Border testimonials: patterns of AIDS awareness across the island of New Guinea

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SUMMARY

This paper compares and contrasts two similar sets of data about AIDS (acquired immune deficiency syndrome) and AIDS awareness from the island of New Guinea. The goal of this comparison is to show that state policies and values can dramatically affect personal knowledge about safer sexual practices. One set was collected in 2001 in the Indonesian province of Papua, which is home to indigenous Papuans and many immigrating Indonesians. The second set was collected in 1991-1992 in the independent state of Papua New Guinea (PNG). Papuans and Papua New Guineans share many sexual beliefs and cultural practices and have experienced similar effects of modernization, but we show that there are marked differences in public knowledge about AIDS and condoms. In general, Papuan respondents know less about condoms and use them less frequently than their PNG counterparts. We argue that a colonial form of government in Papua makes it more difficult to design culturally appropriate and effective programs.

Introduction

The AIDS epidemic predicted in the 1990s for Papua New Guinea (PNG) appears to be coming to pass (1,2). AIDS (acquired immune deficiency syndrome) was first reported in PNG in 1987. The most recent surveillance report available, the National AIDS Council Secretariat and Department of Health HIV/AIDS Quarterly Report (September 2002) noted a total of 6103 cases of HIV (human immunodeficiency virus) antibody seropositivity but actual figures are perhaps 8-10 times higher (3). According to two attending physicians at the Michael Alpers Clinic in Goroka, 2% of all the patients tested positive for the presence of HIV antibodies, suggesting an epidemic that is already well and broadly entrenched (L. Hammar, personal communication).

In contrast, the situation in Papua, Indonesia’s easternmost province and the western half of New Guinea, appears at first blush to be less critical. The first HIV-antibody-positive case was reported five years later, in 1992, and only 1000 people have been tested as HIV antibody positive or diagnosed clinically as having AIDS since records began being kept (4). There are 2.2 million inhabitants in Papua, compared to a population of 5.1 million in PNG. Thus any sense of security about the apparently lower rates of infection in Papua should be short-lived. As in PNG, actual rates of infection have been calculated as being 8-10 times higher than the number of reported cases, and HIV-antibody-positive cases are being found throughout the population. For example, in a random sample of 100 sexually active young highlands Papuan men in 2000, 8 tested as HIV antibody positive. At least statistically, on both sides of the border, increases in the number of HIV-antibody-positive cases suggest that AIDS is approaching epidemic status.

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This paper focuses on similarities and differences in the levels of knowledge about AIDS and how to prevent it in the two countries. In this report, we look specifically at the levels of awareness among the indigenous inhabitants of Papua. Approximately 1.2 million Papuans are indigenous. The remaining 1 million are Indonesian migrants who have relocated to the province, and their levels of AIDS awareness are not considered in this paper. Among indigenous Papuans, knowledge of AIDS and condoms, particularly among youth and in rural areas, is noticeably lower than in PNG. Papuan levels of awareness are overall about a decade behind those of PNG. We suggest the source for this discrepancy lies in institutional policies and practices in the province of Papua, in particular, the effects of colonial politics and cultural values dominant in Indonesia. In short, we show that the ability to practice ‘safe sex’, while ultimately about individual behaviour, is highly conditioned in Melanesia by national and regional political practices.

Methodology

This paper compares two sets of data obtained roughly a decade apart in the two countries. The first set draws from a study conducted in 1991-1992 by the National Sex and Reproduction Research Team (NSRRT) and Carol Jenkins (then at the Papua New Guinea Institute of Medical Research). It was published in 1994 as The National Study of Sexual and Reproductive Knowledge and Behaviour in Papua New Guinea (2). NSRRT and Jenkins’ study gathered data by obtaining personal sexual histories and by conducting focus group discussions in rural and periurban communities throughout PNG. In total, 423 interviews – 160 with men and 263 with women – and 61 focus group discussions were conducted.

