PNG Med J 1996;39:239-242

Ethnographic results of a community STD study in the Eastern Highlands Province

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SUMMARY

This paper reports on women's understanding of diseases believed to be sexually transmitted in the Asaro Valley of the Eastern Highlands Province. Sexually transmitted diseases (STDs) seemed to be a new category of disease as there were no local language terms for them. Women did not associate STDs with infertility. Although some symptoms were recognized and known to be sexually transmitted, STDs sometimes went untreated for years. STDs were thought of as milder than AIDS because they could be treated. Those informants who had good knowledge of AIDS claimed to have known an AIDS patient. It was interesting that those who knew an AIDS patient reported a change in sexual behaviour among people who saw the deteriorating state of their relative who was dying of AIDS.

Introduction

Infertility among women attending maternal and child health clinics in the highlands was first studied in the early 1970s (1). A community-based study was subsequently conducted in the Asaro Valley, which highlighted sterility among the female population (2). The incidence of reported sexually transmitted diseases (STDs) was shown to have increased from 1970 to 1984 (3). Clinical studies of STDs have been carried out in several STD clinics within the country using clinic patients as the study population (4). However, there is need for further research on STDs at the community level. A national study done on behaviour and reproductive knowledge (5) showed widespread risky sexual behavioural patterns and limited accurate knowledge of STDs and AIDS (acquired immune deficiency syndrome). Levels of knowledge on reproductive health are still very low and community-level agencies are required to disseminate a better understanding of diseases that are sexually transmitted.

This study was carried out in conjunction with an epidemiological study of STDs in the Asaro Valley. The main objectives were to elicit local language terms for reproductive tract infections or STDs and to explore local perceptions of STDs. We placed particular emphasis on sources of information on STDs; understanding of risk factors; signs and symptoms; causes and measures taken including seeking treatment; behaviour towards treatment; and suggestions for treatment and protection.

Methods

The study coincided with a community-based STD study conducted by the Papua New Guinea Institute of Medical Research (PNGIMR) involving women from periurban and rural areas of the Asaro Valley (6). Private interviews were conducted with women in five areas during recruitment for the community STD study in villages. Data were also collected when women were brought in for examination at the PNGIMR STD clinic. A total of thirty women were interviewed with ages ranging from 17 to 50 years. Fourteen of those spoken to participated in the clinical side of the STD study while the rest offered to give information independently.

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Notes were either taken during interviews or transcribed from tape-recorded interviews and computer entered for analysis. These were then coded and analyzed using Text Collector, a program for analyzing qualitative data. Background details on informants were entered into a database file in Foxpro.

Findings

Sources of knowledge

STDs seem to be a new category of illness as there were no local language terms for them. When the local language was used, signs and symptoms were described rather than named, or STDs were called simply by a translation of 'sik nogut' (bad sickness). Three main names, 'sik nogut', gonorrhoea and syphilis, were used to refer to any diseases thought to be passed on through sexual intercourse. Almost all informants did not identify particular symptoms with a specific STD. The three names were generally used to mean any diseases that were thought to be sexually transmitted.

The most common way in which people learnt about 'sik nogut', gonorrhoea or syphilis was through gossip or rumours passed on by other village women. Educated relatives were also sources of information. If symptoms were experienced, further knowledge on STDs was sought from friends and relatives who were health workers. Only three of the women spoken to had completed formal education at grade 10, and ten had no formal education. The rest of the women disrupted their schooling at the primary level. Therefore the education system was not mentioned as a source of knowledge about STDs.

Three women reported knowing an HIV/AIDS patient in a neighbouring village. Their knowledge about AIDS was more medically accurate than their knowledge about STDs. Their sources of information were the patient and a health worker who accompanied him to the village to educate people on how he should be taken care of.

Perceptions of risks

The dominant mode of transmission identified by women was sexual intercourse. A couple of the women interviewed stressed that the disease could be picked up if one came in contact with the discharge of a person who had 'sik nogut'. Statements were also made on mother-to-child transmission during delivery resulting in the death of the child a few weeks later. This was not confused with HIV transmission. According to sources, possible risk factors for catching 'sik nogut' were exposure to multiple sex partners, engaging in several marriages, being a highway driver, and being a *geto* (a term that refers to 'loose women' who may or may not sell sex but have plenty of sex partners). It is still a popular belief in some parts of the Eastern Highlands and other societies of the highlands provinces (7) that *getos* are the main ones at risk and are thought to be primarily responsible for the spread of STDs. Only one informant expressed the view that all sexually active persons, either married or unmarried, were at risk.

