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The Smokescreen of Culture: AIDS and the Indigenous in Papua, Indonesia

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"We Papuans want to use a condom, but we don't know how to use it, what is it used for? Now if we knew, oh a condom is used like this, this is the way to use it, then, yes, we would like to use it."

(Simon, Awyu man)

Introduction

Throughout Asia, governments typically have reacted to the spread of AIDS by blaming the "West," outsiders, or the sexual deviance of its modernizing citizenry. In Indonesia, after years of evasion and denial, the government seems to be moving beyond moral judgments about sexuality towards addressing the pragmatics of dealing with rising infection rates. In Indonesia's easternmost province, now known as Papua (also known as Irian Jaya, or West Papua), all levels of government have been galvanized as rates of HIV infection skyrocketed in the past few years. There are presently 20.4 cases per 100,000 people in Papua, a dramatic contrast to the rest of Indonesia, which has only 0.42 cases per 100,000 people[1]. Approximately 40% of the HIV and AIDS cases in Indonesia are located in the province of Papua, even though that province has less than 1% of the country's population. If HIV is a problem elsewhere in Indonesia, in Papua it is rapidly becoming an epidemic.

In Papua, any prevention effort must come to terms with an extraordinarily complex cultural and political situation. Residents of Papua make up two largely distinct groups. Indigenous Papuans of Melanesian descent number

approximately 1.2 million, in 252 different linguistic groups. The second group, the approximately one million Indonesian in-migrants, are of Malay-Indonesian descent and mostly moved to Papua from one of Indonesia's more populated islands after 1969, when the province was incorporated into Indonesia. Indonesian in-migrants dominate political and economic sectors, as well as the military and the police. The island is environmentally challenging, with many isolated areas accessible only by foot or by plane. Illiteracy rates are high among indigenous Papuans, many of whom live in rural communities in the mountains, jungles or along the long coastline. This paper examines the success of AIDS educational interventions in reaching the indigenous Papuan population in the context of their status as a colonized people. On the basis of research conducted in 2001 under the auspices of Family Health International's *Aksi STOP AIDS (ASA)* campaign, we suggest intervention efforts have been markedly unsuccessful in reaching Papuans who are at significant risk of contracting the HIV virus.

Despite the very real logistical difficulties of disseminating AIDS information in the province, this paper will demonstrate that the failure of programs to reach Papuans is due to a combination of cultural and structural aspects of Indonesian rule in Papua. Most project leaders and state bureaucrats are Indonesian migrants who bring with them specific and explicit ideas about appropriate sexuality. These Indonesian bureaucrats generally hold an implicit, but widespread, belief about the role of Papuan "culture" in increasing sexual risk by promoting risky sexual behavior. These moral judgments about proper and improper sex assist in sustaining inequalities in the province that are already aligned along the lines of ethnicity. Inequitable access to AIDS information occurs even though prevention efforts aim to target all of the province's inhabitants. This paper addresses these processes by exploring the problematic use of simplified concepts of culture in AIDS prevention. We show how cultural values and practices potentially become reified as the cause of program failure, when an analysis of structural inequities offers a more compelling explanation. We use the sex work industry in Papua to show how structural factors of economy and ethnicity create conditions whereby those who use sex work services in town and at brothels are most likely to hear about AIDS and effective prevention. A political context of colonial relationships, and a national political culture which reluctantly addresses issues of sexuality, are the reasons for a biased distribution of information about AIDS.

Culture and the Health Transition Model

In Papua, as elsewhere, scholars and activists seek to identify characteristics which might help explain discrepant responses to AIDS prevention and education. The HIV virus can potentially be transmitted to anyone who exposes him or herself to infected bodily fluids. But, while everyone is at risk, patterns of infection develop along lines which are not random. Typically, persons who engage in high-risk behaviors, such as having unprotected sex with potentially infected partners, or sharing needles while injecting drugs, are at higher risk than persons who take less risks. According to the influential argument of health transition theorists, however, there are also behaviors rooted in cultural values which can have a

determining effect on patterns of HIV infection. People act from a nexus of shared values and expected behaviors, theorists argue, which can often place a person at increased risk of contracting HIV.

