

## **Sexually transmitted infections: a medical anthropological study from the Tari Research Unit 1990-1991**

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### **SUMMARY**

**This paper describes medical anthropological research conducted while I was based at the Tari Research Unit for six months in 1990-1991. The research aimed to gain a deeper understanding of the social factors surrounding the transmission of sexually transmitted infections, which had escalated following a local gold rush in 1989. Although HIV/AIDS was a very minor health issue in Papua New Guinea at that time, medical staff were aware of the likelihood of the disease becoming prevalent in the highlands in the near future. The research indicated that many people regarded sexually transmitted infections (STIs) as a nuisance, rather than a serious health risk. Discussions with chronic sufferers revealed that they were more concerned about the dangers of infertility than the immediate effects of the infections. The paper considers the risk-taking that the people of Tari, the Huli, were prepared to accept and suggests ways in which these risks might be minimized.**

In 1988-1989 the people of Tari were caught up in more social change than they had ever before experienced. The gold rush on nearby Mount Kare had brought transitory and unprecedented wealth to a small number of the Huli people, as an estimated 100 million kina passed through the town in less than two years. The prices of food and other consumer goods on the gold field were highly inflated (for example a kilo of rice was K3, a bottle of beer was K5 and a chicken was K20); drinking parties, commercial sex and short-lived trucks had consumed most of the newfound wealth. By 1990, the gold rush had left few visible signs; very little business investment had occurred and the thousands who had lived and worked for months in the mud, enduring an inadequate diet and suffering in the cold, had little to show for their pains. A legacy of disease, however, had more long-lasting consequences.

In 1990 Dr Tim Dyke, Research Manager of the Tari Research Unit (the Tari Branch of the Papua New Guinea Institute of Medical Research), Dr Stephen Flew, Medical Superintendent of the Tari Major Health Centre (Tari Hospital) and Sister Pauline Agilo, Sister-in-charge of the Tari STD Clinic,

observed that sexually transmitted disease (STD) rates had increased by 50% in the previous two years since the beginning of the gold rush. This was a time when HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) was just beginning to enter the consciousness of medical officers in Papua New Guinea (PNG), although almost no one in the general population was aware of the potential problem. Only 51 people in PNG had been identified as HIV positive by 1990 and most of these were in Port Moresby, so most highland medical staff did not rate HIV/AIDS as a health priority. There were always far more pressing problems with respiratory diseases, child malnutrition and malaria taking up much of the research and clinical attention.

However, when I, a social anthropologist who wanted to branch into medical anthropology, presented myself as available for research for a six-month period, the Institute of Medical Research (IMR) was unequivocal in the project they wanted undertaken. The IMR, after reviewing the available evidence from Africa which suggested that heavy STD rates indicated the greater likelihood of an HIV/AIDS epidemic (1), considered it vital to

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investigate the issues surrounding the transmission of STDs in the Tari Basin. Within this broad aim I therefore defined four objectives:

1. To build upon the knowledge of Huli health beliefs and health-seeking behaviour begun by Frankel (2).
2. To examine community knowledge of and attitudes to STDs.
3. To investigate current attitudes and practices that exacerbate transmission of the diseases.
4. To explore the problems facing health workers in the control of STDs and to provide information which would help them to combat the spread of these diseases more effectively.

Anthropological methodology begins from the premise that one must work with the people one is studying. This project posed special problems, as there is no *community* of people who have STDs. The stigma attaching to the diseases creates a code of silence which even marriage partners are loath to break. Therefore, the twice-weekly STD clinic held at Tari Hospital seemed the obvious place to begin. With the full cooperation of the medical and senior nursing staff, I began to interview patients who presented for diagnosis and treatment at the clinic. I worked in a room adjacent to the clinic with a local female interpreter, either a nurse or someone who had a connection to the hospital or research unit. Volunteers for interview were sought from among the patients who awaited their turn outside the clinic door. Over a three-month period I conducted in-depth interviews with 90 patients in an almost equal gender ratio. Couples presenting together were asked if they wished to be interviewed together or separately, most deciding to be interviewed together. I also had access to all clinic records and profile cards which extended back a number of years.

