Impurity and danger: the need for new barriers and bridges in the prevention of sexually-transmitted disease in the Tari Basin, Papua New Guinea

Jenny Hughes

Department of Social Anthropology and Sociology, Faculty of Social Sciences, Deakin University, Victoria 3217, Australia.

Abstract

The Huli of the Tari Basin have a serious problem with the spread of STDs following the opening of the Highlands Highway from Mendi in the early 1980s. Huli territory is now the site of huge mineral exploration and development and fears are held by health officers that the diseases may soon become an epidemic. The likelihood of AIDS entering the area in the near future provides a further need for all available barriers to be erected against the diseases and new bridges constructed to better health practices. Traditional teaching among the Huli emphasized the polluting effects of sexual contact. Missionary activity and the increasing commercialization of Huli culture have combined to weaken deterrents to premarital and extramarital sexual experiences. Traditionally, men believed that dangers of pollution came from two sources; women and outsiders. Only the Huli elders held these beliefs in the 1990s and little heed is paid to their warnings. Travel for work or pleasure has greatly increased among Huli men who no longer fear the outside world but rather wish to be part of it. Thus the traditional barriers which minimized infectious diseases have been demolished. The traditional Huli health-belief model is discussed and the possibility of harnessing traditional taboos in the fight against the spread of STDs is explored.

In 1987 Southern Highlands Province ranked fifth in Papua New Guinea for gonorrhoea and ninth for syphilis per 100,000 population. In that year there were 1393 cases of gonorrhoea and 164 cases of syphilis (Gillett 1990:88). In the same year attendances at the Tari Sexually Transmitted Diseases (STD) Clinic totalled 428: this figure excludes all patients reporting to their local Health Sub-Centres and Aid Posts. By 1988, however, Clinic attendances had increased to 620 and they reached 905 in 1989. The fact that the numbers have doubled in two years cannot be taken lightly and it was in this context that my research was undertaken.

This paper reviews information on traditional health beliefs both from Frankel's work in the 1970s and early 1980s and from aspects of my own research in 1990–1991. Thus consideration is given to some of the traditional barriers which maintained good health, and the means by which local communities and health workers can reverse the trend towards an STD epidemic. The study examines myths and realities of STD transmission and the social and medical outcomes of long-term STD exposure.

Field data were obtained through semi-structured interviews in which prepared questions were asked of respondents in situations which ranged from semi-formal, individual interviews with 60 STD clinic patients, to informal, group interviews in the case of members of the Huli community. Data from several STD clinic sources were also analysed.

The Huli health-belief model

The Huli are best known in the anthropological literature from the pioneering work of Glasse in the mid-1950s when the Tari Basin first came under colonial administration (Glasse 1968), and more recently, from the work of Frankel who undertook the first serious medical anthropological study of the Huli (1980, 1981, 1986). Frankel argues that the Huli found no difficulty in assimilating Western biomedical treatments which were offered initially by the Christian missions and later by the administration. This is partly because the Huli are largely satisfied with naturalistic explanations and only rarely invoke more complex explanations (Frankel 1986). It should be noted that Frankel was a physician before he became a medical anthropologist and has thus a greater investment in the biomedical model than many anthropologists who do not have this double training. Pluralism in both medical explanations and treatment-seeking does not pose major problems for the Huli, although explanations appear to have greater tenacity than treatments. Sexually-transmitted diseases do not stretch the explanatory model unduly as they are seen by most people as new diseases for which no treatment exists within the Huli framework. However, middle-aged and elderly men who are still troubled by the new relaxation of relations between the sexes have some concerns that 'men's illness' (*agali*), which they had traditionally guarded against, has reappeared in new virulent forms in STD. A degree of smugness was evident in discussions with these older men who saw themselves as being in no danger.

