

Attitudes and Behaviours Towards HIV and AIDS and Persons Living with AIDS

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Abstract

This article is based on a baseline research conducted in the three locations of Raikos, Ambunti/Dreikikir and Jimi Valley Districts in February 2005. The research was part of an assessment for Tokaut AIDS, an effort to gain a greater understanding of approaches that will prove effective and appropriate in combating HIV/AIDS in PNG by attempting to gain a deeper appreciation of the attitudes held by rural community members within target districts. In each location, a total of 48 in-depth interviews were carried out, 50% from a 'local' area, and 50% in a 'remote' area. A number of specialized community agents were also interviewed in each location according to availability: church and community leaders, hospital and aid post staff, traditional healers, bush doctors or midwives. This article presents the results of this research.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
PLWHA	Person Living With HIV/AIDS
PNG	Papua New Guinea

Introduction

One of the great challenges to implementing HIV&AIDS awareness programs in PNG is the perceived low prevalence rate as well as the high levels of stigma. The general trend within the national response has been to adopt the ABC methodology (to Abstain, to Be faithful or to wear Condoms). However, it is unclear how effective this approach can be within the Christian and traditional communities of rural PNG.

This article is based on an extensive explorative research study conducted for the Tokaut Aids Project in February 2005¹. Its aim was to reduce the impact of HIV&AIDS in rural areas through developing and supporting rural community-level responses to the problem, as well as supporting national-level structures. Initially focused in three districts (Raikos, Ambunti/Dreikikir and Jimi Valley) the project intends to use community theatre, training and support at the

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community and school levels to increase awareness of HIV&AIDS and to promote safe sexual behaviors.

The objective of the research was to collect baseline information, in the target areas, on current level of HIV&AIDS awareness and knowledge, level of stigma and fear of PLWHA (person living with HIV/AIDS), level of awareness of high risk behaviours, level of condom use, stigma associated with condom use, women's capacity to negotiate safe and responsible sex, and practice of tattooists, practitioners of scarification and circumcision.

The expected project outcomes were that rural community members made positive behaviour changes to reduce their risk, particularly for young people and women, of infection from HIV&AIDS and PLWHA in rural communities, have an improved quality of life and be able to live as respected and productive members of society.

Methodology

The methods used were essentially qualitative, so as to allow the participants to express the broadest possible sample of opinions, perceptions and beliefs. Interviews in pairs appeared to offer respondents the optimal balance between feelings of privacy and peer support to discuss in depth sensitive topics.

The report does not include any figures, the method being entirely qualitative and looking at gathering the largest possible number of opinions, ideas, and motivations. Any valid figure would only be obtained through a subsequent quantitative phase. At this stage, ALL opinions have equal weight, until they are quantified. I have only added relative measures like 'most of the respondents', 'some', 'a few', to make the report easier to read.

The sample was constructed on sub-sampling according to geographical criteria. Geographical sub-samples are referred to as 'local' and 'remote'. 'Remote' locations were at least one-day walk from the 'local' district stations, while these district stations are themselves some of the most isolated and remote in the nation.

In each location, a total of 48 in-depth interviews were carried out, disaggregated into the following sub samples:

- Sex: 50% males and 50% females
- Age: 50 % aged between 15 and 24 years old, and 50% between 25 and 35 years old
- Location: 50% living on the 'local' area, and 50% in 'remote' area.

Locations: Raikos District (Madang Province) with Saidor Station as 'local' and Mur village as 'remote' group; Ambunti-Dreikikir District (East Sepik Province) with Ambunti Station as 'local' and Yarakai village as 'remote'; and Jimi Valley District (Western Highlands Province) with Koinambe station as 'local' and Kompiai and Bogopai villages as 'remote'.

Age: Two age groups, between 15-24 years old and 25-35 years old. were considered because of the particular interest they present in term of sexual activity and movement within and outside the community.

Sex: Because of the particular cultural structure of PNG society, men and women were interviewed separately.

Specialized community agents: According to availability in each community, an additional sub-sample of 'specialized community agents' (community leaders, church leaders, tattooists, village doctors, midwives, aid post and hospital workers) were interviewed for their possible impact on the health and behaviour of fellow villagers.

Timing: The fieldwork was conducted in February 2005. The results were presented in a final report in May 2005.

Constraints and limitations

Topic: Sexual behaviour and HIV&AIDS are extremely sensitive issues considering the taboos and cultural restraints (including the impact of missionarisation).