The works of John Caldwell and others from the Health Transition Centre at Australia National University epitomize the commitment to understanding the relationship between culture and risk [1-2]. Caldwell has argued that beliefs about death, about the merits of polygynous marriage, about early age at marriage, and about the health-giving aspects of sexual activity, have all affected patterns of HIV transmission in sub-Saharan Africa. For example, in a society which strongly values virginity, elders might regulate sexual intercourse assiduously. In another society, where women's ability to reproduce is highly valued, women might more readily engage in pre-marital and extra-marital sex, potentially exposing themselves to the HIV virus. Caldwell argued strongly for interventions to address cultural values if they are to have an effect[2]. Having an "effect," from the perspective of health transition theory, means changing cultural values in order to change sexual behavior, which will in turn reduce risk of contagion. This type of research has been widely replicated by others elsewhere in Asia and Africa concerned to find effective ways to modify sexual behavior[4-6]. However, the issues at play in the relationship between culture and contagion tend to get simplified to the point where culture becomes a black box of blame for all "deviant" behavior. During our research in Papua, for example, many people active in AIDS work asked me what I thought about the "culture problem" of Papuans. There was a strong perception among many of the Indonesian administrators of programs that many Papuans were burdened by cultural values that prevented them from learning and adhering to safe sex principles. Polygyny; "wife swapping;" "promiscuity;" an unwillingness to learn new ideas: these were examples of "traditional" cultural barriers understood to prevent Papuans from embracing knowledge about AIDS.

Clearly there are culturally valued practices, such as polygyny, which have the potential to increase the risk of HIV transmission through unprotected sexual intercourse. However, according to a recent critique of health transition concepts[7], cultural practices such as polygyny are too quickly labeled as "promiscuous" and problematic, and are not as a result understood or analyzed in context. It is one thing to say taking on additional wives is a cultural form of promiscuous sexuality, it is quite another to understand the practice of polygyny from an informed viewpoint. For example, in one Papuan society, ideas about bodily fluids, social relationships, patterns of procreation, and complex exchange relations are potentially all factors affecting whether or not a man decides to take another wife. Calling polygyny promiscuity condenses complex sexualities at the expense of multiple cultural interconnections. It also leaves out the relationship between cultural practice, and the historical, political, and economic contexts of people's lives. Political organizations, economic policies, and globalization, for example, can have far more significant effects on local patterns of HIV infection than cultural values[6]. However, in most health transition studies, culture gets essentialized as a potent motivator which somehow incites deviation from an abstract, but highly valorized heterosexual, monogamous sexual norm. According to Bibeau and Pedersen,

such narrow simplifications of the relationship between culture and risk is tantamount to scientific racism[7]. On the ground, in local AIDS prevention efforts, culture legitimates blame, and local cultural norms are lumped together and made a "culture problem," at the expense of a full consideration not only of real-life complexities, but also of the political and economic factors within which societies are continually enmeshed. It is precisely this process which we argue has occurred in Papua. In the following section, we describe the situation of indigenous sex workers and clients to show how the levels of knowledge and awareness of Papuans about condoms, AIDS and AIDS prevention has less to do with cultural knowledge, than with their structural position as an indigenous majority at the receiving end of health care services seemingly run primarily by, and for, Indonesian men and women.