Like many other groups to the west of Mount Hagen (Meggitt 1964), the Huli have a well-defined sense of correct and incorrect behaviour between the sexes. The Huli health-belief model (HBM) is based very largely on two concepts, the first of which is that women are dangerous beings, who, while necessary for reproduction and maintenance of subsistence, are best avoided by men in most circumstances. This concept was taught to both males and females from an early age and was backed up by both elaborate rituals and everyday behaviour. The second concept is that disease and misfortune encroach from beyond Huli territory and all contact with the outside world therefore carries a risk of contamination. The simultaneous reduction of restrictions on both contact between the sexes and encroaching outside influences is seen by the Huli to be largely responsible for the many new diseases, including STD, which have appeared in the last generation

In common with many marginalized groups, Huli women are simultaneously inferior and dangerous to men. This results in their apparent acceptance of a position of irresponsibility within the society which men control through the exercise of restraint in all their dealings with them. Women, although admittedly 'irresponsible', are simultaneously bound to minimize their dangers to men and expect retribution if they fail to do so. Although much ritual of this nature has been abandoned through mission influence there are still precautions which are followed in the 1990s which suggest that the HBM retains many of its most basic features.

A woman is contaminating during much of her life, especially after commencing menstruation and before giving birth to her first child, during pregnancy, after childbirth and at and after the menopause. The most dangerous time is every month during menstruation when sexual intercourse would cause death to her partner. Frankel attributes these fears to the 'woman's heat' (*pobo*) which was especially active at all these times and caused serious illness in men (1986:106). To minimize their vulnerability, therefore, relations between the sexes were highly circumscribed. Menarche signalled the beginning of a female's dangerous period which ended only at death. Restrictions on movement at menarche or during subsequent menstruation are no longer in force but a prudent Huli woman does not sleep anywhere near her husband or prepare his food at this time. Formerly a menstruating woman or girl would not even look at a man as this alone was sufficient to cause him illness. Beliefs concerning sex at this time are still very strong among men and women of all ages and social groups. The wise woman will still place a red cordyline flower outside her house to advise her husband of her condition and it is

her responsibility if he has sex with her if she has failed to warn him and compensation will be demanded from her family.

An elaborate set of rituals, designed to minimize the young woman's heat, prepared her for the consummation of marriage. While much of this ritual is gone, the restrictions are still thought to be important. Sex during pregnancy, and ideally for several years after the child was born was also forbidden. The pregnancy restrictions are still widely observed, although the postpartum taboos have been reduced to six months, or till the child can first sit alone. Frankel notes that there is little evidence that the taboo was observed more stringently in the past (1986:103), but at least protective magic existed to minimize the risks and provide psychological security.

All the restrictions mentioned above place responsibility on women, which, considering their 'irresponsibility', may be seen as risk-taking behaviour on the part of the men. However, many strategies existed which men could wisely employ to ensure themselves of maintaining their integrity. These commenced at birth when care was taken to separate the child from the contaminating influences of its mother's blood, and continued throughout childhood and adolescence culminating in the now defunct *ibagaya* or bachelor cult. Strict separation from all females was prescribed for a period of eight months for young men, followed by gradually reducing restrictions before eventual marriage. One elderly male informant noted that the later a man married, the more able he was to withstand the polluting powers of women. The ending of this status passage is greatly lamented by many old people, even those who have whole-heartedly accepted Christianity. Although not prepared to lay the entire blame for STD on the demise of the *ibagaya*, many elderly people interviewed were concerned that the free contact between the sexes had brought about the current 'epidemic' of STD. One old male informant, a strong traditionalist, put the blame for the current social and sexual disorder on women's promiscuity which caused men to become sick.

It is tempting to conclude simply that women were treated as jural minors and chattels by this system, but while it existed they had few fears of being casually cast aside by their spouses. Their value was undeniable and they wielded considerable power. The male model of women as possessors of metaphysical powers which could harm men ensured that women were never undervalued. Instead of being liberated by the introduction of Western, Christian concepts of marriage, women are now often devalued and commodified and have subsequently lost much of their power. Extramarital and premarital liaisons undoubtedly occurred in pre-contact times but were not a way of life for women, as apart from the dangers believed to be inherent in such behaviour, payment or reward for services was less possible. In pre-contact Huli society the concept of a woman who lived by selling her sexual services was unknown. To the observer in the early contact period women's lives appeared to be heavily circumscribed by restrictions promulgated by men. Today there are opportunities for education, work and travel but in fact these options are possible for a limited number only and for the majority of women life continues to be limited by marital status. The 'liberation' of Huli women through the intervention of the outside world is yet to occur.