Remoteness: The information about HIV&AIDS, which had reached the remote communities, appeared to be incomplete, incorrect, or misunderstood.

Limited experience of research: The majority of respondents had expected the more commonly known concept of awareness, but were unfamiliar, and in some cases, unprepared for the idea of answering specific and personal questions.

Direct contact with PLWHA: The presence or suspected presence of an HIV positive community member may alter the community's perception of HIV&AIDS. Opposite forces at work are fear and rejection on the one hand, and solidarity and compassion on the other hand.

Results

Generally the 'specialized community agents' presented more accurate knowledge of HIV&AIDS, due to the training they had received. The results hereunder represent the main sample's answers and not those of the specialized community agents, unless specified otherwise.

General Awareness of HIV&AIDS was very low. The majority of respondents had either incomplete or incorrect information or had misunderstood the information they had previously received. Few respondents were able to draw a distinction between HIV and AIDS.

HIV transmission was widely perceived as linked to *sinful* sexual contact. Respondents did not see a risk of transmission between married couples even though they revealed that extra-marital sex was widely practised in the communities.

Sexual behaviours in the rural communities would suggest that the village context is in fact highly vulnerable to HIV transmission. Adolescent and pre-marital sex are common, as is teenage pregnancy, and most young people had multiple partners before marriage. Extra-marital affairs were common among both men and women.

Attitudes towards persons living with HIV/AIDS (PLWHA) were rife with stigma and discrimination. Respondents voiced a strong view that they did not want PLWHA in their communities. This fear can be related to their lack of knowledge on the modes of transmission and the low levels of knowledge on how to safely care for a PLWHA.

Condoms and their appropriateness and efficacy were topics of much debate and confusion within the communities. Generally, respondents understood the purpose of condoms in theory, but few men and even fewer women admitted to having any first-hand experience with the use of condoms, even though they were available in the communities.

Tattoo, circumcision and scarification practices are safe, as traditionally the practitioners reserve one implement for one person. Some isolated reports of non-traditional tattooing sessions, however, suggest less care was given to avoid contamination.

Gender imbalance was at the heart of the behaviour-change struggle. Women were particularly vulnerable due to their lack of access to information and education. In the 'remote' communities women expressed their lack of literacy and Tok Pisin comprehension as a barrier to understanding available awareness messages. Married women reported that they had little or no ability to negotiate with their husbands either to use a condom or forgo sexual intercourse and that a woman's refusal often resulted in domestic violence.

Church influence cannot be ignored as an aspect of appropriate awareness work in these districts. Christian principles were either voiced or followed by community members in all three target districts.

Health services in the target communities were challenged by lack of qualified staff and did not keep accurate records.

Awareness

The interview started with asking respondents about their general knowledge and awareness of HIV&AIDS. General awareness was low across all three districts, although it tended to be higher among 'local' as opposed to 'remote' respondents, and higher among men as opposed to women. Interviews with the

'specialized community agents' showed a higher level of awareness among them.

All respondents were familiar with the Tok Pisin name '*sikaidis*' (AIDS sickness) even if they could not explain the term. Respondents were not aware of a difference between HIV and AIDS; in fact they presented no awareness of HIV. They stated that the illness was fatal, and that there was no cure for it. Only very marginally – and unconvincingly- were options mentioned.

The newspapers had mentioned a herb remedy last year, and some respondents suggested that local plants might be able to provide a cure. Others suggested faith and true remorse for healing.

The more traditional the community, the more disruptive this novelty element was perceived, as traditional communities were more likely to rely, or more used to look for answers in the traditional experience. It is a NEW disease as there are no references to be found in the traditional lore for diagnosis, transmission, nor for cure.

The overwhelming feeling was one of strong, acute FEAR, fuelled by lack of information about symptoms or even diagnosis of the disease. This fear created apocalyptic visions amongst the respondents, especially those in the remote communities, of entire communities being wiped out, with all members dying from the disease.

Despite the fact that most respondents had at one time or another received some kind of information about HIV&AIDS, the awareness of modes of transmission was mostly incomplete or incorrect. Respondents spoke of the primary mode of transmission as transmission through sexual contact, but often tainted with the idea of transmission through 'sinful' sexual contact, almost as a (divine) punishment for unlawful contact.