The Sex Industry in Papua

Indonesian in-migrants have dominated economic and political institutions since the takeover of the province by Indonesia in 1969. In the Department of Health, and in non-profit agencies concerned with health issues, almost all senior staff and directors are of Indonesian heritage. This dominance of Indonesian migrants in social and political life remains strong, despite government efforts to increase Papuan participation as a means to deflect political dissent. And yet, despite the importance of the categories of "Indonesian" and "Papuan" in social life, all AIDS prevention efforts have been enacted without reference to identity. In fact, most efforts in the past decade have focused on only two groups identified as "high risk:" sex workers and their clients. Under the guidance of large-scale international aid organizations, including UNAIDS, AUSAID, and UNICEF, the provincial government has made concentrated efforts to get sex workers in urban centers to wear condoms, and some efforts to get those involved on the peripheries of sex work (brothel owners, client brokers etc.) involved in prevention efforts as well. The sex work industry in Papua is unique, conditioned by history and political economies. If Papuans and Indonesians were equally well represented in the sex-work industry in the province, then programs would arguably reach both groups equally. In effect, ethnic divisions, sustained by political and economic inequities, show up in the sex work industry as readily as they do in other institutions in the province.

In the present, sex workers in Papua are both Indonesian and Papuan. Sex work takes place out of brothels, on the street, in rural makeshift locations, and in open air locations such as on the beach or behind buildings. Sex workers entertain clients from all walks of life, from military leaders to dock workers[8-9]. The majority of sex workers are women (there are also male transvestite sex workers in urban areas, whose concerns unfortunately fall beyond the scope of this paper[10]). Despite the province's relative isolation from urban centers, large tourist industries, or established military bases, there are around 4,000 regulated sex workers. There are another 4,000 "street workers," or sex workers who do not operate from a fixed, known site. There are almost certainly at least another 4,000 women who engage in more secretive sexual exchanges in rural locations across the province. As in many parts of the world, few of these 12,000 women do the job full-time. Driven

by family well-being or survival needs, many engage in the exchange of sex for cash or goods on a temporary basis.

Sex work in Papua is highly stratified along the lines of ethnicity. Jake Morin, one of the co-authors of this paper, has conducted field research in many locations across the province. Here he summarizes categories of sex work in Papua (see Table 1).

Insert Table 1.

As Table 1 shows, the ethnicity of the sex worker is generally correlated with the amount charged for sex. Indonesian women sex workers are most likely to charge large amounts of money. This is not because Indonesian women are inherently more desirable, but because ongoing colonial relationships place Indonesian women at the apex of ideas of beauty and desire. Elite Indonesian sex workers also benefit from a regional economy which pours vast amounts of money into the pockets of military and business clients, who are also almost all Indonesians, and who prefer Indonesian sex workers.

Among the most expensive services, hostess bars (*pramuria*) and state-monitored brothels (*lokalisasi*) are staffed almost exclusively by Indonesian sex workers. Bar hostesses, for example, tend to be young and attractive women who dress in form-fitting clothes as they wait for potential customers to come to the bar. The hostess engages her client in conversation, sits close to him, holds his hand and generally treats him with loving care and attention. After he has been cajoled into drinking as much as possible (hostesses receive a percentage of beer profits), they repair to a hotel where the hostess tries to persuade her client to rent a room for the evening. She may make up to Rp. 1.000.000 (about U.S. $100) for her night's work. She works in a controlled, fixed, and relatively safe environment.

In stark contrast, Table 1 shows Papuan women as more likely to be found at the lower end of the industry. Most Papuan women do not work in brothels, but seek sex partners at public events, through friends, and by approaching potential clients directly. These mostly young and attractive women have sex with partners in a range of sites. Some locations, like urban dwellings, are relatively secure. Others sites, such as outside, by the side of the road or in an empty *honai* (traditional hut), are far less secure. In many cases, these exchanges fall far outside the norm of monetized exchange with relative strangers which provides the foundation for standard definitions of sex work[11-13]. The proliferation of Papuan women who will exchange sex for money or goods has grown in tandem with development activities throughout the province. A newly prosperous mining town, for example, has become a destination for young men who hear they can have sex without repercussions. A research assistant described another major highlands airfield town as "the place to go if you want to have sex." Places where ships dock, and where goods are transported, attract men and women interested in gaining from the cash economy. Rural sites where the government has set up regional offices, and where some Papuans receive small monthly wages, also attract a burgeoning sex work industry. Women less able to eke a livelihood from subsistence production find sex work a way to supplement meager

incomes. In short, in a stratified sex industry, Papuan women are more likely to find themselves at the bottom in terms of income, at highest risk of personal safety, and at highest risk of violence.