The second study was conducted in Papua in 2001. It was geared exclusively towards gathering data about the indigenous Papuan population. Thus Indonesian migrants were neither studied nor employed as researchers. A total of 210 respondents in 11 communities – rural and urban – were interviewed. Researchers complemented this core interview set by conducting in-depth community studies of several locations and enlisting ‘high-risk’ group members, including those of Papuan transvestites and commercial Papuan sex workers, to keep travel diaries. The 2001 Papua study, published as The Papuan Sexuality Study Research Report (5) followed to a significant extent the protocol used by NSRRT and Jenkins in their study in 1991-1992. Both the Papuan and Papua New Guinean studies employed indigenous researchers who went back to their home communities and asked a series of open-ended questions about sexuality. Topics included marriage, reproduction, sexual practice, sexual norms, sanctions, condom awareness, condom use and AIDS awareness.

This paper focuses primarily on the material from 2001, using the 1994 publication of the study by Jenkins and NSRRT and more recent materials from PNG for comparative purposes. We focus here on similarities in cultural patterns in both countries, and then on differences in levels and content of awareness about AIDS. In that results were comparable on most frontiers across both countries, we suggest that in-depth, qualitative interviews on sexuality are a highly effective means of obtaining information about general trends and norms in Melanesian societies. Further, this appears to be especially the case when the interviewer is from the same cultural background as that of the respondents.

Our comparison of awareness of AIDS and condoms across the island faces challenges on several fronts. First, the PNG study and the Papua study were carried out ten years apart, making the majority of our data on PNG somewhat dated. Certain things have improved over the years, such as levels of condom use, while others have not. We also have had difficulties comparing and contrasting data obtained from similar, but not identical research questions. We note...
these complexities in part to clarify our urgency in writing this paper. It is a critical time for AIDS in both countries, and data on AIDS in PNG, and more so in Papua, are in short supply and hard to come by. Insofar as AIDS education and prevention efforts are related to the priorities of agenda-makers in Jakarta, the province of Papua appears to be on the verge of a shift in political boundaries that will divide indigenous communities, split up resources and information and stifle Papuan efforts to gain opportunities for influence over matters such as health.

**Similarities across the border**

Among the core cultural values that continue to affect sexual practice in both Papua and PNG, many key commonalities can be found. This section will explore comparable ideas about bodily fluids, disease, reproduction and cultural sanctions in Papua and PNG and will examine how they influence AIDS awareness, HIV transmission and intervention strategies. We examine the ways in which sexual attitudes and practices in both Papua and PNG have been transformed by similar changes in cultural, economic and political conditions. The introduction of a cash economy, vastly increased levels of internal migration, and the influx of new values – particularly those of Christianity and, on the western half of the island, of Indonesia – have created new norms, identities and expectations that intersect or compete with pre-existing cultural patterns.

Research results from both Papua and PNG show that bodily fluids and bodily substances – specifically semen, breastmilk, menstrual blood and cervical and uterine substances – are believed to be highly potent and powerful. Among certain cultures in Papua and PNG, fluids lost (by men) or consumed (by women) through indiscriminate intercourse can weaken bodies or wreak havoc on the environment. In others, the ingestion of the same fluids can strengthen and protect them. Two Papuan respondents succinctly state what is culturally obvious to them:

“If we eat semen when we do oral sex, we can die.” (Sela, highlands Lani woman) (5)

“If we get sick, we ask for semen, then we eat it, mixed with coconut – we get better right away.” (Roma, south coast Marind woman) (5)

In our study, beliefs about body fluids, such as fear of the toxicity of semen, were found to be influential among Papuans in terms of shaping the nature of their sexual relationships. Among highlanders, for example, sex needs to occur the right way, that is, ‘missionary style’:

“In body positioning, the woman cannot be on the top, because on the man’s shoulder sits the strength of war/ancestor spirits, and so a woman cannot press on the top of his shoulder . . . Steam from the woman’s genitals can chase away the powerful warrior spirits which sit on the shoulder of the man.” (highlands Dani man, quoted by researcher One Wakur) (5)

Beliefs about reproduction and fertility were consistent across the island. In both studies, respondents noted that a man and a woman must have sex several times together before a woman can conceive, making the use of a condom for contraceptive purposes seem less urgent (2,5). Various forms of fertility control were widely desired and practised in both Papua and in PNG.