Expressions varied from '*bungim bodi*' (join body) and '*pasim bodi*' or '*slip wantaim*' (sleep with), to '*raun*' (go around) or '*raun pamuk*' (go around for casual sex), or simply '*pamuk*' (illicit sex), to '*mangal*' or '*aigris pasin*' (eye contact/flirting). All were heavily laden with 'sinful' associations, usually in relation to religious beliefs. Most often too – but not exclusively – it was the men who were credited with the 'sleeping around'.

Another often mentioned mode of transmission was the sharing of a razor blade or a needle. However, the information appeared as incomplete, as often the association with 'blood' as vector of contamination was absent. It was the action of 'sharing' that was perceived as the prime vector.

Transmission from mother to child or through breastfeeding was not mentioned spontaneously, but was recognized as probable or definite by all respondents upon suggestion from the interviewers. Some men in 'remote' Raikos expressed concern for their wife to be contaminated as she helped another woman to give birth. They wished that village birth attendants had access to

rubber gloves in this case. In Saidor and Yarakai, the hospital staff expressed concern about their own health, with regard to contact with the disease.

Other suspected modes of transmission were: saliva, urine and faeces, sharing clothes, insect bites, skin contact, sweat, contact with sores, sharing lime and pepper when chewing betel nut, sharing a toothbrush and even breathing the same air. Most respondents admitted that they could only guess what the symptoms might be, as they had no clear information.

Whatever the actual mode of transmission, the real origin of the disease was 'taun' (town), a place ill defined by most respondents who do not know any town well, yet perceived as some demonized 'dark hole', where the disease 'kalap' (jumps) on people who then spread it back to the village. From this, all three localities were observed to be highly suspicious of anybody who has been in touch with 'taun' – including the research team! Women in Jimi started to actively approach the female interviewers only after having received the assurance that none of the five interviewers had the disease.

Modes of prevention suggested were on a par with the respondent's knowledge of the modes of transmission. The respondents who reported no knowledge of the modes of transmission obviously found it difficult to suggest methods to avoid the disease. Just as transmission was often mentioned as the result of men going around, prevention was seen as possibly staying away from 'other' women.

The church's teachings were a reference to avoid the disease: 'abstain or be faithful to your partner'. Some respondents spontaneously mentioned the use of condoms as means of prevention: they were mostly health workers and community leaders, and to a lesser extent, church leaders. Very pragmatically, they said: *'You can't suppress sexual desire; condoms are the only safe way'*. Those respondents who reported a basic knowledge of the modes of transmission or had taken part in previous awareness campaigns mentioned the ABC approach. Finally, respondents voiced one last way of avoiding HIV&AIDS and that was to avoid the people who had the disease.

The specialized community agents were the only ones to make a distinction between HIV and AIDS, and able to say that there were no initial, detectable symptoms. Other respondents looked for early symptoms. Initial hesitations were perceived when respondents were asked about the symptoms of a person with 'sikuids'. The symptoms mentioned were second-hand information, passed on mostly during informal conversations, with no certainty of accuracy. Supposed symptoms commonly mentioned were: weight and hair loss, skin rash and skin problems, repeated diseases, diarrhoea, sunken eyes, and a persistent cough.

Generally, the perceived lack of certainty concerning the symptoms was a strong factor for stigma against 'PLWHA'. In line with the very low awareness of HIV&AIDS symptoms, 'remote' respondents in Mur, Yarakai and Koinambe clearly expressed a general suspicion towards strangers or fellow

community members who had recently come back from the outside world. This trait was dominant among the 'remote' respondents: 'sikaidis' is a disease that comes from 'taun' – a term that designates Wewak, Madang or Mount Hagen, but also the district stations of Saidor and Ambunti for people living in Mur or Yarakai.

Sources of information about HIV&AIDS

The large majority of respondents mentioned some form of HIV/AIDS awareness that had taken place in their area. Often however, their own access to information had been second-hand. The sources of information were workshops, newspapers, radio, posters, and more rarely pamphlets, information given by pastoral and by health centre or aid post staff, in relation to the treatment of sexually transmitted infections (STI's), or together with family planning information. Stories and gossip were rife, especially from those who had been into town and had returned to the (remote) community, complete with horror scenarios.