The problem of STD in the Tari Basin

There is a popular perception among the Huli that sexually-transmitted disease continues to enter the Tari Basin through outside contacts. While this is largely true, there is now a well-established pool of infection which is much greater than people wish to believe. Clinic figures from 1983, the earliest year for which organized data are available, indicate that women's attendances are comparable to those of men, varying between 66 and 102 per cent of male attendances in all years but 1985 when they fell to less than 50 per cent. Over 80 per cent of all patients are married adults between the ages of 21 and 40. This shatters a popular perception that STDs are diseases of promiscuous single young people. Almost no teenagers appear in the Clinic register and I interviewed only one unmarried patient under 20.

Although clinic figures are comparable for both sexes, there is a strongly held belief among the Huli population that STD is spread from men's illicit contact with a small infected pool of prostitutes (*pasendia meri*). Both men and women find this group a convenient scapegoat on which to lay responsibility. This has resulted in a casual attitude to preventive measures and the expressed attitude of men that the women they sleep with do not fall into this category and therefore they are not at risk. This myth masks the reality that many women, for a multitude of reasons, will make their services available in certain circumstances. Clinic records contradict the popular image and increasingly women are catching up on the men and contracting STD from a partner who is not their spouse. This belief has obvious implications for the transmission of the diseases.[1]

Although the Tari Basin was officially 'pacified' in the early 1950s, the Huli did not experience the full force of social change until thirty years later when the infamous Tari Gap was breached and Tari was finally connected to the outside world by an extension of the Highlands Highway from Mendi. Many artefacts have entered Huli territory in that ten-year period, not the least significant of which has been STD. Until recently economic and social conditions were such that men who wished to earn cash had to leave home to find work in highland or coastal plantations beyond Southern Highlands Province. In the time away from their wives they were likely to seek the companionship of women who drift around such areas. Over 80 per cent of male patients interviewed had travelled beyond Southern Highlands and seen the 'good life' as it may be experienced in such places as Hagen or Goroka. The common wisdom has it that STD was brought home with the men along with their remaining cash and trade-store goods.

Conditions are changing in the Basin, however, and the 1990s will see a number of natural resources, particularly oil and gas, reaching production in quantities which cannot fail to have an impact on the wider community. Progress has many unforeseen consequences and the need for many small pieces of land on which to build power pylons is one such example. I interviewed a number of Huli from all walks of life who had recently profited by spin-offs of instant cash from the companies in exchange for small land packages which would allow the inexorable march of power pylons to proceed apace. This type of windfall does not result in long or short-term investment either traditional or modern however, and instead the cash is frequently dissipated in impulsive parties.

A 45-year-old male patient from Hiwanda who attended the Clinic on a Tuesday in October 1990, said that he had caught gonorrhoea at such a party the previous weekend from a woman who was a paid participant.[2] On an earlier visit to Moresby he had been with prostitutes and had suffered the same symptoms but was surprised to have contracted gonorrhoea at a local party, as he had believed that Huli women were uninfected. The purpose of the celebration was to spend the 'compensation' payout from the oil company for land on which a pylon was to be built. Older informants were well aware of the connections between such occasions, which are becoming very frequent, and the likelihood of STD transmission, but as with many other aspects of life now their warnings go unheeded. For a number of these elders, the strife, violence and STD which often result are compounding the folly of selling off land for transient gain from which they are benefiting little.

While legal and non-health-threatening commercial opportunities for diversion around Tari are minimal it is not surprising that small-scale entrepreneurs, the new Highland big men, will create

[1] Fifty-six per cent of women for whom individual cards were filled out claimed multiple sexual contacts when questioned by clinic staff in 1989 and 1990.

[2] Such women are known around Tari as *pasendia meri* which is Pidgin for prostitute, literally 'passenger woman'. The function described is known as *dawanda* in which liquor is illegally sold and frequently women are available for sexual hire.

opportunities where none exists. Economic changes which have occurred in the 1980s will appear insignificant by contrast within a year or two, however, as employment opportunities for both men and women proliferate, land sales increase and cash exceeds the availability of goods and services.