Sexual practice on both sides of the border continues to be affected by sanctions, a cultural system of fining which makes guilty parties or their families pay for having sex that is deemed inappropriate. ‘Improper’ sex is, for the most part, premarital or extramarital sex. Although both Papua and PNG are experiencing the erosion of traditional cultural sanctions, sexual behaviours seen as culturally deviant continue to provoke
physical punishment and stigma in many areas. In Papua, sanctions remain very strong, though they appear to be on the decrease in periurban regions. Many women and men engaging in pre- or extra-marital sex take extreme measures to avoid being caught. A pattern we term ‘secret sex’ is widespread in Papua. ‘Secret sex’ is clandestine, often requires the use of brokers, occurs between primarily Papuan partners, occurs often in the context of public events, occurs between highly mobile partners, and usually occurs outside the spatial boundaries of a cultural community. All these measures, we suggest, have evolved as a means to avoid paying fines, suffering a beating or being stigmatized in the person’s home community (5).

In PNG, many respondents mentioned pack rape as a traditional punishment (2). While group rape has also been reported in Papua, Papuans strongly argue that it has never been a part of their cultural tradition. In general, the Papuans interviewed in 2001 associated rape with drugs, drunkenness and town living. Not a single respondent mentioned sex or rape as punishment – present or past. However, the practice of sequential sex – a form of sex in which a woman provides sexual services to several men one after the other in return for money or goods – is becoming increasingly common. In Papua, 30 respondents (17%) said they had ever participated in sequential sex (seks antri, literally, line-up sex). 11 male respondents (37%) under the age of 25 said they had ever taken part in sequential sex. The majority of Papuans who spoke of forced and sequential sex came from the capital or communities near the capital of Jayapura. Marilena’s case illustrates this urban trend:

“Marilena likes to spend time at the Sentani market (on the outskirts of Jayapura). Marilena had on several occasions been drunk and met up at the market with a group of boys who negotiated with her to have sequential sex. They bought her whisky or sniffing glue, and drew together Rp30,000 (about $US4). She had sex with each of them in turn. One of those times, she was quite drunk and had felt ‘desire rising’ (nafsu naik ke atas), which she said had to be addressed through sequential sex. Now that she has a boyfriend, she doesn’t want to have that kind of sex, but since he is so violent when he is drunk, she is afraid of him and gives him the kind of sex he wants.” (5)

Despite the ongoing weight of sanctions, both studies report an increase in sexual behaviours falling outside the ideal of heterosexual sex within marriage. Alcohol and drugs are increasingly available, and are often seen to add fuel to the problem. In PNG, marijuana is used alongside alcohol, especially in the disco and ‘six to six’ scene, and is said to lead to uninhibited sexuality (6). In Papua, researchers find that alcohol and sniffing glue – aibon – play a role in enabling unsafe sexual practices. As one Papuan male from the highlands commented:

“People didn’t used to have sex with other people. But now people like to have casual sex because of the influence of alcohol. Indonesia made alcohol to destroy the Papuan people; this is Indonesia’s refined politics. The Papuan people are dying because of alcohol.” (5)

In both Papua and PNG, pornography is widespread and remains one of the few sources of sexual knowledge (6). In Papua, men told of many incidents where pornography incited sexual violence. The distribution of hard-core pornography DVDs is tightly controlled in Papua (some suggest by the military) and features movies from twenty different countries, including India, Thailand and Denmark.

The last major area of overlap is in general awareness of AIDS. While most Papuans and Papua New Guineans state they have heard of HIV and/or AIDS (in other words, respondents note a familiarity with the terms HIV or AIDS), data show that awareness of
the particulars of the disease syndrome is low. Among Papuans surveyed in 2001, 81% had heard of AIDS, but researchers found that many of those who had ‘heard’ of AIDS actually knew little about it. A researcher in that study estimated that fewer than half of the respondents were able to sketch in even the broadest outlines what AIDS is and how HIV is transmitted. In comparison, NSRRRT and Jenkins believe that 93% of Papua New Guineans surveyed in 1994 were familiar with the disease syndrome (see Table 1). While many PNG respondents also knew little about AIDS other than the name, the data still suggest that Papua New Guineans were, overall, more familiar with AIDS than Papuans.