Generally, respondents, including specialized community agents, expressed uncertainty about the accuracy of their own knowledge, and a sincere eagerness to learn more, together with helplessness as to where to turn to find reliable information. Considering the quality of the information held by some community and church leaders and health workers, one must identify why all community members did not more equally share awareness. Is the general lack of awareness due to the quality of the information (unclear, too difficult to grasp), or the language (English, Tok Pisin or even Tok Ples [talk of a place, vernacular] in remote areas), or to the lack of repetition and subsequent support?

Respondents comment on this gap:

- Population have only been told, but not actually involved, so information bypasses them
- The sexual urge is so strong, it dilutes the fear
- Reactions to local attempts at awareness are mixed: women are not taken seriously, or respondents in a group are ashamed and choose to make fun rather than participate
- The population does not take the problem seriously, HIV&AIDS is not at the top of their mind, and it would rather look for traditional explanations, such as sorcery.

Awareness of available testing facilities

All respondents were aware that tests are available for accurate diagnosis, and that this could be done in town – respectively Madang, Wewak and Mount Hagen. Regrets were expressed as to the fact that such facilities were not available in a closer location, reinforcing the resentment that the remote districts suffered from this 'sik bilong taun' (sick belong town), yet were offered no opportunities to counter it. A majority of respondents expressed the

wish that a 'blood-testing machine' be installed at the local aid post, to help them determine how present the danger of transmission was in their community.

First-hand experience of person living with HIV&AIDS (PLWHA)

In all three localities, the research team was able to interview respondents who had had direct experience of looking after a person living with HIV&AIDS. In all three cases, the interviewed persons had had at least direct conversation with the sick person, and in two cases were actively involved in looking after him/her. All reported receiving good information about the disease, which led to a lessening of their fear, and allowed them to come near and care for the person. They also reported witnessing a high level of stigma towards the sick person.

Stigma against people living with HIV&AIDS

Expressions of a very high level of stigma against a people living with HIV&AIDS were encountered in all three locations. Testimonies included: not coming near the HIV positive person while he was sick; calling children back when he was walking around; not buying the wife's vegetables at the market; not attending the funeral, and fear of 'pulim win, na pulim sik' (breathing the wind and getting sick).

It was also interesting to note that family members said that the sick people died 'of worry', because of feelings of ostracism and neglect, with no external signs of the disease, while non-eye witnesses described the terrible sores that were covering them from head to toe. Comments appeared to not have been said directly to the PLWHA.

A female respondent was currently nursing her HIV positive brother, who was expelled from his home village. She explained that she took precautions such as wearing gloves when he had open sores, but otherwise led a 'normal' life next to him. She did not talk about his disease to other community members; in fact she kept it hidden, for fear of reactions. Recently, she convinced her brother to fetch his wife from their village, in order for her to get a HIV test in town.

Only those respondents who had received clear and sufficient information about the modes of transmission expressed 'Christian compassion' when talking about people living with HIV&AIDS. Any kind of counselling mentioned tended to involve Christian beliefs. All other respondents, who had had no contact with a person living with HIV&AIDS, wanted to have as little as possible to do with them. They argued that, because they did not know the disease, they did not know how to look after the person. Respondents were quite clear and vocal that the person with HIV&AIDS should stay away, or go away. If not, they would be forcibly removed.

Suggestions were made that, if the community did not hurt those who were HIV positive, they would at least keep them well separated. The fact that the person got HIV&AIDS was often interpreted as the result of their own 'loose' behaviour. Many respondents only identified 'sinful behaviour' as the mode of transmission.

Another expression of stigma was the general demand, from all communities interviewed, for a local HIV test centre and a local care centre. They would like the HIV test in order to identify those community members who presented a threat, and the care centre in order to isolate them, with the expectation that government staff – not their own family or fellow community members – would look after the sick.

The general feeling of fear was compounded by feelings of anger, directed against the possible danger the infected person represented. Women felt particularly vulnerable as they felt unable to control their husband's whereabouts and actions and they empathized with women who had been infected.

It was observed that clear information about the modes of transmission had the effect of lessening the stigma against people living with HIV&AIDS. Those interviewed who had first-hand experience of contact with a person living with HIV&AIDS testified of this evolution. This was particularly true of health workers, who reflected a low level of stigma. Their reaction however was still dictated by the climate of fear and the level of stigma within their environment. They were torn between two options: 'No ken tokaut' (you can't speak out), for fear of negative reaction, ostracism, rejection, and 'no ken haitim', (you can't hide it) lest the present climate not evolve into one that was more supportive of persons living with HIV&AIDS.

