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Introduction

Death and disease are the lot of all peoples. The knowledge and techniques which every culture evolves to combat them must in some sense be adaptive for the society to survive. This knowledge also provides the means whereby individuals come to interpret the threat that disease represents to them, and guides the measures they use to attempt relief. Besides such knowledge, a number of influences combine to affect the patterns of behaviour in illness which characterise each society. These include the nature of the particular diseases to which people are exposed; environmental influences of benefit or disadvantage to health; and aspects of the social order which may affect the incidence of illness, and which set the manner in which the sick are cared for. The interaction of these diverse influences is such that each society displays a distinctive pattern of response to illness. This study is an investigation of the responses to illness of the Huli people of the Southern Highlands of Papua New Guinea. My intention is to trace the various strands that combine to produce the pattern of behaviour in illness that is particular to them. In this introduction, I first make explicit the considerations which led me to select for study certain areas of Huli life.

The scope of the study and the premises underlying it

The universal characteristics of bodily functioning, growth and development represent limits to the extent of cultural variation. Certain bodily changes have implications which are broadly similar whatever significance the particular culture attaches to them. For example, the pain and incapacity that follow the breaking of a leg have similarities wherever they occur. This does not imply that the practical consequences of such an injury may not differ between, say, a mountain farmer and an urban telephone operator. Also, interpretations of such an injury may vary widely according to the particular views of those affected, and the types of explanation favoured by their culture. The social implications of the injury will be influenced by the interpretation of its cause. Where it is seen as largely accidental, the effects may be confined to the immediate consequences of the sufferer's incapacity upon close kin. The ascription of blame to others may lead to litigation and disputes. The injury

could be seen as evidence of divine displeasure, and ceremonies may be performed to secure healing. Even the most straightforward lesions can lead, therefore, to a wide range of social responses. But various constants follow from the medical aspects of the lesion. In this simple example it is likely to have developed suddenly, probably by the application of considerable force. The limb probably will not support the person affected without some sort of mechanical assistance. The period of recovery will be counted in weeks and months rather than days. Complete recovery is possible, and an adequate return of function likely. These aspects, which derive from the biological nature of the lesion, clearly pattern the experience of the sufferer and the outcome.

In this study I am therefore assuming that disorders of the body and mind have sufficiently common features in the sorts of undesirable discontinuities they imply for those experiencing them that one society's responses to them can properly be compared with another's, and that both responses are in some measure referable to the knowledge of scientific medicine. This approach is applicable both to the paradigmatic diseases clearly describable in biological terms, and to the 'penumbra where the dubious cases lie' (A. J. Lewis 1953). The dubious cases include deformities, blemishes, mental illness and other marginal categories where moral judgements are clearly involved in the significance ascribed to the affliction. Where there are differences in the inclusion or exclusion of such attributes within a particular society's general category of illness, the isolation of the area of study on biological grounds makes such variations more, not less, discriminable.

Such an approach, first advocated by Gilbert Lewis (1975: 146–51), seems preferable to the exclusion of aspects of illness behaviour on grounds that may not be clearly defined. Such exclusion usually occurs tacitly, guided by the theoretical concerns of the anthropologist and the conspicuousness of different sorts of illness behaviour. Defining the field of study according to local priorities is likely to reflect the dominant concerns of the culture in question, but it does not allow us to determine the criteria by which the people of that culture come to stress some aspects of illness and not others. Glick (1967) suggests that this tacit exclusion of illnesses which do not lead to elaborate explanations and cures should become explicit. He proposes that 'ailments', which he defines as conditions which have no socially significant cause and are treated by simple means, should be omitted from an anthropological analysis of illness. Such an approach would make comparisons between the medical responses of different societies impossible as the boundaries of each would differ greatly, and within the same society such boundaries would alter with time.

In deliminating my area of study I am therefore assuming that illness, with its general, though varying, relation to man's biological basis, is on a priori grounds a distinct aspect of all peoples' experience. Of course there are wide

differences in illness behaviour between different societies. As Freidson (1970:206) points out, medical practice 'constitutes a social reality that is distinct from (and on occasion virtually independent of) physical reality'. However, the social construction of illness, and the cultural variations that this allows, are more apparent in the expression of illness and the social organisation of care than in definitions of what does and does not constitute illness in each society. Of course, this does not imply that there is any necessary relation between the biological and social aspects of illness in all cases. There are many examples of folk diagnoses in cases where a Western doctor would be unable to discover disease. For example, the Huli diagnosis *kuyanda* (p. 101) may be applied in the absence of disease as this is defined medically. Conversely, changes that might be defined medically as pathological might be regarded by lay people in the West or all people in other cultures as unexceptional, or even desirable. The shaman who might also be seen as suffering from a psychosis is perhaps one instance of a culturally valued disorder, though Devereux's (1956) view of the shamanic role as an adaptive cloak for the schizophrenic is not borne out by empirical studies of the personalities of practising shamans (Fabrega 1972:33–39).