Patterns of condom use repeat the stratifications found within the sex work industry. As Table 2 shows, the sex workers and clients who are more likely to use condoms are Indonesians working in brothels and bars. This is because most condom promotions target brothels and hostess bars as the places where people are most likely to engage in unprotected sex with a potentially infected partner. For example, at one of Papua's largest brothels located just outside the capital city, managers have been able to convince (almost exclusively Indonesian) sex workers to insist on using condoms at work, and some of the women have managed to get up to 70% of their clients to use condoms[14]. But not everyone is able to afford these elite services. Indonesian men who are financially well-off make up the majority of clients. With their firm hold on the military, the state bureaucracy, the police, and the private business sector, Indonesians are more likely to have the cash required to enjoy the services of a bar hostess or brothel resident who is, in turn, more likely to educate them about the use of condoms. In contrast, the only street worker intervention program in the same capital city, geared almost exclusively towards Papuans, has a condom use rate of less than 5%. The manager is constantly writing letters just to try and get together enough condoms in stock to actually be able to run the peer-educator program.

Insert Table 2.

Brothel workers and street workers have different experiences with condoms because more effort is expended to educating brothel patrons and brothel workers. Irrespective of the fact that some 8,000 sex workers operate outside of brothels and bars in the province, the 4,000 workers in brothels get priority in interventions in part because the sexual culture predominant in Indonesia assumes that sex workers only operate out of known, semi-official locations. In contrast, it is much harder to reach Papuan sex workers who may engage in sexual relations outside of brothels or other expected venues associated with the formal sex work industry.

Whose Culture Problem?

To explain Papuans' seeming reluctance to use condoms or to practice safe sex, many Indonesian administrators are quick to reduce complex knowledge about Papuan sexuality to specific behaviors. "Wife swapping," for example, is often described as a pervasive phenomenon throughout the coastal Asmat tribal group. In actuality, though, the practice is deeply rooted in complex ideas about semen, growth, strength, and gender, is highly dependent on location, and is only occasionally practiced. In another example of behavior being used to label a tribal group, the highland Dani have recently been described as having "free sex parties", "free sex" and sex that is "out of control"[15]. And yet, only thirty years ago, this same group was described as having a sexuality so muted it was virtually absent! Clearly, categorizations about sexuality reflect political conditions. With both the Asmat and the Dani, those creating the discourse of a promiscuous sexuality rooted in cultural practice do so in order to implement narrow solutions which fit

within the limited parameters of health transition models of culture and sexual risk. We suggest it is the culture of Indonesian bureaucrats and health administrators, not that of Papuans, which further entrenches unequal access to information about AIDS.

In Papua, state and non-profit agency employees work together to educate the general population about AIDS, using a simple prevention message. This message promotes "A" for sexual abstinence (*Abstinen*), "B" for monogamy (*Baku setia*), and "C" for condom (*C/Kondom*). However, a "culture of shame" widespread throughout Indonesia discourages open discussion about sexuality and foments enduring stigmas which prevent candid public discussion about "C", or condoms[16-17]. While each public servant will interpret ideologies personally, it remains the norm for most Indonesian officials in Papua to be strongly influenced by this repressive national sexual culture. They are thus very reluctant to discuss or promote safe sex through condom usage. For example, a huge billboard in the province's capital, one of less than a half-dozen throughout the province, describes all the ways one can get AIDS, but says not a thing about condoms as a way to prevent contagion. On another billboard in a highlands town, a confusing drawing emphasizes the danger of blood transfusions, and shows a person lying sick in a hospital bed, rather than communicating the dangers of unprotected sexual relations.