General patterns of sexual behaviour

Respondents agreed that adolescent sex and pre-marital sex were common, and that multiple sexual partners were an occurrence even among married people. A difference in the perception of the magnitude of the phenomena differentiates 'local' from 'remote' respondents. Generally the district stations were perceived as more sexually active than the remote areas. In the district stations respondents were aware of more adolescent and premarital sex, and married people were more likely to conduct extra marital affairs.

The age for onset of sexual activity for boys and girls was deemed 'young'; with difficulties however on the respondents' behalf to give an exact estimate in years. Teenage pregnancies were deemed 'frequent' (planti), however, there were no statistics to support these comments. Some respondents, especially in the stations of Saidor and Ambunti, reported a perception of increased early sexual activity, linked to the loss of traditional taboos and community and parent influence.

Respondents also noted that the education system, removed adolescent children from parental control when they leave for boarding school, and exposed them to other/new values and customs. Some respondents, however, said that adolescent sex was always present in the community, and that people traditionally would marry at a young age.

The age of marriage appeared to be around 18 for the women, and 20 for men, although this perception may not represent any statistic reality. The interviewers got the impression that, in reality, most marriages seemed to be decided once the woman became pregnant.

At any rate, it appeared that, despite the fact that parents may want to invoke the word of God to keep their children out of harm, most young people had multiple partners before they married. Church leaders, Catholic as well as SDA and Anglican, deplored the fact that young people 'play with sex'.

After marriage, there is said to be a lull in most couple's sexual activity, as they become involved with a new family and small children. However, later, according to most respondents especially in 'local areas', the husband resumed his 'playing around'... and the woman may do the same, a while later, as retaliation for his unfaithfulness.

Economic reasons were mentioned to explain the behaviour of some women. In Ambunti and Raikos, some cases of 'prostitution' (which we would call transactional sex) were mentioned as women needed or wanted cash, especially after a divorce or separation. Sexual encounters before marriage and extra-marital affairs took place most often in the bush, while marital sex usually took place at home.

'Remote' areas appeared to feature less separation and divorce, and reported fewer cases of infidelities. Again, these perceptions are not substantiated by statistical figures. Remote areas also were said to provide better parental control over their children in line with strong traditional patterns in these communities.

It was noted that polygamy appeared to be on the rise in the Koinambe area, not as a traditional custom, but rather as a mimic of 'big man' behaviour that degrades women. This practice was overtly criticized by the Anglican Church and the churchgoers, and by traditionally minded community members, especially women.

There appeared to be very little discussion among peers over one's sexual activity. This was even more pronounced among women in remote areas. There seemed to be a lack of sexual education from older to younger women, and women did not appear to discuss sex within their peer groups.

Finally, women's group leaders in Ambunti and to a lesser extent in Jimi, mentioned a very slow change in the attitude of men towards an improvement in couple relationships. In their words, the younger men (about 25 years old),

married for a few years, presented a (slight) tendency to work on having better partnerships with their wives. Examples included sharing more household chores and childcare, and generally dialoguing better with their partner.

Perceptions of high/low risk sexual behaviour

The general reaction from respondents, when asked to evaluate the degree of risk associated with behaviours, was surprise at the very concept of a risk level relating to behaviour. The concept of high risk or low risk behaviour appeared to be completely foreign to the majority of the respondents, to the point that they were unable to answer the questions or give an opinion. 'Mi no klia' (I don't understand) was an answer often heard, especially, but not exclusively, among women.

Some of the sexual practices respondents were asked to comment upon appeared to be unknown to them. The vocabulary would be subject to interpretation. For instance, in Koinambe, 'repim' (to rape) may be used for common sexual intercourse. In doubt, most respondents, especially in the remote areas, chose to describe the practices they were not familiar with (such as oral or anal sex) as high risk.