Knowledge of transmission and prevention of STD

Not all patients are as certain of their diagnosis and contact as the man from Hiwanda. Not surprisingly, male patients have much clearer ideas of STD transmission than female patients but self-delusion is common among both men and women. Over 75 per cent of my male patient sample were aware of the method of transmission of STD although the actual source of the disease was not always known. Most men regularly attended local *dawanda*, but like the Hiwanda patient were reluctant to connect their infection with the women whom they met there. It was thought much more likely that the disease was contracted while the patient was absent from home, thus reinforcing the myth that STD is still an imported product. A number of male patients, some of whom clearly understood the mechanism of transmission, added several other possible means of transmission of which they had heard. These included catching STD from wearing trousers borrowed from a sufferer, inhaling smoke from the cigarette of a sufferer and sitting on a surface which a sufferer had recently vacated. These myths provide convenient excuses for men with gullible wives and are perpetuated by men when they meet informally.

That 25 per cent of male patients claim ignorance of STD transmission or have a level of confusion concerning transmission is questionable and needs further follow-up. The majority of men who fall into this category attended the interview with their infected wives and the perpetuation of these myths is obviously most convenient for the maintenance of domestic harmony. Belief among the population in non-sexual means of transmission makes the task of clinic staff and health educators much more difficult. Female patients were found to be much less prepared to discuss their knowledge of STD transmission. Only 55 per cent appeared to have had full knowledge of the means of transmission before contracting the disease. This is not surprising in view of the popularly accepted belief that women, other than *pasendia meri*, are not themselves spreading the diseases.

Knowledge of preventive measures might be assumed to be synonymous with knowledge of transmission but this was not necessarily the case. Almost 30 per cent of the women identified *pasendia meri* from outside the local area as the likely sources of their husbands' infection. However, only half of this group identified *dawanda* attendance as a contributory factor and spoke of their opposition to their husbands' attendance. Condoms were mentioned by only four of the 25 male patients as a means of preventing transmission, but not one man had ever had the opportunity to use them within his local area because of their total unavailability.[3] Two couples were confident that if they practised *coitus interruptus* no harm would come to either partner.

Members of the Huli community were less well informed than the patients, although it was evident that STDs were an important topic of conversation, particularly among men who were full of information and misinformation which they were keen to impart.[4] The topic of condom availability and use was raised with community groups of both men and women in single-sex groups and met diametrically opposed attitudes. Women were aghast as they said that without the fear of contracting STD, men would 'go wild'. Condoms and IUDs were not readily distinguished by the women of any group which may be accounted for by the use of the generic term *gumi* or rubber, which is Pidgin for

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[3] I did not use the word condom or *gumi* in any question and left it up to the interviewees to bring up the topic.

[4] These interviews were conducted among groups of men who were approached by Ross Hughes assisted by Gibson Akobe of IMR.

both devices. Concern was expressed that *gumis* became lost inside the woman and babies were born intertwined in them. I canvassed opinion among those women whose opposition in principle was not total, as to the outlets for condoms which would be acceptable to women. Sexually Transmitted Disease and Family Planning Clinics were the only outlets deemed acceptable by the most liberal minded and the suggestion that trade stores could sell condoms was greeted with universal horror. Married couples attending together at a hospital clinic were the only people to whom distribution could be made and the thought that single people could obtain access was looked upon with dismay. In Pari, I was told that no single people would need them.

Men were not universally in favour of ready availability of condoms but almost all know of their existence and purpose. Fears concerning the probably 'wild' or 'loose' sexual behaviour of some younger men were expressed by older men, which reflected women's anxieties. This was a minority opinion, however, and married men evidently believe that condom use was no concern of their wives who would be fortunate if condoms were available to prevent STD transmission.

Longer-term implications of STD

Apart from the obvious reduced quality of life of a person who suffers from untreated or poorly treated STD and one who is constantly at risk of re-infection (often the same person), there are two major concerns for the Huli community if STD continues to spread widely through the population. The first is the problem of infertility which is recognized by the patients themselves, but not by community members, and is not yet seen as a problem by health authorities. The second is AIDS.