Through friendship with a female expatriate lecturer, I gained access to a Christian Teachers' College, some thirty minutes away from Tari. Here I conducted 21 separate interviews with student volunteers. Questions were asked on the students' knowledge and

understanding of STDs, without questioning them on their own sexual behaviour. Travelling with hospital staff, I was able to spend time at several health subcentres and aid posts where I discussed STD problems with staff and conducted casual interviews with people waiting for treatment. By the last two months of my research period, I had gained enough local credibility to be able to gain access to a number of women's community groups. These were all part of a Women's Christian Fellowship and I was invited to meet the members at specially convened meetings. These meetings were informed by my knowledge of focus group methods which were common in sociological methodology and were just beginning to be used in anthropology. However, the nature of life in the highlands militates against the conduct of focus groups as their designers intended and I later characterized them as group interviews (3).

Medical anthropology is more than just a handmaiden to western medicine, however, and political aspects on both large and intimate scales should not be ignored. Critical medical anthropological practice in this case would have suggested that research be conducted with the 'bigger' people of the area: politicians, provincial medical supervisors and the senior staff of the mining companies that had recently begun operations in the area and which employed many expatriate and non-Huli PNG staff. However, this was politically difficult for the research unit and the hospital and so the issues investigated remained within the Tari community. A fiction was maintained that the Huli had few outside links, except those which they made individually.

Medical staff were more interested in information that would lead to the production of health promotional material than in any data that might implicate developers or a transnational mining corporation. The entrepreneurs of the great mineral exploitation in Southern Highlands Province were patrons of medical research; for instance, during the period of my research, funds were sought from multinational companies for research on antimalarial bednets and other projects. Permissible, however, was the more intimate political arena of gender politics and I ensured that gender awareness informed my practice.

The methodology I had adopted was an anthropological one, and it took some time to convince the research manager of the importance of in-depth interview in which interviewees have a voice. His initial expectations were that rapid ethnographic assessments (REA) and knowledge, attitudes and practice (KAP) surveys would form the basis of my research. I was gratified toward the latter months of my fieldwork to find that the research manager began to take account of and value anthropological methodology as an addition to his understanding of the problems facing both the Huli and the medical services. The medical anthropologist in the field must negotiate his or her path, gaining the cooperation of medical professionals rather than seeing them as obstacles.

The twice-weekly sessions interviewing clinic patients were invariably challenging to a non-clinician. As I had found on previous research trips to areas of the highlands, many local people still believe that expatriates can get things done more efficiently than PNG staff. Although I clearly informed interviewees that I was not medically trained and I did not use the title 'Dr', many people saw this as their chance to talk to a 'white doctor', as STD patients were invariably seen by the clinic sister.

Contrary to Gillett (4), whose PNG-wide study suggests that STDs were diseases of young people (15 to 24 years), patients presenting at the Tari Clinic were mostly in their twenties and thirties. Of the women interviewed 90% were married, compared with 76% of the men interviewed. Education levels were very low: 80% of the women and 50% of the men had never been to school. More than two-thirds of the women had consulted their local aid post orderly (APO) or health subcentre before coming to Tari and most were dissatisfied with the treatment they had received. In some cases, no antibiotics were available at the local centres. In one two-week period the Tari STD Clinic was unable to provide antibiotics for presenting patients.

Lack of completion of the prescribed course of drugs, when they were available, was frequently cited by clinic staff as a reason for both reinfection and the building up of

antibiotic resistance. In the prevention area, advice of abstinence until the symptoms had disappeared for some time and then avoidance of infected partners was the only option. Condoms were never available from the STD clinic as each month they were taken off the list that went to Mendi provincial health office in favour of more necessary items such as bandages, drugs and dressings. In a recent United Nations Development Fund for Women (UNIFEM) article on HIV/AIDS in PNG (accessed through the Internet), the author (unnamed) observed that "...during 2000, condoms were not available on a regular basis in many health centres" (5).