The reactions to the items in the list below then takes into account the respondents who were able to express an opinion:

- *Holding hands and kissing*: usually considered low risk
- *Heavy petting*: usually low risk, but may lead to high risk if the partners lack control
- *Sex with condom*: low risk, but morally unacceptable to some Catholic churchgoers
- *Sex without condom*: high risk, although condoms were not reliable anyway
- *Oral sex, anal sex*: most respondents appeared to not understand exactly what practice was being referred to. Those who ventured an answer did so on the basis that 'with condom would be generally considered safe, without condom would be generally considered unsafe'.
- *Rough sex*: 'rap, strongpela koap': this concept also seemed to elicit puzzlement on behalf of the respondents. Some women said that they were able to tell their husbands about practices they did not like. Generally however, the section on negotiation will highlight that women felt like they had little say in sexual matters; that men did not appear to be listening to needs or wants they might express, that women themselves did not appear to talk about sex among themselves, and that, therefore, in this context, they lacked opportunities to establish comparisons between 'rough' and 'not rough' sex. As for men, their interpretation of 'rough sex' seemed to include shaking or even bashing, as a response, for instance, to an uncooperative wife.

- *Rape*: mention of rape leads to further cultural misunderstanding. An opportunistic or scheming man in Ambunti or Raikos may force a young woman on her way to the garden into sexual intercourse, but this did not appear to be considered as 'rape' by the local respondents. Rape was most commonly understood as 'pack rape'. Although this did not appear to be a common or well-known occurrence to the respondents, they mostly thought that it might be high risk, especially as the men were not likely to be wearing condoms.
- *Bung koap* (group sex): The concept of group sex was clear only to a very limited number of male respondents. All other respondents, male and female, think rather of '*lain koap*', where a woman, whether consenting or more likely drunk, allows men to line up before coming to take her. Again, this view of opportunistic rather than calculated circumstances caused respondents to think that participants were not likely to take any precautions and use condoms, hence a perception of high risk.

Katim Skin: Tattoo/ Circumcision/ Scarification

In the three locations, scarification of some type was practiced traditionally. In all cases, tattooists and other respondents reported the use of separate utensils for each individual. After the scarification ceremony, all these implements were disposed of. However, modern tattooing methods may be an issue and needs to be addressed.

Other non-sexual practices: share a meal, feed and care for a PLWHA, share a toilet

The respondents were asked to evaluate the risk associated with such practices as sharing a meal or feeding a PLWHA, sharing a toilet, washing a PLWHA. The level of risk awareness of non-sexual practices varied greatly. In many cases respondents appeared unsure of their response and when in doubt, would choose to label an activity as high risk.

All the respondents with low or uncertain knowledge of how to care for and live with a PLWHA considered the practices mentioned to be high risk. Even respondents who mentioned having heard that such practices were safe appeared as almost reluctant to believe the accuracy of this information, and expected further reassurance.

Women's sexual negotiation ability

The large majority of respondents able to comment on the topic of sexual negotiation belonged to the older age group. The younger ones present generally only had 'hearsay' knowledge of sexual or marital behaviour.

In all remote areas, both male and female respondents reported precise traditional circumstances involving negotiation for sexual activity. Examples of circumstances where partners should abstain from engaging in sexual intercourse included: preparation for tribal fights, hunting and fishing; for traditional celebrations and clearing gardens, when pregnant and when nursing the baby (at least 2 years, but up to 3 or 4 years), during menstruation or when a child was sick.

Other, more modern circumstances for negotiating sex were mentioned in relation to family planning, particularly in the SDA and Anglican supported areas of Ambunti and Jimi. The burden of school fees had brought an apparently large number of men to accept the need to space their children and limit their number. Hospital staff underlined the fact that, according to the law, the woman did not need her husband's agreement to undertake family planning methods. However, in most cases, both husband and wife came to the hospital, at least for the initial family planning visit.

Younger women and unmarried women felt that they were able to make themselves heard by their lovers or boy-friends, as the relationship had not been made official, and they did not 'belong' to the man. In the same way, married women appeared to have a possibility to negotiate sexual behaviour with lovers but not with their husbands.

In relation to HIV&AIDS it appeared that married women's ability to negotiate for safer sex with their husband to use condoms or forego sexual intercourse, was nil. A number of women, all married, mentioned that they suspected that their husbands were seeing other women, and feared contracting HIV&AIDS, yet found themselves having to put up a fight and, in the end, unable to stand up to their husband when asked for sex.

Generally, all female respondents reported having heard of domestic violence when a woman refused to have sex with her husband. The hospital staff confirmed these comments, adding that they had no accurate records of such incidents, as couples were reluctant to come and be charged a higher fee at the hospital when seeking treatment for domestic violence (up to 15 Kina in Koinambe). This was confirmed by interviews with community leaders.