A number of medical conditions that people of other cultures do not classify as illness are cited in introductory texts to the field of medical anthropology to illustrate the point that illness is culturally defined. However, in view of the importance of such conditions in suggesting the possible limits to cultural variation, it is interesting how poorly supported these stock examples actually are. The Mano of Liberia are said not to regard yaws as an illness. Ackerknecht (1946) is the usual source of this observation. Ackerknecht derives it from Harley (1941). Harley, a medical missionary, does indeed quote the Mano as saying of primary and secondary yaws 'Oh, that is not a sickness,... Everybody has that' (ibid:21). But the significance of this observation in the discussion of the cultural definition of illness turns on the referents of 'sickness'. Harley's point in the passage from which the quotation is taken is that primary and secondary yaws are so common that they are treated by what he refers to as 'rational treatment' and not attributed to witchcraft. He does not say that the Mano regard their yaws lesions as unexceptionable and so ignore them. Indeed elsewhere (ibid:67) he details the various illness terms that relate to yaws, and describes the range of measures that they apply to obtain relief from the 'considerable discomfort' caused by these lesions.

One of the most widely cited examples of this sort is the condition *pinta* (dyschromic spirochaetosis), which leads to discolouration of the skin. The affliction is said to be so common amongst some Amazonian peoples that those whose skins are disfigured with *pinta* are thought of as normal. Ackerknecht (ibid) cites Biocca (1945) as the source of this observation. However Biocca, who was Professor of Medicine at the University of Rome,

was concerned in his paper with likely means of transmission of *pinta*, and not with native concepts of normality. The condition was common amongst the peoples of the Icana River, but the paper does not suggest that those affected regarded the condition as normal. The ethnography is sketchy, but his discussion of 'criminal transmission', where *Pintados* would secrete infected blood from the edge of a lesion into the food of unwelcome guests, suggests that *pinta*, though very common at that time, was nevertheless regarded as an abnormal and unwelcome affliction.

The Thonga are similarly well known in this literature, not only for not regarding infestations with intestinal worms as illness, but for even considering them necessary for digestion. The source here is again Ackerknecht (ibid), who cites Junod. However Junod (1912:(I)46) also tells us that the Thonga believe convulsions and diarrhoea in childhood to be caused by the intestinal worm 'which is in every child and must always be combated because, if unchecked, it will pass from the bowels to the stomach: it will come and beat the fontanella and will finally penetrate the chest. Then the little one will turn his eyes, be seized by convulsions and die. Happily there are some drugs which have a wonderful effect on this dangerous guest!' These conditions are cited to suggest that there are wide cultural variations in the definition of what constitutes illness. However, I suspect that unequivocal examples of this sort that would withstand careful scrutiny are very rare. As Kleinman (1980:83) points out, 'the problem with most ethnomedical studies is not that they impose an alien category on indigenous materials, but rather that they fail to apprehend a profound cross-cultural similarity in clinical interest and praxis'.

One of the concerns in anthropological writing about illness is to examine the pattern of response to illness in each society, and to show the relationship between the society's social organisation and the particular form of expression and resolution of illness favoured by its members. Turner's account (1967:385) of an Ndembu doctor's practice is an elegant example of this approach. But the patient's symptoms 'consisted of rapid palpitations of the heart; severe pains in the back, limbs, and chest; and fatigue after short spells of work. He felt that "people were always speaking things against" him.' Such symptoms are commonly found to be somatic expressions of psychiatric disorders, and Turner felt that they were 'mainly neurotic' in this case. Somatisation of psychic distress accounts for the symptoms in many cases that are analysed in such terms. Other studies concerned with the cultural patterning of illness deal with behavioural disorders. A number of exotic syndromes have been described (Simons and Hughes 1985; for Papua New Guinea see Frankel 1976). This literature seeks to demonstrate that the stresses to which individuals are responding are explicable in terms of the conflicts inherent in their society, and that the particular expression of such conflict is appropriate or even adaptive for the members of each society. The

cultural origin and the cultural moulding of illness has been clearly demonstrated in such behavioural disorders. But this task is made easier by the fact that, to a degree, the illness *is* the behaviour. Illnesses explicable largely in terms of the somatisation of psychic distress and behavioural disorders are the most plastic disorders, and so the most amenable to analysis in terms of cultural influences.