Gonorrhoea is a major cause of infertility among women in developing countries (Raikes 1989:448). In women patients the symptoms of gonorrhoea are frequently mild and detection is often delayed. This can result in damage to Fallopian tubes and ultimately to pelvic inflammatory disease (PID) which is associated with ectopic pregnancies and infertility. Evidence from Africa suggests strongly that men also may become sterile through urethritis which leads to epididymitis. The result of this is a total obstruction of sperm (De Schryver and Meheus 1990:648).[5]

Fifty-eight per cent of the 60 patients interviewed said that they were very concerned that they were apparently unable to have children and associated this with their condition. This group included 60 per cent of the women and 55 per cent of the men. Twenty respondents had no child of their current marriage and a further nine, who still desired more children, had not had a child for at least five years. For a number of respondents, perceived infertility ranked more highly than the immediate symptoms. The tragedy for these patients is that they have discovered the problem long after the damage has been done. When either counselling or public-education material is considered, great emphasis should be placed on the likelihood of infertility as a result of long-term STD infection. Painful and apparently distressing symptoms were frequently not taken very seriously by respondents. Their major worry was most commonly infertility which, too late, they had learned was caused by their inadequately treated disease.

Sexually-transmitted diseases are totally lacking in glamour in Tari as they are in other parts of the world. They are an unattractive concomitant of contact with the outside world and have never received the attention paid to diseases such as tuberculosis and pneumonia which are much more obvious killers.[6] Sufferers often prefer not to openly discuss their disease and symptoms; prevention and

[5] De Schryver and Meheus note that in Uganda, 28 per cent of a community sample, not STD patients, had evidence of chronic epididymitis and in Lagos, Nigeria, 40 per cent of the husbands of women patients at an infertility clinic were also infertile. Questioning revealed that most had a history of inadequately treated urethritis.

[6] In 1908 Dr R. Bellamy mounted a full-scale program to eradicate sexually transmitted diseases on the Trobriands Islands. He introduced a case-finding method involving an annual examination of every man, woman and child.

treatment are poorly understood in the community. My study indicated that health authorities prefer STD facilities and staff to maintain a low profile. The Tari Clinic is at the end of the supply line for drugs, equipment and treatment facilities. This situation is not unique either to Tari or Papua New Guinea in general however, and it is likely that STD clinics would have remained the Cinderellas of the health service if a greater threat to community health had not arisen in the 1980s. The threat, of course, is AIDS, a new disease, capable of transmission through bodily fluids in several ways, the most common of which is through sexual intercourse. AIDS is fortunately not yet a major problem in PNG but it is unlikely that this will continue to be the case. To mark World AIDS day in 1990 the PNG *Post Courier* included a supplement with articles on AIDS. One noted that there were 51 confirmed cases of AIDS in PNG, of whom 13 had died.

Heterosexual intercourse in the industrialized world has not so far been found to be a major factor in the transmission of AIDS. However, this is not the case in the developing world, particularly in Central Africa and Haiti (Schopper 1990:1265). There is a real fear among authorities in the National Health Department and among practising physicians that PNG will follow the pattern of Africa and in the 1990s will suffer the enormous consequences of depopulation which is now beginning to become reality in parts of Africa. My research clearly indicates that AIDS is far down the health agenda for the Huli population. There are many more pressing health and social concerns. AIDS exists, at best, as a nasty word which conjures up images of death. However, for most Huli, even the term is unknown. Men, as usual, were better informed than women, but knowledge was extremely limited. Only eight of my 60 clinic informants could supply any information about the disease. Four knew that no cure existed, one man said that it was a terminal disease. Other respondents mentioned that AIDS was spread by *pasendia meri*, gold seekers at Mt. Kare and expatriates working in the oil industry or tourists from Ambua Lodge. One young male patient said that he had formerly worked in the Ambua Lodge kitchen and was afraid to handle the plates in case the tourists had left AIDS germs on them.