As in much of the rest of the world, many Papuans and Papua New Guineans link AIDS more readily to sexual immorality and lax bodily hygiene than to viruses and immune systems (1). Both Papuans and Papua New Guineans suggested that the usual disease prevention tactics of personal and environmental hygiene would stop sexually transmitted diseases (STDs) and AIDS. Other persistent beliefs about AIDS across both sides of the border include associations with sorcery. Some Christians in both Papua and PNG interpret AIDS as a punishment from God (2), although Richard Eves describes a greater tendency among the Lelet of New Ireland to invoke explanations involving God than was noted in the Papuan study (7). In Papua, more respondents thought that AIDS could be cured by a trip to the dukun – a traditional healer – than through prayer.

Differences across the border

Within the general trends described above, there are specific divergences that suggest that broad political factors (not, therefore, indigenous cultural ones) have had an effect on AIDS educational efforts. The issues touched on here include STDs, sex work, levels of AIDS awareness and knowledge about condoms, which we will examine in turn.

Sexually transmitted disease awareness

The first arena in which awareness levels appear significantly different is in self-diagnosis and knowledge of STDs. As seen in Table 2, Papuans and PNG residents self-report similar levels of STD infection.

However, Table 3 shows that among Papuan respondents, 36% were unable to name any potential symptoms of STDs, as compared with only 14% of PNG respondents. Among Papuan youth, STD awareness was even lower. Notably, even though STD rates are high among Papuan

<table>
<thead>
<tr>
<th>Heard of HIV/AIDS</th>
<th>Total respondents</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua overall (16-72 years)</td>
<td>196</td>
<td>159</td>
<td>81</td>
</tr>
<tr>
<td>Papuan adult (25-72 years)</td>
<td>132</td>
<td>103</td>
<td>78</td>
</tr>
<tr>
<td>Papuan youth (16-24 years)</td>
<td>64</td>
<td>56</td>
<td>88</td>
</tr>
<tr>
<td>PNG overall (15-60 years)</td>
<td>896</td>
<td>829</td>
<td>93</td>
</tr>
<tr>
<td>PNG adult (25-60 years)</td>
<td>579</td>
<td>526</td>
<td>91</td>
</tr>
<tr>
<td>PNG youth (15-24 years)</td>
<td>317</td>
<td>303</td>
<td>96</td>
</tr>
</tbody>
</table>
TABLE 2

RESPONDENTS WHO HAVE HAD AN STD

<table>
<thead>
<tr>
<th>Ever had an STD</th>
<th>Total respondents</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua (2001)</td>
<td>196</td>
<td>32</td>
<td>16</td>
</tr>
<tr>
<td>Papua New Guinea (1994)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>22% of men and 24% of women (2)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE 3

AWARENESS OF STD SYMPTOMS

<table>
<thead>
<tr>
<th>Cannot identify an STD symptom</th>
<th>Total respondents</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua (2001)</td>
<td>196</td>
<td>71</td>
<td>36</td>
</tr>
<tr>
<td>Papua New Guinea (1994)</td>
<td>176</td>
<td>24</td>
<td>14</td>
</tr>
</tbody>
</table>

youth, fully 40% of youth respondents were unable to name even a single STD symptom.

