PACIFIC JOURNAL OF MEDICAL SCIENCES

{Formerly: Medical Sciences Bulletin}

ISSN: 2072 – 1625

Pac. J. Med. Sci. (PJMS)

www.pacjmedsci.com. Email: managingeditorpjms1625@gmail.com.

COVID-19 IN PAPUA NEW GUINEA 2020 – 2023

GLEN MOLA

Professor and Head of Reproductive Health, Obstetrics and Gynaecology, School of Medicine and Health Sciences, University of Papua New Guinea. Senior clinical consultant, Port Moresby General Hospital, Papua New Guinea
Email: gmola4@gmail.com

[*This article is based upon a presentation I was asked by the PM to make to the PNG-Australian Business Council meeting in Brisbane in 2022: and updated herewith*.]

Submitted: March 2023; Accepted: April 2023

COVID-19 IN PAPUA NEW GUINEA 2020 – 2023

GLEN MOLA

Professor and Head of Reproductive Health, Obstetrics and Gynaecology, School of Medicine and Health Sciences, University of Papua New Guinea. Senior clinical consultant, Port Moresby General Hospital, Papua New Guinea
Email: gmola4@gmail.com

[*This article is based upon a presentation I was asked by the PM to make to the PNG-Australian Business Council meeting in Brisbane in 2022: and updated herewith*.]

Submitted: March 2023; Accepted: April 2023

INTRODUCTION AND HISTORICAL SKETCH:

The first recorded case of COVID-19 in PNG was in March 2020. He was an Australian "Fly in fly out" (FIFO) mine worker who had been holidaying in Spain and came to PNG via Singapore; landed in Port Moresby and transferred to domestic flight to Lae, and then bus pick up to the Mine site. He became ill the next day and tested positive in the Mine site clinic. Hundreds of contacts were tracked down and one (a female on the same flight from POM to Lae) tested positive. Some people deliberately avoided testing, (including the bus driver from the airport to the mine site).

From this first case (to the end of 2020), active case detection and detection of COVID-19 in contacts of cases was the PNG policy and strategy of the PNG government and National Control Centre. However, by the end of 2020 it was clear that there was extensive community transmission and a policy of individual case surveillance and quarantining, and contact tracing was no longer appropriate.

Since 2020 we have had a number of waves of infections – December 2020, April 2021 (alpha or UK variant), June 2021 (Beta or South African variant), and November 2021 (Delta) and now with Omicron – since February 2022.

The Changing Epidemic and the beginning of 'way-out' community views:

By lockdowns and case surveillance, contact tracing and quarantining cases and contacts, PNG was able to avoid community transmission for quite a long time – 8 months from March to November 2020. The purpose of the lockdown strategy was to give time for the health system and the community (awareness, availability of vaccines and ramping up a vaccination program) to make adequate preparations for the local epidemic – so that the health system can cope, and that as many people in the community as possible can get vaccinated.

Looking back (wisdom in retrospect!), we should have scaled back lockdowns and started opening up the country again – for a return to

more normal economic activity – in about August 2021 when it became clear that lockdowns were causing very serious harm to the PNG economy, vaccine uptake was not progressing apace and the health system was as prepared as it was going to be for the circumstances we were in.

But as has been the case in many countries around the world, it took PNG several more months to become aware that we needed to move from the 'zero cases strategy', to managing the epidemic. And by taking rather extreme lockdown measures (when there was very little transmission, cases and deaths) the community developed the view that COVID-19 was not a problem for PNG, that Papua New Guineans were probably inherently immune to COVID-19, that vaccination was not necessary, and that the government did not know what it was doing.

I can remember taking part in some extraordinary meetings of the Senate of University of PNG (in April and May of 2020) where many non-medical members of the Senate wanted to close down the whole university – either for the remainder of the first semester (that is to open again in July), or for the whole of the rest of 2020 academic session. Members from the School of Medicine and Health Sciences (SMHS) tried to get the message across that "things are going to be worse in July (so it is not sensible to think of closing now and re-opening in the second semester in July 2020). And, as for next year (2021), it would not be sensible either, as we would probably have a full blown community transmission epidemic on our hands by that time".

We were saved by our 'poverty' at the time – we did not have sufficient funds to send the students home and bring them back again: so we just limped on from week to week – with the opportunity to review things at frequent intervals.

This was the first time I became aware of one of the extraordinary things about the COVID-19 pandemic – and that is, that lay people (those with no training, qualifications or experience in medical matters, public health or epidemiology) think they know as much as, or more than (or the very least, their opinion has equal weight to that of experts), the health experts. And, if there is a COVID-19 issue, then lay people think that if they can find one opinion (usually on the internet) that agrees with their opinion, then this trumps the 99% consensus of medical and public health views in the country and the world.

Between November 2020 and October 2021 we had small surges of new variants (Alpha in February/March, and Beta in June/July). These variants were a little more infectious, but they had the same demographic morbidity profile – that is, that young people were only seriously affected (or had the risk of COVID-19 disease death) at the rate of only about 1/1000 infections. Then, in October 2021, the Delta variant reached PNG, and in the month of November, we experienced between 30 to 50 deaths per day at Port Moresby General Hospital (PMGH), 8 young women died in the

labor ward, and there were 250 recorded COVID deaths in Goroka, Eastern Highlands Province (EHP) – including 27 school teachers.