Male respondents confirmed that 'planti taim bai I gat birua' (many times there are fights), when the woman did not agree to have sex. Respondents reported that refusal of sex may result in direct bashing or shouting and breaking objects around the house, or indirect revenge, as not doing chores, taking it out on the children, or threatening to go and see another woman (and doing it).

Both men and women mentioned that for a man or woman to refuse to have sex may lead the partner to suspect that he or she was having another relationship, leading to more jealousy and domestic problems. For some female respondents, were it not for the fear of HIV transmission, they reported that they had no problem with their man seeing another woman.

The level of education was mentioned, especially by younger respondents in all three locations, as a factor of assertiveness for women, and of respect from men. This was confirmed by the perception that Jimi women, who appeared as most dominated by men, were the most self-conscious about their 'illiteracy'. Their reaction when asked about sexual negotiation was mostly of puzzlement and/or embarrassment, as if the concept itself was making them uncomfortable.

Access to beer was mentioned by many, as being responsible for the origin of male violence. Stories were told of 'town life', where getting ready for a party amounts to getting ready for rape. Men's power over women seemed to be compounded by cultural traits: the custom of bride price makes the man the official 'owner' of his wife.

All in all, the reasons for women's restricted or non-existent ability to negotiate (safer) sex were compounded to make it a key topic for the outcome of the project. Institutional support was given, for instance by the Catholic Church in Ambunti, who advocate equality in marriage, and by the Anglican Church, via the Mother's Union in Jimi Valley. Their *motto*, 'Mipela, bodi bilong mipela yet' (We women, our bodies belong to us) underlined the idea of self-respect advocated by the group.

Condoms

The respondents already knew about condoms from awareness campaigns for family planning, especially in district towns. In recent years, the presence of condoms had increased, this time in association with the fight against HIV&AIDS. Condoms had become available free of charge, in all aid posts and hospitals. Hospitals reported giving away several hundred condoms each month, although more precise figures were not available. All respondents were aware of this fact, and most had seen posters advertising the use of condoms, usually at the hospital or in some private homes.

Most respondents, both male and female, knew that condoms could be used to avoid getting pregnant and to avoid STI's. They requested more information about the purpose and use of condoms. Some women had never actually seen a condom. Most men appeared to have seen condoms, but did not know how to use them.

The ease of access to condoms however, appeared as uneven. Some aid posts offered condoms in a box on a table outside the office, for anyone to 'anonymously' pass by and help themselves, while others expected clients to ask for them and answer questions before they received them.

Generally, men were less shy and more comfortable with condoms. Women did not report using or asking for condoms. Indeed, it was said that 'pamuk meri' (prostitutes) carry condoms around in their bags. Some women were embarrassed to say that they knew about condoms, lest they be negatively judged. However, it was also reported that educated (young) women, and not only men, carry condoms with them and share them with their friends.

The SDA and Anglican Church were generally supportive of the use of condoms, with a clear and loud message about the safety aspect of their use. In parallel to these comments, however, all churches in the area, more or less strongly (depending on the personality of the church leader), emphasized control in sexual behaviour. Some aid post workers clearly expressed a 'faith versus awareness dilemma'.

A very strong following of Catholic precepts was encountered among older female respondents, who appeared during the interviews to be in some cases almost hysterically vocal against condoms. The less conservative Catholic Church leaders appeared to reluctantly accept the use of condoms in 'extreme circumstances', for instance if one partner is HIV positive. In some areas, the health services and the church services emitted contradictory messages that weakened the fight against HIV&AIDS.

Another factor working against the widespread acceptance of condoms was their novelty, especially for the remote areas, where respondents were too shy to ask for them, or how to use them. In conjunction with the novelty of HIV&AIDS itself, respondents feel inadequately informed about the use of condoms and simply shied away from them.

Worse still, for some respondents, condoms were so strongly associated with HIV&AIDS, that they had become part of the cloud of fear surrounding the disease. The association of condoms with HIV transmission may be a result of distorted messages on the dangers of using a condom more than once.

Another stigma was repeated complaints from villagers that condom users were not disposing of used condoms properly. Parents were outraged to see that their children had found used condoms on the roadside and had blown them up as balloons.

Generally, younger people were more comfortable using condoms than older people. Clearly, condoms were used outside a marriage context: husbands reported not using condoms with their wives but did so with girlfriends, who in turn reported appreciating this for the safety in preventing both STI and pregnancy. Such comments reinforced the dominant perception among (Catholic) churchgoers, that condoms perpetuated the current 'pamuk' (illicit sex) trend among young and married people.