I talked to community women in groups ranging from ten to over one hundred; they were even less well informed on the subject of AIDS. Almost no one had even heard the term and incredulity was the common response to the minimal information I decided to impart. The information was obviously slotted into the existing, albeit skeletal framework of knowledge concerning STD. The instant consensus was that here was evidence of a further incursion of disease from outside Huli territory. The implications of AIDS being more likely among people who had long-term or frequent STD, particularly syphilis, were pointed out, and the women asked that a male health worker should talk to their husbands. Men living in the vicinity of Tari Station were generally better informed on the subject of AIDS than more rural men, but little real knowledge was evident. Only one man volunteered that he had seen a poster at the hospital depicting the dangers of AIDS. Another said that it was spread by homosexuals and all who had any knowledge at all said that it was entering the Southern Highlands from places such as Hagen or Port Moresby.

Discussion

In pre-contact Huli society sexual contact was officially kept to a minimum and all activities involving both sexes were hedged with restrictions. This is not to suggest naively that no unsanctioned behaviour occurred. It is certain that it did, but the non-existence of sexually-transmitted diseases in those times meant that ritual was adequate to restore balance and alleviate the male illnesses which were believed to

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Information was gathered on incidence, spread and other circumstances affecting the transmission of STD. Staff were trained and medical supplies were assured. The STD rate dropped from 5.2 per cent in 1908 to 1.4 per cent in 1915 (Cummins 1990:295). It is ironic that with minimal drugs, facilities and trained staff, Bellamy could achieve so much.

be caused by improper sexual conduct. Today, such ritual lives only in the minds of old men who are consigned to the margins of relevance, and more than ritual is required to heal the sickness which is becoming a threat to the Huli community. The other facet of the Huli health-belief model is the concept that disease and misfortune encroach from beyond Huli territory. Today this is seen in the concept of *nambis poison*: sorcery-based illness which comes from 'out there', which is anywhere distant from the Tari Basin. These traditional barriers served the Huli well, at least in their psychological well-being, for many generations. Today, however, the barriers have proved to be more permeable than in the past and new barriers may need to be constructed.

It is possible for a population to continue to function with a high rate of endemic, debilitating disease, but there will inevitably be heavy losses in the long term. STD has come late to Southern Highlands Province, as have most other artefacts of the modern world, and the combination of unsophistication, recent unprecedented cash availability, freedom from old restraints, and sometimes inadequate and inappropriate health services, has resulted in sharp increases in sexually-transmitted diseases. However, gonorrhoea and even syphilis are relatively insignificant health problems when set against the imminent threat of AIDS. The concern that PNG will follow the African model of infection is very real and evidence suggests that STD, particularly syphilis, provides a fertile ground for HIV (Schopper 1990:1268). Education, therefore, is the most critical weapon if the war is to be won. Improved clinical practice is always important but prevention is imperative.[7] Knowledge of STD in the community is grossly deficient among the women, and only partial among the men. Knowledge of AIDS in any sector of the Huli community is virtually non-existent.

General STD education and specific AIDS education cannot be left until a patient presents at a clinic but must extend to all community groups. Research on AIDS in this project was necessarily hypothetical as for almost all respondents it remained just a meaningless word with unbelievably frightening connotations. Suggestions for STD education could also prove effective for an AIDS program while further research is awaited. While any STD education program must not neglect AIDS, my research suggests that fear of AIDS is not sufficient to convince the community of the dangers of unprotected, casual sex. AIDS is too appalling to be contemplated seriously yet by most Huli, and will remain in the category of the horror story for some time to come. The mechanism of denial was noted as a coping strategy by an AIDS researcher in Zimbabwe (Wilson et al. 1990:615) and may be in its initial stages among the Huli.

The strongest weapon available to STD/AIDS educators currently, is the threat of infertility, which to the Huli is a huge catastrophe. Widespread dissemination of this effect of gonorrhoea in women and urethritis in men could be a strong deterrent to both men and women who desire more children. I believe that education concerning the long-term effects of STD on the fertility of both men and women will provide the most readily constructed and durable bridge between the health authorities and the at-risk Huli population. This can be achieved in many ways and if all sectors of the vulnerable community are to be reached effectively, it is necessary to use innovative and diverse measures.