However, when I returned to Tari for a short visit in October 1991 the local 'supermarket' had taken up the challenge to stock condoms. Expatriates were the major purchasers, however, as they were beyond the means of most Huli men and women.

No prior knowledge of STDs was claimed by almost half of the women to whom I spoke and 88% said that their husband was their only sexual partner. Misinformation concerning transmission included sharing clothing, passive smoking and sitting where an infected person had sat. All were aware that sex with an infected person was the basic cause, but for women, avoidance of sex with their husbands was not a possibility unless they were able to leave home and attempt to secure a divorce. A number of my female informants had tried to leave or eject their husbands, but this was usually unrealistic and many had suffered serious violence as well as reinfection.

Perhaps the most significant finding for a future health educator was the realization by many men and women that through constant reinfection, which was the norm, infertility had resulted. Informants rated themselves infertile if they had not borne or fathered a child in the previous five years. Of the women interviewed, 60% said that they could no longer conceive and 55% of men believed themselves to be infertile. The pain and discomfort of the diseases, which were frequently multiple and serious, were minor issues compared to the horror of infertility, which for women in particular was the worst imaginable curse.

I heard a number of stories from infertile women rejected by their husbands and unable to find a new stable partner who had become prey to any partnership, however transitory. Regular commercial sex, reported by 70% of men, was seen by the men as the source of their infections. This accords with a recent WHO survey in Port Moresby which suggests that 60% of men frequent sex workers (prostitutes) (6). In Tari, as in many places, the definition of who is a prostitute needs examination. I discovered that for Tari people, a prostitute is a woman from outside the area who is a full-time worker and is identified by her dress and general appearance. The reality is that many Huli women receive money and gifts for sex occasionally, if there is no alternative income source.

The Huli institution, the *dawanda* house, which nowadays fulfils the functions of weekend pub, gambling venue and brothel, is frequented by women and girls who receive money for sex and yet are not seen as prostitutes. Sex with these local women is not seen as dangerous by the clients, who never use condoms. A final question concerning knowledge of HIV/AIDS among clinic patients revealed almost total ignorance; while most men and a few women had heard the term 'siks' (AIDS), no one knew what it meant or what to do about it.

Attitudes among the 21 tertiary students I interviewed were probably coloured by the nature of the religious college education they were receiving and most took a condemnatory tone towards STD sufferers, which indicates the heavy stigma attached to the infections. Students' knowledge of the infections, their prevention and treatment was factual, although they disapproved of condom availability. To them, as for STD patients, transmission of an STD was purely hypothetical and therefore not worth further consideration.

Work in the wider community among the women's groups, while methodologically challenging, was less stressful than earlier interviews. I initially presented my interests in women's health at the Christmas meeting of the combined Women's Fellowship groups. I was made welcome to talk with five of the women's groups and listen to members'

concerns. I did not directly indicate that my special interest was in STDs, but allowed discussion to range over a number of concerns, including domestic violence, badly behaved husbands and children and the general stresses of making a living. When the subject of STDs was raised I encouraged discussion and learned that a number of women were prepared to state that they had been infected by their husbands. All blamed outside forces and most were aware that STDs had not been present before contact with Europeans.

Over the past 40 years the fabric of Huli society has been ruptured and many traditional beliefs and practices have been discontinued due to external pressures. Administrative and mission contact in the early 1950s, the extension of the Highlands Highway to Tari by the 1980s and later the Mt Kare gold rush have all contributed to this rupture of society.

Today Huli women live with heavy disease and injury burdens. Some are caused by infections, others by child-bearing, many by male violence. The women believe that the attendance of their husbands at the *dawanda* drinking parties was a likely source of the infections which they knew to be common. Symptoms, however, were poorly understood, although women who had been infected provided accurate information.