Local ideas about causes of STDs

The causes of 'sik nogut' were believed to be sores in the uterus, 'sanguma' or 'poisin'. 'Sanguma' is a living human being that has another spirit that invisibly enters another person and sucks up blood or eats internal organs. Since the reproductive tract of a woman is inside, her explanation of her pains is associated with 'sanguma', who is thought to destroy internal organs making someone look yellow and sickly. The 'sanguma' attacks if it has been offended. 'Poisin' is a curse made on younger females by old dying people. 'Poisin' is done to some girls so they will not have children after their parents or grandparents die. The old people are said to do this because they will miss out on her brideprice once they are dead.

How is 'sik nogut' recognized?

Obvious signs recognized were not walking straight, bad odour, skirt wet from discharge, loss of weight with the skin looking 'yellow' (pale), and sores on the face and some parts of the skin. Those who had experienced symptoms spoke of burning pains when urinating, abdominal pains, pains during sexual intercourse and discharge.

Behaviour towards treatment

Despite a woman having symptoms,

treatment was often delayed, sometimes for years. ‘Sanguma’ was said to be responsible for causing these discomforts and they could only be healed after some form of payment was made to the ‘sanguma’. Treatment at a health facility was considered only if discharge and sores were seen. Remaining childless for years was also not thought of as a health problem. It was a common tradition for women to be given ‘kawawar’ (ginger) or bush herbs after menarche to avoid pregnancy. In certain areas of the Asaro Valley, mud was rubbed on a young woman’s belly button as protection against pregnancy. This influenced women to believe that their infertility was the result of this practice. Of the twelve who admitted having symptoms, only one attempted to visit the STD clinic after consulting a known health worker for further information on STDs. Four received treatment after their partners or spouse had been checked, with only one completing her course. The other three stopped taking medication after urine pains had decreased. None of the women mentioned any form of traditional treatment for ‘sik nogut’.

The reasons that women were reluctant to visit health facilities included lack of privacy, being shouted at by hospital staff and not knowing which section of the hospital to go to; others just did not bother, thinking that their symptoms would disappear. A change in the attitude of health workers, more private STD and separate gynaecology clinics within the hospital, and more educational awareness were suggested as ways of providing more acceptable and effective treatment.

Protection against STDs

Protective measures against STD transmission were quite rare. Condoms were used by women only if available but probably only once or twice in their sexually active years. Although there was not much objection to the use of condoms among younger women, older informants were rather reluctant to speak about condoms. Five women reported that although they only have sex with their husband, they were aware that they still could get infected by him. The mean number of reported lifetime sexual partners was 8, and numbers ranged from a low of 3 to a high of 50. The majority of the women were either in their second marriage or had co-wives. Thus it seems that the level of protection against STDs is very low in the Asaro Valley. However, it was interesting that sources who knew of an AIDS patient said that male relatives of the infected person took protective measures by decreasing their numbers of sex partners and going to hospitals for STD treatment. According to these sources, seeing someone waste away with AIDS was enough of a threat to make people change their sexual behaviour.

Discussion

According to these findings, there is still plenty of need for educational awareness. Although people know about ‘sik nogut’, gonorrhoea and syphilis, knowledge of the diseases is still vague. There is a great need for information on STDs at the community level, including proper understanding of the signs and symptoms, when to seek treatment, and the importance of taking preventive measures. This should also cover information on AIDS.

With considerable sexual activity outside of marriage, engaging in several marriages, many premarital partners, and involvement in sexual intercourse at an increasingly younger age, safer sex practices need to be encouraged. Condoms are becoming acceptable by people but are not used because they are not available. Operational research with the aim of decreasing the spread of AIDS and STDs should be carried out into effective ways of community-based condom distribution (5). According to informants in this study, people are changing their sexual behaviour but only after seeing known relatives die of AIDS. We cannot wait to have more people die of AIDS before others change their sexual habits. Preventive measures and changes in sexual behaviour have to be seriously considered in educational awareness programs.

When women did realize that they needed to be checked at a health facility, there were barriers that made them hesitant to go for treatment. The women themselves identified their need for private STD clinics with caring staff that should also serve as information sources.

One of the major findings of this study was that women did not associate infertility with STDs. The local female perception of being

childless had a traditional reasoning, even if symptoms were felt in and around the reproductive tract.

There is also a need for further research on local practices for preventing pregnancies, traditional beliefs about diseases spread through sexual intercourse, and the relation of these diseases to infertility and other complications. How can local beliefs about STDs be incorporated into educational materials without losing sight of the facts on STDs? Understanding the local beliefs, ideas and knowledge is important in order to identify points of congruence or disagreement between local beliefs and the biomedical model. This understanding can then be useful when developing awareness programs. Further behavioural studies are also required to fill gaps in information needs.

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