A bureaucratic fear of plain talk about sex means that few Papuans possess basic knowledge of AIDS, even though most have heard of the term. In a standardized interview conducted with 196 Papuan respondents in eleven different locations across the province, 159 (81%) respondents had heard of AIDS, but only 57 (29%) could identify a condom when shown one. Among rural Papuans, only 8 respondents (8% of rural respondents) could identify a condom. Not one of the rural respondents we interviewed, male or female, had ever used a condom, even though there are large numbers of Papuan women engaged in semi-commercialized sexual relations in rural communities. Our Papuan researchers reported that few respondents, even in cities or towns where brothels were well-established, knew how to use a condom properly or when to use one. In one rural region, where condom use among Papuan sex workers was less than 5%, a non-profit organization ran a random test for HIV among100 Papuan men who admitted to ever having sexual relations with a sex worker. Eight out of the 100 were HIV positive[8].

Indonesia's health care system could be an effective vehicle for AIDS education, even in hard-to-reach rural areas. Most Papuans have experience of the Indonesian health care and family planning program. As Murray notes, "Indonesia has a very efficient education, health and family planning system that reaches down to the household level and could be rapidly mobilized for public information and HIV prevention…However, the Ministry of Education is resistant to providing any form of sex education and the ideology surrounding deviant behaviour and public morality have prevented this from occurring so far"[17]. As a result, general AIDS awareness campaigns have been sporadic, mostly urban, and overall inadequate. Since most Papuans live in rural regions and are therefore likely only to get information about AIDS and condoms through general promotions, they are,

again, less likely to obtain the minimum knowledge required to give them the choice about reducing sexual risk. If the information is presented to them in a peremptory fashion, they are even less interested. As one survey respondent noted, "Papuans would be angry if shown condoms by a *rambut lurus* [Indonesian]. They would say, 'Ah, here is another place where they are trying to push us again into using something.'"

The combined discriminatory effect of a brothel-based condom program, an Indonesian sexual culture of silence and shame, and a tendency to blame Papuan culture, is particularly evident in the following example. In the town of Merauke, site of the highest number of HIV/AIDS cases in the province, bar and hotel owners have been trying to get their sex workers to remain disease-free. The state has provided a free monthly medical checkup for sexually transmitted diseases (STDs) for any sex worker who shows up at the clinic. In September 2001, for example, 172 women in Merauke went to the clinic for a free checkup. However, even though there are approximately 400 Papuan women involved in sex work in Merauke, in bars, on the street, and in open-air locations, only one Papuan woman out of several hundred patients had been to the clinic for a free checkup in the past year. Is this because of the "culture problem" of Papuan "shyness," as the clinic director charged? As he intimated, is Papuan "tradition" too strong for women to choose the service? Or is this because Papuan women do not know of the service, have not received enough information about the risks of unprotected sex, and have not received enough training, support and validation for promoting safe sex with their partners and clients? Is it because the clinic office is set up in such a way that women have to walk by a half-dozen Indonesian administrators sitting at their desks to get to the clinic? Is it because the doctor and attendant nurse are not Papuan? If assisting everyone in the province really is the aim of AIDS promotions, then clearly the culture needing scrutiny is not so much that of the client, but that of the organization that imagines this structure and system to be appropriate for all. Before the culture of Papuans can be named as a problem, non-discriminatory fundamental access to information, resources, and condoms must be assured.

Discussion

In the province of Papua, for individuals of any ethnic background, rates of AIDS awareness and condom use are unacceptably low. There are many concerned activists from several agencies working to improve knowledge levels. Patterns appear to be changing under the direction of a more aggressive government and NGO promotion campaign set in motion in 2001 by Family Health International through *Aksi STOP AIDS* (*ASA*). *ASA* has increased the number of programs in smaller, rural sites, and they are collaborating with other institutions to get more condoms into the province and in the hands of those who might use them. However, condoms still remain very difficult to locate outside of pharmacies in urban centers.