Despite the many arguments against the use of condoms, the interviewers perceived a general feeling of 'unofficial' acceptance of condoms. HIV&AIDS was seen as new to the communities and called for new solutions.

Conclusions and recommendations

The picture emerging from the baseline research is complex. The primary impression is deceptively simple:

- HIV&AIDS awareness is low to very low among the target population
- The level of stigma against persons living with HIV&AIDS is high and fraught with misinformation, misconceptions and an overriding fear of this new, incurable disease
- The very concept of risk behaviour is new to most respondents
- Women have almost no opportunity to negotiate for safer sex, and many arguments are invoked against the use of condoms.

Looking at sub-samples, definite trends arise, according to sex, age, and place. Men know more about HIV&AIDS than women, as they are freer and mobile, and therefore have greater access to information. In remote areas men are generally more literate or speak better Tok Pisin.

Young people reflect greater awareness of HIV&AIDS and a greater eagerness to receive relevant and accurate information, in particular about risk behaviours. People living in remote areas feel safer in their enclosed society, yet at the same time more vulnerable to HIV&AIDS because of their lack of information. People in the 'local' areas are more vulnerable because of the weaker social structure and the increased migration, but have greater access to information and care facilities. Specialized community agents are more informed than the general population but reflect varying degrees of ability to share awareness information among the community.

Inside this simple picture, we encountered numerous 'exceptions' that render a more complex reality. Some apparently well informed health workers have expressed prejudice and fear, while a villager looking after her HIV positive brother showed amazing enlightenment and open-mindedness. Some churchgoers expressed extreme and very un-Christian stigma, while some church leaders agreed to deviate from the Bible to pragmatically support the fight against HIV&AIDS.

Overall, three forces have been identified that shape the community's identity, and that need to be channelled or harnessed to support the achievement of project outcomes. These three forces are *kastam* (traditional customs), *misin* (the presence and influence of the church), and the presence of modernity, in the shape of government administration.

In each location, these three forces are present in a unique way, combining or, alternatively, undermining each other's influence and creating confusion. Community members choose to find guidance in tradition and/or in the church, or to find support from government services.

A program like Tokaut AIDS would benefit from a positive association with these three forces. The use of existing networks would prove to be as determinant of the project's success as the old trade routes proved to be to the early missionaries.

The overall impression left to the research team was a strongly expressed eagerness for clear information built gradually, in degrees. In the first instance, respondents are looking at overcoming 'primal' fears through basic survival information: how is HIV&AIDS transmitted, and more specifically, how can one not get it? After this initial information is processed and the population is reassured, only then will additional information lessen the level of stigma (against PLWHA's and against condoms).

The key to achieving outcomes will be carefully monitored awareness, repetition of the message and presence of the messenger (foreign and local) and reliable and accessible references (in print and in recognized local expertise). The use of a language accessible to the whole community appears to be crucial. Use of local languages will help to avoid misunderstanding and allow the community to 'own' the message.

Women's ability to negotiate for safer sex may be developed in different ways. In some communities it may be possible to build on traditional negotiation terms. In other places, it appears that gender issues are so strong, that in the short term, only men's instilled fear of contracting the disease will give women an opportunity for safer sex.

Deep and careful groundwork may bring about some change in gender relationships and negotiation ability based on a more equal and trusting partnership. At the core of the crisis is the fact that men feel safe with their wife and look at their own safety only, not understanding how their behaviours impact on their family. Women are left with little opportunity to negotiate their own safety.

An appropriate approach will be in training local community members to conduct theatre awareness and to serve as peer educators. Repeated visits to communities within the target districts will mean that Tokaut AIDS will be able to move on from the basic HIV&AIDS transmission and prevention information and begin to address deeper issues such as stigma and discrimination, gender relationships and the importance of open communication.

It will be important for the work to target community health workers in order to ensure they have accurate information and to encourage positive attitudes among community health workers, enabling support towards PLWHA and promotion of condoms within the communities.

In order for the program to be successful it will need to work in coordination with the local church groups and advocate, whenever possible, for the churches to address the HIV&AIDS issue. It would be irresponsible to ignore the fact

that PNG is a Christian nation and that communities want to see their members following Christian principles. Abstinence and being faithful can be promoted, as positive behaviours while condoms are a positive choice when abstinence and being faithful are not achievable.

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