Sex work

The second significant difference occurs in the exchange of sex for material goods. It differs because of the presence in Papua of a large number of Indonesian migrants, many of whom are active in the sex industry. In PNG, there are considerable numbers of young women and men who receive goods in exchange for casual sex as well as men and women who are more fully entrenched in the sex work industry (8). According to NSRRT and Jenkins, these women are at greater risk for STDs and AIDS, as they tend to have more partners and are less able to control the nature of the sex act (2). In Papua, the sex industry is highly stratified along ethnic lines, and higher-priced services are offered almost exclusively by Indonesian women in sites such as bars and regulated brothels. Papuan sex workers, in contrast, typically make less money and are much less likely to use condoms; they mostly work in unsafe sites that are in the open air or that are perpetually in flux. They earn less money than do their Indonesian counterparts, and are less likely to have been the target of condom promotions than Indonesian women working in brothels. In other words, in Papua, risky sex is quite explicitly racialized. This does not mean that Indonesian sex workers necessarily or exclusively have safe sex but, rather, that the promotions which do exist consistently target women in 'fixed' locations such as brothels, rather than the highly mobile, street-based sex work typical of Papuan sexual encounters. It also means that clients of Indonesian sex workers are more likely to hear about condoms and perhaps to use them than are the clients of street-based Papuan workers. One senior researcher in Papua estimated that condom use by Indonesian women in brothels ranged between 30% and 80% of clients, whereas unregulated Papuan sex workers used
condoms with clients between 2% and 5% of the time (9). It may be productive to study links between ethnicity and sex work in PNG to see to what extent similar, inadvertent patterns of discrimination result from promoting condoms mostly in regulated, known brothels or bars.

As in PNG, accounts of forced sex within commercialized transactions were common. In PNG, forced sex by policemen ‘in-line’ appears to be a common feature of urban life (10), and Papuan respondents throughout the province also raised the issue of aggressive and violent soldiers. Indigenous women, particularly from rural highlands locations, describe forced sexual encounters with Indonesian soldiers stationed in the region. Coercive sexual relationships often transgressed ideas of safe sex inscribed in cultural terms, notably regarding the poisonous effects of semen, as one woman describes:

“Supri and Frenky from ABRI (Indonesian Armed Forces) came over; then they invited me to have sex with them. I looked after Frenky first, he forced me to give him oral sex, but I refused because I said it was not normal for us, and I said I would scream, and so we just had the regular kind of sex. He used a condom and I had sex once. He gave me Rp15,000 (about $US2) and some noodles. Then I looked after Supri. He forced me to give him oral sex. I threatened to scream at him, but he returned the threat and said he’d go and get his rifle. So then I gave him oral sex, and I threw up all his sperm, spit it out. I felt disgusting.” (5)

AIDS awareness

Although most Papuans and Papua New Guineans had heard of AIDS (see above), this is where the similarities in levels of awareness began to depart. As seen in Table 4, Papuans were generally less knowledgeable about AIDS prevention than Papua New Guineans. Of 196 Papuan respondents, 40% were unable to name even one means of AIDS prevention promoted by outreach efforts or government and NGO information brochures. It is clear that basic AIDS information is not making its way to the local level in a way that registers with members of the population. In contrast, only 14% of PNG respondents did not know any preventive measures. Among rural Papuan youth, basic knowledge of AIDS prevention was alarmingly low, with 76% of respondents unable to name any possible ways of preventing infection.

Remarkably, nearly half of all respondents in PNG mentioned monogamy as a means of avoiding AIDS. In PNG, abstinence and monogamy have been widely promoted as a primary means of AIDS prevention, even by international organizations such as the United Nations. As Hammar notes, AIDS interventions that exhort monogamy not only

### TABLE 4

<table>
<thead>
<tr>
<th>Preventive measure mentioned</th>
<th>Papua (196 respondents)</th>
<th>Papua New Guinea (896 respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have sex with a single partner</td>
<td>21% (n=41)</td>
<td>48% (n=430)</td>
</tr>
<tr>
<td>Avoid sex with prostitutes</td>
<td>32% (n=63)</td>
<td>33%*</td>
</tr>
<tr>
<td>Avoid anal sex</td>
<td>0% (n=0)</td>
<td>not asked</td>
</tr>
<tr>
<td>Don’t know any ways</td>
<td>40% (n=78)</td>
<td>14% (n=125)</td>
</tr>
</tbody>
</table>

*% calculated from the urban portion of the sample – 746 of 896 respondents
overlook the possibility that a partner may already be infected, but also ignore the social reality that few women in PNG have full control over when, how and under what circumstances they have sexual intercourse (1). In contrast, only 21% of Papuan respondents mentioned sex with a single partner as a preventive measure, although religious and state authorities in Indonesia promote both (9,11).