Ultimately, it is the culture of the political leaders, and of the powerful Indonesian migrant community, which are primarily reflected in AIDS promotions. The free STD checkup system shows how the mostly Indonesian officials in the health and

provincial AIDS offices initiate prevention efforts which reflect dominant Indonesian cultural values about ways to treat STDs. They support interventions which validate nation-wide ideologies about prostitutes as professional, full-time, regulated brothel and bar workers. They are reluctant to promote condoms aggressively throughout the province to lay populations because dominant Indonesian values associate condoms with shame, with professional sex workers, and with stigma. It is convenient to seek problems within a simplified notion of culture, and even more convenient to propose solutions drawn from a nation-wide strategy which ignores inequities. Most of the time, the real effects of programs simply go unnoticed, because in Papua officials do not use ethnic identification in published health reports. Statistics show a wildly successful STD checkup program in Merauke, for example, but there are no formal, accessible records to show that it is only Indonesian women who go for those checkups.

If officials really were concerned about the relationship between culture and sexual behavior, they would need to explore specific practices at the individual tribal level. Exchange relations, ideas of sociality, gender norms, ideas of the body, ideas of desire and shame, and the use of cultural sanctions against locally-coded forms of "deviant sexuality" have all been identified as critical factors[8]. They might consider how indigenous persons can act as peer educators within specific tribal groups and communities. They might eliminate large-group educational seminars in favor of small, gender-specific groups, where condoms are freely passed around and discussed. Last, they might recognize the importance of ethnicity as a mobilizing force in the province, and promote the use of Papuans, and of Papuan identity, as a potential means to communicate effectively about AIDS.

HIV/AIDS does not discriminate along the lines of ethnicity. But in Papua, it appears likely that one group will be more likely infected than the other. Two unpublished reports, showing more Papuans as HIV positive than Indonesians, may be early warnings of what is to come[8]. The study of culture as relevant only to risky behavior, as found in health transition studies, is inadequate for understanding patterns of infection in Papua. Factors such as limited access to information, biased service delivery, and simplified ideas about culture all have a significant effect on how much Papuans hear and learn about AIDS and safer sex.

Getting governments involved in AIDS prevention is crucial, notes Caldwell [3]. But it is not enough to scrutinize the overall commitment of national governments to AIDS prevention. It is equally critical to examine how that commitment gets translated into practice on the ground. A focus on "politics" as nation-wide practice, and on "culture" as localized belief-driven systems, leaves out the domains in the center which are so crucial—in particular, the sexual culture of the colonizer, and the political culture of local rule. It is in those domains where we can come up with at least part of the answers on how to make AIDS prevention an effective strategy in a changing world.

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Table 1
General characteristics of the Social Structure of commercial sex in Papua

Site of sex work	Ethnicity of sex worker	Ethnicity of Client	Cost Per transaction
Regulated Hostess Bar or Hotel	Indonesian (85%)	Indonesian (80%)	Rp. 150.000 (USD $15)
Regulated Brothel	Indonesian (85%)	Indonesian (80%)	Rp. 60.000 (USD $6)
Unregulated Street Dwellings	Indonesian (50%) or Papuan (50%)	Papuan (60%)	Rp. 50.000 (USD $5)
Unregulated Open Air Street Sites	Papuan (95%)	Papuan (90%)	Rp. 25.000 (USD $2.50)

Table 2
Condom use by sex worker worksite and ethnicity

Type of sex worker	Ethnicity of sex worker	Ethnicity of Client	Condom use
Hostess Bar or Hotel worker	Indonesian (85%)	Indonesian (80%)	30% - 80% condom use
Brothel worker	Indonesian (85%)	Indonesian (80%)	30% - 80% condom use
Unregulated Street Worker	Indonesian (50%) or Papuan (50%)	Papuan (60%)	3% - 7% condom use
Unregulated Open Air Worker	Papuan (95%)	Papuan (90%)	2% - 5% condom use