There were, of course, many more deaths in the community. In fact, PNG has only recorded about 700 deaths in total, whereas there have probably been thousands of COVID-19 related deaths. This is because, to have a death recorded as COVID -19 related in PNG, there are a number of statutory requirements:

- The death must occur in a hospital – because only hospital deaths are death certified in PNG; deaths in the community are not registered.
- The person must have had an illness which clinically was considered to be typical of COVID-19 disease – that is, a clinical viral pneumonia scenario, and
- The patient must have had a positive PCR test for COVID.

Even if all the above are the case, many relatives ask the doctor certifying the death NOT to mention COVID-19 on the death certificate because of stigma issues, and also a COVID-19 death is much more expensive to transport to the home area for burial.

The actual number of COVID-19 deaths in PNG is anyone's guess – but it is probably in the tens of thousands. There was an excess of about 10,000 of adult 'pneumonia' deaths in 2021. I have recently sought some assistance from WHO for the Public Health division of the School of Medicine and Health Sciences to conduct community verbal autopsies of community deaths in 2021 in selected sites: let's see what this reveals.

Misinformation, Conspiracy Theories and Community Myths:

Misinformation and Conspiracy theories have hampered the government's effective response to the epidemic and produced massive community hesitancy and COVID-19 anti-vax views throughout the country. Examples of such community views are:

1. If the COVID-19 pandemic is real and a threat to PNG too, why are so few people dying from it? [The Wild strain, and the Alpha and Beta variants only produced serious morbidity (that is, disease) in very few young people: 75% of PNG's population is below 30 years of age.]
2. COVID-19 is just like a common cold or mild 'flu' – so what is the big deal? [No, it is not. When influenza viruses go down into the lungs, they cause an inflammatory response in the air-sacs, where gaseous exchange takes place; the inflammatory response can lead to an exudate of fluid which, if it fills up the air-sacs, can lead to lung dysfunction (Shortness of Breath: SOB; breathlessness), and serious disease or death. COVID-19 causes damage to the walls of the little blood vessels that form a basket around the air-sacs so that they cannot perform their function of taking oxygen into the blood stream and

releasing CO_2 - and this is why other parts of the body can be affected by COVID-19, because the little blood vessels in many other parts of the body can be similarly affected (leading to loss of smell, heart failure etc.) – and this damage can be permanent or long term. This is why people die or have symptoms lasting for months to years afterwards, a.k.a. 'Long COVID'].

3. Taking home remedies like ginger, garlic, betel nut, herbal treatments or some prescription drugs (like Hydroxychloroquine or Ivermectin), or ''steaming'' is all that is required to prevent or treat COVID-19. [Nothing wrong with home treatments, if they make you 'feel' better. But none of these treatments has any proven efficacy in scientific trials; and be careful of steaming, which can burn your airways and actually make your viral infection worse].
4. God will protect me/you, so just relax and keep praying. [This, of course, is just spiritual arrogance – we are not God's supervisors, and prayer is not giving orders or directives to God. And, Jesus gave very direct admonition to the Devil when he came to tempt Jesus that we are not to test or give orders to God – the Gospel story of Jesus being tempted in the wilderness by the Devil – go up to the highest pinnacle of the temple and jump down, because as you are the son of God He will direct his angels to carry you down without even leading to a scratch of your feet on the stones below. Jesus dismissed Satan with the admonition that God says that no one has the right to test God; not even the Son of God.]
5. COVID-19 vaccines are not safe, because they have not been properly tested and they are causing lots more deaths than COVID-19 disease itself. [This, of course, is not true – it is true that testing and safety trials have been done with great speed, but they have been done properly and there is no truth in the rumour that the COVID-19 vaccines cause lots of serious side-effects.]
6. COVID-19 vaccines are being brought to PNG to use on us as guinea pigs, and can alter our DNA so that we can be controlled from outside and be programmed to die in 6 months to 5 years. [Vaccines do not cause coins to stick on your arm, you cannot charge your mobile phone on the vaccination site, light bulbs do not light up when applied touched to the vaccination site – in spite of the hoax videos that one can see on U tube. There is no way the vaccine can alter your DNA, and it is just *'bullshit'* that people who have been vaccinated can be controlled by Bill

Gates, the Devil or anyone else, or are programmed to die at some specified time in the future by the vaccine. And there are actually some White Supremacist bloggers who are deliberately spreading rumours – 'so that black people will believe these ridiculous rumours, not get vaccinated and, therefore, will have a higher chance of dying in the epidemic.']

7. COVID vaccines are not effective, because vaccinated people are still getting COVID-19 infections and some are dying? [COVID-19 vaccines are not designed to completely stop infections – they actually have no way of stopping the virus of getting into your nose and mouth – but your chance of getting seriously ill (or dying) after vaccination is reduced by more than 100 fold.]
8. Vaccination can cause infertility, miscarriage, stillbirth and period problems. None of these rumours are true, and it is very much recommended by all international professional bodies that all pregnant women should get vaccinated. [This is because pregnant women are more likely to suffer fatal morbidity in late pregnancy with COVID-19 infection.]