In PNG, some respondents said that non-reproductive sex acts, such as oral or anal sex, were the most risky in terms of transmitting STDs or HIV (12). This contrasts sharply with findings in Papua, where respondents were overwhelmingly unaware of the dangers of penile-anal or penile-oral sex. Not a single Papuan respondent in the 2001 survey said that abstaining from sexual relations with men who engage in anal intercourse with other men might be an effective preventive measure. Given that Papuan waria – male to female transsexuals – are increasingly prominent in Papua’s sex industry, and that members of their diverse client base rarely use condoms, this seems to be a critical omission in AIDS prevention efforts.

Condoms

Currently, Papua and PNG are facing similar challenges in regard to the most practical element of any AIDS prevention program – the distribution and normative usage of condoms. Information and access to condoms in Papua and PNG are both poor, making the actual everyday use of condoms infrequent, inconsistent and often incorrect. Papua, however, faces a simpler condom issue: the majority of Papuans don’t know what they are. As seen in Table 5, Papuans are far less knowledgeable about condoms than Papua New Guineans. In a 1993 survey, 83% of PNG respondents claimed to know of condoms (although a much smaller percentage, 59%, said they had actually seen them). Eight years later in Papua in 2001, still only a dismal 29% of respondents were able to identify a condom – even when one was shown to them.

Papuan youth aged 16 to 24 years are dramatically less familiar with condoms than their PNG counterparts. In a 1996 survey in PNG, Jenkins and Alpers found condoms to be widely known and appreciated as protection against STDs among the majority of their young respondents (6). In contrast, only 39% of Papuan youth were able to identify a condom when shown one. In Papua’s rural highlands, even though the numbers are small, a staggering 94% of youth could not identify a condom, even though STD rates among highlands youth in the area are twice the provincial average.

A 1998 study conducted in PNG that promoted condom usage by sex workers in urban sites was notably successful: 50% to 60% of sex workers reported 100% condom use with clients in the previous week (10). Condoms in PNG are now widely available

![Table 5: Condom Awareness](image-url)
in night-clubs, bars, guest houses, motels, hotels, canteens and some stores. Some health workers, however, remain reluctant to hand out condoms. In Papua, condoms are only available in pharmacies in large towns and at some brothels. They are occasionally available at health centres, but they are only handed out to married couples wishing to use condoms for family planning purposes. In short, while there are similar efforts ongoing in both countries to get condoms out and in the public eye, efforts lag behind significantly in Papua, in terms of both timing and success rates.

Both Papua and PNG face a rural/urban divide in condom awareness and use, but in Papua the discrepancy is particularly distinct. Condom awareness in Papua varies across the province, seemingly in accord with the amount of condom promotions set up. In the 1994 study, NSRRT and Jenkins found significant differences between condom usage rates in rural versus urban settings in PNG. 20% of the urban sample reported having used a condom, but only 10% of rural respondents had. Similarly, in urban Merauke in Papua, a site of active condom promotion, 40% of Papuan respondents could identify a condom. In contrast, only 8% of rural respondents could identify one.

In Papua, 13% of respondents overall (Table 6) and 18% of youth said they had ever used a condom, but this rate varied strongly by location. Respondents from the urban site of Merauke were more likely to have used condoms, with 29% of respondents saying they had used one. As seen in Table 7, reports of condom use do not guarantee that condoms are being used properly or with any sort of regularity. When asked how many times a condom should be used, only 34% of Papuan male respondents knew they should be used only once, and 54% said that they didn’t know the answer to the question. In comparison, 64% of men in the PNG study said that a condom should be used only once.