My position became ambiguous in each of the five sessions attended, as all participants wanted to receive information as well as to provide it. My known association with the hospital suggested to them that I was a medical expert of some sort, even though they accepted that I was not a clinician. I trod a fine methodological line. This was especially the case when I sought knowledge and attitudes concerning condom availability. Many women confused condoms with IUDs (intrauterine devices), which were an unpopular family planning method. Ideally, I would have had some condoms with me at these sessions, but they were completely unavailable at that time. After some time of explanation on my part, the women declared their total opposition to condom availability. Their reasoning was that if men could have sex with any woman at any time they would 'go wild' and all women would 'be used up'. Perhaps, as a family

planning method, they could be available from the Family Planning Clinic, but then, of course, only for married couples. My suggestions that condoms could be sold at the local shops was met with total disapproval.

Almost no knowledge of HIV/AIDS was found in any of the groups to whom I spoke, but in most the seriousness of the illness was understood and the women wanted much more information. While I imparted a small amount of informed lay knowledge to them, I did not wish to either frighten them unduly or obscure any future research that the research unit might conduct. Regardless of the incurable nature of this new disease, almost all the women were adamant that condoms should not be available for sale. They requested me to ask the hospital for separate community information sessions ('tok save') for women and men so that they could be fully informed about this new and dangerous sickness.

The recommendations in my report to the PNG Institute of Medical Research stressed such matters as upgrading the status of the STD clinic by improving its premises so that patients did not have to wait with no privacy in an open area adjacent to the rest of outpatients; increasing staff levels to allow time for health promotional work; inservice training for APOs; utilization of existing networks such as the Women's Fellowship and the Teachers' College to devise plays, posters and other ways to disseminate information in the vernacular; and, of course, condom accessibility in places acceptable to the people. However, none of these matters reached into the cultural life of the Huli people and it is here that more attention was needed.

Many men and women had spoken of the importance of traditional concepts of maintaining distance between the genders. Traditions such as the men's house and, most significantly, the bachelor cult, *ibagaya*, through which young men learned the correct behaviour towards women, had been important until the late 1970s. These institutions had maintained gender relations where 'improprieties' were not an everyday occurrence as they were in 1990. Women now believed that men behaved 'like pigs and dogs', having sex with whomsoever they pleased at any time. Huli sexual relations had

formerly been very circumspect as women were believed to hold polluting powers that could bring illnesses upon men if they were not respected. It is ironic that both government and mission personnel were at pains to disabuse the Huli of this notion. Though it was done with good intentions and in the cause of truth and gender equalities, now Huli women have lost much of the respect and all of the fear in which they were formerly held (7).

In the last few weeks of my work I spent a number of sessions with a small group of middle-aged men who were promoting the Huli Cultural Centre, a small house built in traditional style in which a number of items were displayed as in a museum. Visitors were encouraged and were told of plans to make the centre a vibrant and lively place, especially by one man who lived nearby. One of the group members was a technician at the hospital and he discussed the upsurge in STD cases in the community with the rest of his group. He also told them a little about HIV/AIDS. Their conclusion was simple. If the people were to take hold of the root (*tene*) of their culture they would once again be strong and be able to fight these new diseases (8). While a return to all the traditional ways and attitudes is not realistic, a return to Huli pride and values not dependent on excessive amounts of alcohol or prostitution must be considered important.

An education and empowerment scenario is vital in the fight against all STIs, including HIV/AIDS. However, this may be unrealistic as each year through the late 1980s and early 1990s the budget at the Tari Hospital was reduced. Thus as drugs are more and more often unavailable and condoms remain off the supply list when the truck arrives back from Mendi yet again, local health workers become unmotivated and unproductive. In the early 1990s HIV/AIDS was still hypothetical in Tari. With confirmed cases in PNG numbering 2342 at the end of 1999 (9) and estimates of under-reporting suggesting a range of 6000-22,000 nationwide, it is likely that several hundred HIV-positive people are in the Tari Basin already (10).

The Huli place a high value on the beauty of their bodies. The public discussion of diseases that detract from that beauty should be

encouraged so that educated choices may be made. Some individuals will always choose to maximize risk; it is the spice of life for them. This is fine, providing that the risks are known and the odds may be calculated. "Medical anthropologists cannot heal the sick, but they can work to assist, and sometimes prod, developers in health and other fields, to ensure that cultural aspects are not over-looked, nor are political and economic processes denied" (11).

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