In this study I am following the convention of using the term 'disease' to refer to disorders of the body or mind which are describable in terms of medical science, and 'illness' for the individual's experience and expression of such disorders. Disease is thus defined in terms of biology and psychology, while illness is a necessarily social phenomenon. Coughs, colds, belly aches, sprained ankles, bronchitis and the like are of course illnesses as well as diseases. But the place of cultural influences in determining the experience, expression and outcome in such illnesses has received considerably less attention from anthropologists than it has in behavioural disorders. This study is intended to redress the imbalance.

One of the concerns that guided the design of this research, therefore, was that the findings should be representative of the range of Huli responses to illnesses of all sorts. An adequate description of a society's responses to illness should include the more common complaints. First, illnesses of this sort are quantitatively the most pressing concerns of the people themselves. Secondly, unless we can place the relatively rare cases where more exotic explanations are applied within the total body of illness, we cannot understand the importance of such explanations in the range of responses to illness. Nor can we distinguish what may set such cases apart for more detailed consideration by the people themselves. In addition to following the normal practice in anthropological research of studying the community in which I lived by means of participant observation, the considerations I have outlined led me to gather in addition data of a more epidemiological nature. A further factor here was the level of social change. I therefore collected quantitative information on how they explained instances of illness and what they did for them as a way to study their choices between alternatives and their relative commitment to different kinds of treatment. Finally, unless we take note of conditions that most concern the people we are studying and not only those that relate to the established anthropological debates, the findings of research of this sort will not be relevant to problems of evaluating and planning improvements in rural health services.

I am therefore handling two distinct analytical frames: on the one hand the Huli's particular culturally determined set of ideas through which they interpret instances of illness, and which guides their responses to it; and on the other the disease pattern which can be described in medical terms. These two areas interact at the analytical level. Disease patterns are in some aspects the product of culturally specific adaptations to the environment. And

conversely, characteristics of the culture may represent particular responses to noxious environmental influences. Most importantly for this study, these frames come together at the level of the individual. A key characteristic of illness is an indesirable discontinuity in an individual's experience, entailing discomfort, incapacity or even the threat of dying. The recognition of this state on the part of individuals or of those caring for them will be guided by a number of issues particular to the society, such as their conceptions of normality. Similarly, the ensuing experience and events will be guided by circumstances peculiar to that culture. But most such illness events may equally be described in biomedical terms. The varying importance of these influences will emerge only from the study of ill Hulis, rather than Huli illnesses.

In his stock-taking paper Prins (1981) applied the metaphor of the three-legged Lozi cooking-pot to the study of therapy and affliction, with the supporting legs representing the contributing specialisms of medicine, anthropology and history. Epidemiological aspects of Huli health and illness are introduced here where appropriate, though the more medical aspects of this research and the detailed exploration of its relevance to questions of health care are considered in accounts which are intended to complement this one (Frankel 1984 and 1985; Frankel and Lehmann 1984 and 1985; Frankel and Lewis forthcoming). I have already indicated the cut of the anthropological leg. It therefore remains to introduce the third support of this account of Huli medical pluralism: the historical background to current practice.

The early controversies concerning the place of historical material within an anthropological enquiry have no relevance here. The rejection of 'conjectural history' was in part a response to the excesses of the speculations of some diffusionists, and in part a means of establishing the academic respectability of the novel subject of social anthropology. Nevertheless, while ahistorical ethnographies are no longer the norm, accounts of the sort of timeless 'Anthropologyland' so scathingly debunked by Cohn (1980) still appear. Such an approach would be especially inappropriate here. The past is of great relevance to the Huli. The way that they use history is in some respects similar to the use of myth as charter, a familiar concept in anthropological writing from Malinowski onwards. But the Huli are perhaps unusual in that they do not, as many other such societies are said to do (Leach 1961:126), remain in a constant relationship with the distant past. Huli creation myths are not 'like concertinas' (I. M. Lewis 1976:122). Instead, the Huli consider that the progression of the generations is accompanied by predestined moral and social changes, so that for them time does have 'depth' (Leach:ibid). They interpret the present and anticipate the future in terms of this progression. Their own historicism cannot be understood without considering their particular view of the past, and the nature of the past events that they deem significant.

An historical perspective is also essential for understanding the current medical mix. Ethnographies of illness have until recently stressed the symbolic or ideological coherence of the medical practice of other cultures. Modern responses have been seen as marginal to this project. The Huli did not come under direct outside influence until the 1950s. Many former treatments were used only rarely if ever by most people by the time I made my study, but knowledge of their rationale, procedures, materials and spells was still retrievable by observing the relatively rare occasions when a traditional rite was employed, or by talking with retired specialists about techniques now generally discarded. Methods such as these can be used to reconstruct an ideal 'traditional medical system'. However, this approach would be based on the false assumption that for these societies it was usual for a timeless tradition to be disturbed by the physical arrival of colonial intruders. In the case of the Huli, and most such societies, the limited evidence available concerning their experiences in the early part of this century and beyond suggests the meaninglessness of dubbing a particular historical period as representing 'tradition'. In Papua New Guinea the rate of change has certainly increased markedly over the last twenty years, but our preoccupation with the adoption by members of other cultures of the trappings of Western living can distract us from the significance of other and earlier changes, changes which may or may not have been prompted by the secondary effects of colonial expansion.