Examples of such measures could include use of existing networks such as the Women's Fellowship, which around Tari has hundreds, if not thousands, of members. These women are very receptive to education; their leaders are all literate in Pidgin and many are literate in Huli as well. Their co-operation in promoting public-health measures is currently totally underutilized. The Health Department STD leaflet 'Facts not Fear' which is in English and Pidgin seldom reaches those who need

[7] Economic issues are felt to be beyond the scope of this paper and although their importance is recognized in the post-colonial, dependency debate they await further research and analysis.

it and is limited to that small percentage of the adult population which is at present literate.[8] Novel means of educating an illiterate population must be examined at least in the medium term. These means could include pictorial posters with very few words, 'street theatre' in markets and churches, and SHP radio broadcasts in Huli. The old medium of *tok save*, through which the most effective *kiaps* communicated with the people in the colonial period, could be rediscovered. These information-exchange sessions were unhurried and time was allowed for questions and discussion among all participants. I found myself using this medium when working with women's groups. There is strong participation from community members, and single-sex and family groups could initiate these sessions. The importance of the transmission of correct information cannot be stressed too highly; there is enough misinformation already in existence. Publicity must emphasize both the curability and long-term consequences of STD. Thirty per cent of male and female patients in my sample claimed that they had suffered symptoms of STD at least intermittently for over twelve months, which is ample time for permanent damage to occur.

Education must have content as well as form however, and will fail miserably if its aim is to restore a lost morality. The bridge to the rest of the wicked world will not be dismantled by pious wishes. Recreation demands may be expected to grow exponentially in line with cash availability and exposure to Western culture. Choices and consequences must be presented, not admonitions. Education must be suitable for adults if it is to be presented to adults, and equally importantly must be culturally acceptable. Collaboration between educated Huli in the health, education and business fields and the health authorities is vital if any program is to have a chance of success. Facing the fact that *dawanda* are venues for the spread of STD could initiate some degree of regulation of the activities and participants. Encouragement of health checks after attendance for both men and women could prevent much suffering. Alternatives to *dawanda* and illicit alcohol sales must be promoted, as while they remain the only form of 'modern' entertainment, the Huli are short-changed in their moves towards a new life.

The most sensitive issue which my research disclosed was the possible provision of condoms to prevent infection spreading. To a people who have abandoned much of their traditional morality and had forty years of Christian morality overlaid on its remains, the provision of a device which seemingly permits licence without penalty, appears to be problematic in some quarters. The almost total opposition of community women questioned on the topic indicates that if condoms are to be successfully introduced this issue will need to be handled very sensitively. Research to discover the best ways to present condom use is urgently needed, as a study in Rwanda revealed that even when condoms became readily available, women were opposed to their use as they contravened their image of the construction of the person and their concept of meaningful exchange (Taylor 1990:1023). Men's interest in condoms is more predictable but their ignorance was also found to be immense, so condom provision must be accompanied by graphic education measures in single-sex groups. The total opposition of the Catholic church also currently presents a huge barrier which will not be readily overcome. The image of the Huli population dying out from either infertility or AIDS may need to be disseminated, albeit with care for cultural and religious sensibilities, to all sectors of the population. Ultimately, however, AIDS itself is unfortunately not endowed with such sensitivity and with the predisposing conditions which the Huli share with much of Africa, speed and effectiveness in prevention and education must become an urgent priority. The barriers against disease have been

[8] My research among the 60 STD patients indicated low levels of literacy. Only 30 per cent of female patients and 44 per cent of male patients had received any education and only two men had received education beyond Grade 6.

breached and are unlikely to be reconstructed; the bridges to a healthy community, in which STD is uncommon, must be rapidly and securely constructed with full community participation.

Postscript

Towards the end of the fieldwork period seventeen trade-store owners were surveyed by Ross Hughes concerning their interest in selling condoms in their stores. Eleven replied positively, four were opposed and two were undecided through lack of knowledge. The Australian manager of the largest wholesaler and retailer in Tari agreed to stock condoms for sale through both outlets, and store owners who had given a positive response were revisited to advise them of the forthcoming availability of condoms. Delivery was delayed several months but by early May condoms were available. Research on the outcome of this development is urgently required.

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