My view is that the Government of PNG should have stomped on misinformation and conspiracy theories early on. However, this did not happen, and the conspiracy theories spread around the whole country, so that rural people in some of the remotest parts of the country are now not willing to get vaccinated because they have been influenced by them.

The other (related) issue is that there has never been a trusted and knowledgeable health/medical 'face' on the Pandemic and vaccination issues who was there to give regular information bulletins and Q&A sessions on various media channels and platforms. This person must be expert in communication, be able to explain complicated medical and scientific issues in simple and understandable language and have back up from expert public relations and media operatives.

Financing of the COVID-19 epidemic, vaccination and audit-acquittals:

There has clearly been a lot of money brought into PNG to assist the government continue its routine work and to finance the additional expenses of the COVID-19 epidemic and vaccination of the PNG population.

Over the past year, there has also been a lot of talk in the community about the misuse of 'COVID-19 money'. And indeed, the amount of money involved is huge. The COVID-19 funding situation in PNG is very complex, but it is clear where most of the K4 billion that people have been talking about derives from, and has been allocated to. Most of the money is concessional loans and grants to the Government of PNG for budgetary support to offset the financial

downturn of our economy due to the COVID-19 pandemic: these allocations have been made through the Department of Treasury. Example: 2 allocations of K520m and K865m, respectively, from the Asia Development Bank, K960m from the Government of Japan, K1.2 billion from the International Monetary Fund, K346m from the World Bank, and about K300m from DFAT (Australia). This all adds up to K4.1 billion. Much of this money will need to be paid back (albeit over a very long period of time and attracting very low interest rates.) Some is gift/grant money, like the K300m from DFAT. In addition, DFAT allocated about K220m to the Parliament of PNG, so that all MPs got K2m each, 'so that they could assist the COVID-19 epidemic response in their districts'. Everyone should consider how much of this K2m per MP has been seen to benefit the health district health services and, in particular, the district health response to stop the COVID-19 epidemic. The K4.1billion that has gone into budget support (mostly in 2020 when we hardly had any COVID-19 in PNG), so that PNG would not suffer too much economically because of the shut downs and travel restrictions, can only be accounted for by the Departments of Treasury and Finance. The K240m that was gifted to the MPs for the COVID-19 district health response is up to the audit mechanisms of parliament to account for. The remaining K50-60 million that has come to various NGOs, UN agencies, etc. (from DFAT, UN agencies central HQs, European Union, USAID, NZ aid) are recorded in the "UN donor tracker" mechanism – that information is available to the public.

There has been some ill feeling between some organizations which have been the recipients of some of these 'donor funds' and the Controller (Police Commissioner Mr. David Manning), who is answerable to the parliament for COVID-19 expenditures. The Controller has asked various agencies who are known to have received COVID-19 funds for an accounting of the money. Some of the UN agencies have responded that they are not bound to respond to the Controller, as they have 'diplomatic immunity', or that they only 'report to their own organization's auditors'. Other organizations have ignored the Controller's request for information about how they have used COVID-19 money.

The situation in 2023:

Over the past 12 months, there have been very few serious illnesses from COVID-19 in the national capital, and few deaths recorded at Port Moresby General Hospital. One otherwise healthy University of PNG student was found dead in his accommodation after contracting an acute respiratory illness in 2022, but as this was a community death, it was never confirmed as COVID-19.

Many health workers in the division of Obstetrics and Gynaecology at Port Moresby General Hospital tested positive, when they presented with respiratory symptoms, but as all doctors in

the division are vaccinated, these illnesses have been mild.

Although only about 20% of the eligible (over 18 years) and accessible population (who live where vaccination has been made available) have been vaccinated, many other people have been infected and developed an immune response because of community acquired infections. It is unknown how many people are being infected in the community and there is no mechanism to keep track of community acquired infections. There is also no information from the verbal autopsy project in the community to help us understand whether there continues to be an excess of respiratory deaths occurring.

Vaccination is not readily available in health facilities. At the Port Moresby General Hospital maternity division, we tried to set up a vaccine clinic at the antenatal clinic in 2022; it took over 8 months for the responsible officers in the National Department of Health to eventually assist us in getting this vaccination centre set up.

REFERENCES:

1. Papua New Guinea COVID-19 response https://www.dfat.gov.au/crisis-hub/papua-new-guinea-covid-19-response
2. World Bank announces additional support for COVID-19 response and vaccine rollout: US$30m Boost for PNG's COVID-19 Response. https://www.worldbank.org/en/news/press-release/2021/06/25/us-30m-boost-for-png-s-covid-19-response
3. United States provides $4 Million U.S. Dollars to Support Papua New Guinea's COVID-19 Surge Response. https://www.usaid.gov/pacific-islands/press-releases/nov-15-2021-united-states-provides-4-million-us-dollars-support-papua-new-guinea-covid-19-surge-response