In Papua, respondents who used condoms almost never did so consistently, and did not

<table>
<thead>
<tr>
<th>TABLE 6</th>
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<tbody>
<tr>
<td><strong>RESPONDENTS WHO HAVE USED A CONDOM</strong></td>
</tr>
<tr>
<td>Ever used a condom</td>
</tr>
<tr>
<td>Papua (2001)</td>
</tr>
<tr>
<td>Papua New Guinea (1993)</td>
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<td>Papua New Guinea (1994)</td>
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<tr>
<th>TABLE 7</th>
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<tbody>
<tr>
<td><strong>PROPER USE OF CONDOM AMONG MEN</strong></td>
</tr>
<tr>
<td>Know to use condom only once</td>
</tr>
<tr>
<td>Papua (2001)</td>
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<tr>
<td>Papua New Guinea (1993)</td>
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</tbody>
</table>
use them with the casual sex partners they called ‘friends’. The relationship to the sexual partner, as opposed to the actual experience of wearing a condom, appears to determine when and where condoms are used, as the case of Dipen shows:

“Dipen knows of AIDS and condoms, but he uses them in a sporadic fashion, relying on an inconsistent logic. AIDS is something you get from outsiders, he argues, so he uses condoms whenever he goes to the town of Wamena. He also says he uses them if he has sex with a sex worker. Dipen said he used condoms a total of three times in his last 13 sexual encounters. Yet, he had sex with Siska three times, a known sex worker, but he only used condoms twice with her. He also went to Wamena and said he had sex twice while there, but did not use a condom either time, because both his Wamena partners were ‘friends’. He never used a condom with his girlfriend, with whom he had sex four times in 14 days.” (5)

**New Guinea and AIDS strategies**

The data discussed above suggest two general trends. The first is that similarities across the border testify to the enduring strength of many cultural norms in the domain of sexuality. The second is that differences in awareness appear to be systemic. The problem is fairly straightforward: four years after the report of a case of AIDS in PNG, many Papua New Guineans knew about AIDS, knew about condoms and knew how to use them. In Papua, 10 years after the first diagnosis, and 15 years after the first reported case of AIDS in Indonesia, Papuans may ‘know about AIDS’, but they don’t know much, and they know even less about condoms and how to use them. The data strongly suggest that in Papua knowledge and practice relating to the most general aspects of AIDS and AIDS prevention are slow, late and inadequate. In other words, awareness levels are linked to the impact of different policies and programs of each country. This is not to suggest that programs in Papua New Guinea are exceptionally successful and timely, but rather that, in comparison, Papua clearly lags behind. In this section, we review policies and political climates in both countries to suggest that a key factor preventing Papuan awareness lies in Indonesian political strategies.

There is little doubt that governments on both sides of the border have attempted to come to terms with AIDS. In PNG, politicians, health workers, researchers and international consultants who have detailed knowledge of Melanesian culture and values have shaped AIDS policy. Yet while a short-term national AIDS plan was promptly drafted in 1988, just one short year after the first reported case of AIDS in PNG, inertia has prevailed as government decentralization policies have made AIDS outreach and prevention difficult to carry out (13). In particular, Prime Minister Bill Skate’s administration of the late 1990s gutted what few AIDS intervention efforts had been mounted to date. Thus far, there have been no major efforts towards the nationwide promotion of safer sex or AIDS education, although innovative projects working with members of putative risk groups appear to have been successful in increasing condom use, for example, in the work of STOPAIDS, the Transex Project, the National AIDS Council Secretariat and Angels of Mercy and in the system of Provincial AIDS Committees.

In Papua, in contrast, policies have been shaped primarily by Indonesian decision-makers located in Jakarta, the national capital of Indonesia, some 3000 km away from Papua. National AIDS policies have been implemented locally mostly by Indonesian in-migrants who have relocated to the province. Papua is highly stratified along ethnic lines. Indonesian in-migrants dominate the political and economic sectors, as well as the military, the police and the health bureaucracy. They also play a dominant role in the National AIDS Council’s provincial activities.

We suggest that agencies working to combat AIDS in Papua are profoundly
shaped by national Indonesian cultural values and their local implementation by Indonesian migrants. The Indonesian government has always evaded and denied in its dealings with HIV/AIDS. Despite official awareness of AIDS and the transmission of HIV in the late 1980s, it was not until 1995 that a national AIDS strategy was implemented (11). This strategy, dubbed the ‘Family AIDS Awareness Movement’, was broad, mass-oriented and strictly in line with Indonesian moral values (11). These values are shaped by a ‘culture of shame’ widespread throughout Indonesia, one that discourages open discussion about sexuality and foments enduring stigmas that prevent candid discussion about sexuality in general and condoms in particular.

