analysis on how you benefit from this experience and put it into practice in your own countries on your return.

Ladies and Gentlemen, thank you very much for your kind attention. I wish you all a very successful meeting and some fruitful discussions.
CHAIRMAN, RAPPORTEUR, GROUPS

Workshop Chairman
Mr John Vilivili
Workshop Vice-Chairman
Dr I. Leweniqila
Workshop Rapporteur
Dr C.J. Miller

Group I
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Dr Soesilo
Mr C. Goie
Mr J. Johang
Mrs K. Rengiil
Ms M. Phillips
Mr T. Benjamin

Group III
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Ms V. Tekiree
Mr J. Vilivili
Mr S. Waisi
Dr M. Elisaia
Ms D. Vesikula

Group III
Mrs Dobui
Mr J. Yali
Dr L. Sialis
Mr D. Lilimae
Mr A. Bule
Dr C.J. Miller
Ms U. Pula
SUMMARY OF COUNTRY REPORTS

1. General information

(a) Size and population range

Sizes of countries range from less than 25 sq. km to 462,840 sq. km, while population ranges between 1600 and 3,010,727 with three different groups of population sizes: (1) less than 10,000; (2) = 100,000; (3) over 0.5 - 3 million.

(b) Organization of health care system

The organizational pattern of health care systems appears to be either two-tier or three-tier systems having secondary or tertiary medical care on the top tier.

Due to large bodies of water between different outer islands, which is common to all island countries, communication and transport seem to present major problems in the delivery of health care, especially in referral services.

(c) Types of health personnel

Types and categories of health manpower available in different countries reported appear to be similar, namely, physicians, nurses, medical assistants/health assistants or health extension officers, and various categories of technicians and aides.

A trend is observed in the development of medical assistants and other middle level health workers such as nurse practitioners to man health centres or similar facilities while peripheral health workers such as village health workers in some countries are also developed where there are no peripheral health workers such as APO.

(d) Disease patterns and common health problems

Communicable diseases, skin conditions, respiratory ailments seem to be the most common health problems in most of the countries reported while malaria presents one of the major health problems in the Melanesian countries. Diarrhoea and malnutrition remain important health problems. Water supplies seem to be commonly seen as a major problem related to health and daily living in most island countries.
2. Overall picture of the status of primary health care development

(a) Present status of primary health care development

Most countries seem to have adopted some policies regarding primary health care as they are committed to HFA/2000 through the primary health care approach. It would seem that the promotional activities have not yet been able to get the countries to systematically implement primary health care with a detailed plan/strategy for overall primary health care development; however, different components of primary health care seem to be implemented in various activities.

(b) Training of health personnel in primary health care

Health workers such as medical assistants, nurse practitioners, village health workers, and village sanitarians have been introduced for primary health care activities.

Initial reorientation of existing health personnel in the primary health care approach has been done; need for training in primary health care management and technology in primary health care is upcoming.

Village health workers in some countries seem to be voluntary health assistants while in other countries they serve as liaison between the health system and communities, receiving remuneration from the government and from the village they serve.

(c) Status of community involvement in primary health care

Most countries, although limited to certain areas, seem to have developed community organization or strengthened existing traditional community organizations such as village development committees or women's committees as mechanism for community participation in primary health care.

(d) Financing of primary health care

It seems that financing of primary health care was not discussed in the reports.

(e) National coordinating mechanisms for primary health care development

Only a few countries, including Papua New Guinea and Solomon Islands, are reported to have established a national coordinating mechanism for primary health care development at the central level with a post of national coordinator for primary health care or chairman of primary health care committee. Otherwise, ad hoc meetings of various departments concerned seem to serve the purpose of national coordination for primary health care development.
(f) Restructuring of training curricula, including nursing training for primary health care work

Although most countries seem to favour the restructuring of training curricula for various health workers in primary health care, few countries appear to have taken actual steps.

(g) Problems encountered in relation to primary health care development

- lack of understanding in primary health care concept/approach on the side of the community;
- no national coordinating mechanism for primary health care development;
- lack of knowledge of technical details of primary health care development;
- target population is scattered in outer islands and health workers are hampered due to lack of transport;
- low morale of health workers due to adverse living and working conditions;
- lack of community enthusiasm and involvement;
- low credibility of health workers perceived by community in some countries;
- due to transition period of organization of local government, primary health care does not get sufficient support;
- lack of community system between outer islands and periphery;
- shortage of qualified health manpower in primary health care;
- insufficient health budget.

3. Developmental areas in primary health care project

Developmental projects or pilot projects in primary health care development in selected communities have been observed in many countries including Papua New Guinea, Vanuatu and Fiji. These projects seem to be at different stages of development.
Annex 4

4. Plan for future development of primary health care

Future plans for development of primary health care in the South Pacific:

(a) intensify pilot/developmental projects to develop mechanisms for community participation, and technical knowledge for primary health care development and country-wide implementation;

(b) establish mechanisms for intersectoral coordination at various levels;

(c) solicit external support for:

- financing projects;
- expertise in manpower training;
- implementation and evaluation of primary health care development.
ANNEX 5.1

PRIMARY HEALTH CARE IN PAPUA NEW GUINEA

by

Dr Kingsley Gee

The Papua New Guinea health systems has for many years contained some elements of a primary health care approach. A framework exists on which a strong system of primary health care can be developed. Whether this will happen or not will depend on solutions to problems raised in this workshop and especially upon the degree of practical commitment shown by the national and provincial governments.