Condoms are widely associated with prostitutes, who are in turn widely associated with an absence of morals. The acronym for ‘sex worker’ in Indonesia is ‘WTS’, meaning *Wanta Tuna Susila*, or Woman Without Morals. General assumptions about morality and sexuality are encoded within state policies. Some of these policies include making condoms available only to married couples in family planning centres, leaving condoms out of AIDS information materials until very recently, and providing free STD checkups only to women who work in recognized brothels. The headline of a newsletter published by Jakarta’s Department of Health for World AIDS Day 1996 speaks volumes for the conservatism driving Indonesia’s AIDS intervention policy throughout the 1990s: “With faith and piety, and following the principles of ‘Prosperous Families’ we will tackle AIDS” (14).

In addition to national policies, local practices also reflect Indonesian moralities. Most Indonesian bureaucrats located in Papua are strongly influenced by this repressive national sexual culture and they apply it to their AIDS work. Thus some local policies include fining people at health clinics in the highlands who have an STD, because they ‘brought it about on themselves’; putting up large posters about AIDS in urban centres which focus on disease, not on prevention; and targeting preventions strongly towards sex workers because the assumption is that they are the most likely source of infection (if not also contagion). Researchers report a strong perception among Indonesian administrators that Papuans are burdened by ‘cultural values’ that prevent them from learning and adhering to safe sex principles, in reference to a widespread belief that Papuan ‘culture’ increases sexual risk by promoting risky behaviour (9). There have been some innovative programs, notably a street sex worker outreach project in the capital of Jayapura, and the non-profit YASANTO’s work as an AIDS hospice organization in Merauke, but these have had arguably far smaller an effect than have similar efforts in PNG. Churches have so far remained resolutely conservative in Papua: no church group has yet to endorse condom use.

In 1997, in commemoration of World AIDS Day, there were two months of government-supported and/or sponsored activities and seminars held in Jakarta, East and West Java, Bali, South Sulawesi and Central Kalimantan (15). There were no activities held in Papua, despite the fact that by the early 1990s the Department of Health’s own statistics indicated that 41% of Indonesia’s HIV-antibody-positive cases were located in the province of Papua (16). We argue that Indonesian foot-dragging, combined with reductionist moral arguments, has significantly reduced indigenous Papuans’ access to the basic information that is critical to their development of personal safer sex practices.

**Conclusion**

This paper has sketched general trends of AIDS awareness between an independent country and a province of another whose inhabitants have similar cultural backgrounds. Serious misconceptions continue to dominate knowledge of AIDS in both countries, and neither Papuans nor Papua New Guineans possess sufficient
understanding of HIV or STD transmission routes effectively to protect themselves from infection. Scarce medical and monetary resources further challenge AIDS intervention programs, which must also attempt to meet culturally diverse and often specific regional needs. If future AIDS education programs are to succeed in promoting healthy sexual practice in Papua and PNG, they must explicitly address cultural values and fears. This is particularly true in Papua, where interventions drawing on Papuan cultural identity can avoid pressuring Papuans to accept dominant Indonesian moralities which may poorly match, or even condemn, indigenous beliefs.

An obvious lack of resources is not the only limiting factor for AIDS education in Papua. Relations are poor between the Indonesian government and most Papuans, and the level of mistrust is high. Some Papuans have said that they would not want to hear about AIDS from the government anyway – they would suspect false or incomplete information. Indonesian authorities must address issues of ethnicity and state-sponsored violence head-on if AIDS education is to become more efficacious.

Looking at rates of infection across the island, it is difficult to conclude that one set of initiatives is more effective than the other. But in at least giving a measure of choice to Papua New Guineans through information and condom promotion, PNG agencies, activists and institutions are doing more to enable safe sex than their Indonesian counterparts in Papua. However fragile and half-hearted, what goes on in PNG hints at the kind of HIV activism that could be in place in Papua were Papuans given the opportunity to govern themselves and work with their own understandings of safe sex and healthy lives.

REFERENCES

2 National Sex and Reproduction Research Team.