Medical services developed by the colonial administration were initially restricted to centres of European population and to plantations and mining fields. The German administration set up a system of heil-tultuls to provide a very basic level of health care. This was later expanded and covered many villages by the late 1930's.

After the second world war training schools for all levels of health workers were established and in the 1950's and 1960's there was a great expansion of health services.

With independence in the mid 1970's decentralization became important and now provincial governments have control over most aspects of health care with the national health departments providing mainly technical and advisory services.

Papua New Guinea has accepted primary health care as the basis for developing health services but a true system of primary health care does not yet exists in the country.

Some of the problems are:

(1) Conflict between traditional beliefs about disease and health and the western medical system. Traditional beliefs remain very important to many people. Attempts to integrate elements of both systems were discussed.

(2) Community participation is often limited perhaps as a result of seeing health services as something to be provided by the government without opportunity for local decision making.
Annex 5.1

(3) Integrated development programmes are relatively new to Papua New Guinea but the idea of a multi-sectoral approach to community development is becoming accepted.

(4) Aid post orderlies are underutilized and poorly supported. They could be used much more to assist in community development programmes.

(5) If there is no strong active political commitment to accepting primary health care and a willingness to re-allocate resources the initiatives taken at the local level will not develop.
THE ROLE OF THE AID POST ORDERLY IN
PRIMARY HEALTH CARE IN PAPUA NEW GUINEA

by

Dr J.M. Bolton

The origins of the Aid Post System started 80 years ago when Village Health Workers were appointed in New Guinea to treat wounds and minor illnesses. They were mostly illiterate and received three months initial training. They were real "grass roots" health workers and by 1939 there were over 4 000 working in New Guinea, over twice the number of Aid Post Orderlies today employed in this region.

Training of Aid Post Orderlies (APOs) started in 1946; these part time workers received some support from this community. By 1960, they numbered over 1 000. Between 1960 and 1970 there was a change of policy. Aid Posts in remote areas were closed, APO training was stopped and untrained Hospital Orderlies, displaced from Health Centers by trained nurses, were posted out to Aid Posts. In 1969-1970, a severe influenza epidemic left many people dead. With poor communications and inadequate supplies in rural areas, the health authorities were unable to cope with the situation and many of the deaths were only reported later when a study of the mortality was undertaken. This led to a change of policy and in 1972 it was decided that the Aid Post System should be re-organized and expanded and that APOs should become full time workers. The training of APOs was restarted. The trainees had completed their primary school education and some had been to high school. The training course for APOs was now a two year course.

Whereas the medical aid of 1903 was illiterate, he was very much part of his community. Today, the APO is a full time government servant, socially and financially better off than the community he serves and not regarded by the community as one of them.

Although the Health Department today states that the APO is the backbone of the Health Services and the front line man in the thrust towards primary health care, only 2% of the health budget is spent in the APO system, the APO is looked down on by other health staff and receives few supervisory visits.

The community appreciate the service the APO provides them but they do not regard him as one of their community and the people rarely make a complaint against an APO who is frequently absent or lazy unless the APO has committed a moral offence in the community. The APO regards himself as neglected Public Servant in a 'dead end' role.
Annex 5.2

The APO is a vital link in the health system between the health services and the community. Owing to the APOs detachment from the community and the poor supervision and neglect by his supervisors in the health service, this vital link is often fragile.

The APO usually performs well in giving treatment for acute infections, malaria, diarrhoea and skin diseases, but makes little attempt to educate the community in health or nutrition. On an average he is present at the Aid post for three hours a day from Monday to Thursday, and for one hour on Friday.

The Aid Post Orderly is in need of regular and appropriate supervision and of regular and better in-service training. With these, the quality of service could be much improved. The proposed duties and training curriculum for APO Supervisors still need to be ratified and training for APO supervisors has only been held in two provinces. The in-service training for APOs is best combined with the in-service training of all other health staff in Health Centre; this is what is done in the Southern Highlands Province.

A communication gap has been identified in some areas between the traditional clan leaders who are influential in the community and the government and political leaders through whom government service and policies are implemented.

Formerly communities were deeply concerned with health, spending much time and expense on rituals directed towards health and combating diseases. Now, in as much as they have accepted Western medicine, the people have allowed outside professionals to take over responsibility for their health. Of the three institutions in the villages, the church, the school and the aid post, the church and school are very powerful with well educated people in-charge and their services are constantly needed by the community. The APO is less well educated, less authoritative and is not needed by the people unless they are sick.

The APO through his Village Health Committee should give technical advise and support to the village development committees when they plan and implement their PHC projects. However, this is not always the case and sometimes the APO is by-passed by more senior health staff when they are giving support to PHC projects in the village.

Health staff in Papua New Guinea have often identified the weaknesses in the Aid Post system but the difficulty has been in implementing the recommendations that have been made.

The article ended with 19 recommendations that have been made concerning improvements in the Aid Post System.
THE MALALAUA PROJECT
AN INTEGRATED COMPREHENSIVE COMMUNITY EDUCATION
FOR DISADVANTAGED CHILDREN PILOT PROJECT

by

John Vilivili

The main objective of this pilot project is to reduce the level of disadvantage where possible by attaching the root causes of malnutrition, by a concepted and integrated effort in order to improve education, health, nutrition, agriculture and the total community life generally.

In order to achieve this objective, the focus should be on community health and nutrition and the fundamental methodology must be educational in a broad sense. Detailed programmes must be district related and developed in close consultation with all levels of people in the villages concerned.

The Integrated Comprehensive Community Education for disadvantaged children project has programmed for improvement in the total living standard in the homes and villages. These programmes will either directly or via secondary persons improve the health and nutritional status of young children, pregnant and lactating and child rearing women by:

- direct intervention, remedial care and primary education in nutrition and basic health care, sanitation and hygiene.

- community based cooperative production of nutrition foods for consumption by the residents.

- training of intermediary extension workers in nutrition and basic health care concept thereby improving their ability to educate and motivate at village level.

The consequence of this project will be healthier, livelier and more receptive children. This project is programmed for areas with high malnutrition rate and the focus is on combating malnutrition.
DRAFT AGENDA

Monday, 25 April

8:00 - 9:00  - Registration
9:00 - 10:00 - Opening

- Welcome speech by
  - WHO Regional Director, read by WRC/Port Moresby
  - ADAB Representative, Ms M. Philips
  - Minister of Health, Papua New Guinea, read by Dr C. Babona
  - Premier of New Ireland Province, Papua New Guinea, Mr R. Seeto

10:00 - 10:30 - Coffee break
10:30 - 11:00 - Overview of PHC development in WPRO (Dr G. Nugroho)
11:00 - 12:00 - Open forum
12:00 - 1:00  - Lunch break
1:00 - 2:30  - Plenary session
  - Country presentation
2:30 - 3:00  - Coffee break
3:00 - 4:00  - Country presentation
4:00 - 4:30  - Summary of country presentation (Dr K.S. Lee)

- Introduction to the field visit (Dr L. Sialsis)
Annex 6

Tuesday, 26 April
8:00 - 4:30 - Field visit, with a short presentation on New Ireland PHC activities by Dr Sialis. Lunch served in the village.

Wednesday, 27 April
8:00 - 10:00 - Plenary session:
PHC in Papua New Guinea (Dr K. Gee)
The Malalaua project (Mr J. Vilivili)
10:00 - 10:30 - Coffee break
10:30 - 12:00 - Plenary session:
Health services research, findings and recommendations (Dr J. Bolton)
12:00 - 1:00 - Lunch break
1:00 - 2:30 - Introduction to group work
- Group work
2:30 - 3:00 - Coffee break
3:00 - 4:00 - Group work

Thursday, 28 April
8:00 - 9:00 - Group discussion cont'd.
9:00 - 10:00 - Plenary session
10:00 - 10:30 - Coffee break
10:30 - 12:00 - Group discussions on Situation I
12:00 - 1:00 - Lunch break
1:00 - 2:00 - Plenary presentation on Situation I and introduction to issues and strategies
2:00 - 4:00 - Group discussions on Situation II
- Coffee break
<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>8:00 - 10:00</td>
<td>Group discussions on Situation II cont'd.</td>
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<td>10:00 - 10:30</td>
<td>Coffee break</td>
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<td>10:30 - 12:00</td>
<td>Plenary presentation and introduction to identification of areas of collaboration</td>
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<td>12:00 - 1:00</td>
<td>Lunch break</td>
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<td>1:00 - 3:00</td>
<td>Individual preparation of plans of action</td>
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<td>3:00 - 4:00</td>
<td>Presentation of participants' individual plan of action for development of PHC</td>
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Saturday, 30 April

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<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>8:00 - 9:00</td>
<td>Presentation of participants' individual plan of action for development of PHC</td>
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<td>9:00 - 10:00</td>
<td>The future development of PHC (Introduced by Dr K. Gee)</td>
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<td>10:00 - 10:30</td>
<td>Coffee break</td>
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<td>Plenary session</td>
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<td>12:00 - 1:00</td>
<td>Lunch break</td>
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<td>1:00 - 3:00</td>
<td>Presentation of draft report</td>
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<td>3:00 - 4:00</td>
<td>Closing</td>
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<td>- WRC/Port Moresby closing remarks read by Ms C. Knaub.</td>
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<td>3:00 - 4:00</td>
<td>- Response from the participants.</td>
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