The shifting scene of medical choices is a difficult one to capture. The methodology employed in this study was designed to derive as representative a picture as possible. The result is primarily an analysis of the range of Huli responses to illness that I observed during the particular years I have spent with them. This account is thus a single slice across an evanescent subject. The analogy with a microtome is apt. The two-dimensional image examined by the microscopist is essential for the appreciation of form, but it cannot offer more than grounds for speculation about process. My intention here is to understand the process of decision-making and the process of change. The Huli are responding to a profusion of novel influences, both in terms of new ideas and of new techniques. Their acceptance or rejection of these novelties is not a passive process. Innovations are assessed according to the empirical evidence of their value. Their incorporation or rejection is also influenced by resonances between particular novelties and traditional knowledge. This process is both creative and dialectical. The pattern of medical pluralism that emerges in the following pages is commonly informed by the syncretistic resolution of discrepances between traditional thought and the elements of Western thought that are presented to them.

The organisation of the data

Scientific medicine categorises its knowledge of diseases according to their aetiology, clinical features and pathological changes discernible through

special investigations. On the basis of such categorisation, statements concerning likely prognosis can be made, and treatment strategies are selected. Diagnoses in most cases refer to the particular pathological lesion deemed responsible for the illness, and may also define the causative agent. Diagnosis is an important aspect of all medical systems. Through diagnosis the amorphous threat represented by illness may become definite, and particular strategies of treatment are indicated. Amongst studies of diagnosis in other cultures, Frake's (1961) account of diagnosis among the Subanun is unusual in the coherence of the classification of disease that is presented. One reason for the rarity of such elegant accounts of disease taxonomy in the ethnographic literature may be that data of this sort have not in general been relevant to the concerns of anthropologists investigating illness, and so, like Evans-Pritchard, they may therefore have 'tired of the fruitless labour of collecting the names of innumerable diseases and medicinal plants' (1937:481). While the preoccupations of their ethnographer may have had some influence here, the Subanun are distinguished from many other societies in the extent of their knowledge of medicinal plants, and the consistency of their criteria for prescribing one rather than another. Schemes of classification do not exist in the abstract. In this case, the Subanun's intricate discrimination between diseases is an essential preliminary to the selection of one of 724 different herbal remedies.

The ordering of Huli illness terms reflects their cultural preoccupations, just as the Subanun system reflects theirs. But the Huli possess no complex taxonomic hierarchy of disease names comparable to that described by Frake. Their language of illness is rich and varied, but to attempt to arrange all their illness descriptions into sets of contrasting categories distinguished according to the nature of the symptoms would not reflect their view. As we shall see, the nature of the symptoms can be important in a number of Huli diagnoses, though in others the symptoms may be of little interest. In some circumstances the symptoms may follow from the diagnosis. The symptomatology therefore comprises one aspect only of the complex set of interactions between the disease process, culturally grounded interpretations of the significance of the illness, and social influences that guide responses in particular cases of illness. Good (1977:27) stresses these wider ramifications of diagnosis when he refers to a disease category as 'a syndrome of typical experiences, a set of words, experiences, and feelings which typically "run together" for the members of a society. Such a syndrome is not merely a reflection of symptoms linked with each other in natural reality, but a set of experiences associated through networks of meaning and social interaction in a society.' A presentation of Huli responses to illness according to sorts of symptoms would be similarly inappropriate. Instead, a breakdown of their concepts according to the level and type of explanation that they imply does reflect their concerns. And this approach is convenient for analysing the relationships between their beliefs

about illness and their responses to it. However, the detailed distinctions that Hulis make can only emerge from the analysis of instances of illness. Here I will outline the scheme which has guided my presentation of that material.

In a large proportion of cases, Hulis become aware of the presence of illness, but offer no complex interpretations of it. In such instances their illness terms are largely descriptive, addressed to the question, What is wrong? In addition, Hulis have theories about a number of physiological and pathological processes. In a number of cases they may describe illnesses in terms of the nature of the lesion, referring to the bodily process that is disordered. Illness descriptions of this sort are broadly addressed to the question, How did this illness occur? Where such diagnoses are applied, specific therapies are often indicated which are understood to reverse the pathological changes. I consider their understanding of and responses to illnesses of these two sorts in chapter 6. One aspect of bodily processes that is particularly important to the Huli, and which is central to their concepts of health and illness, is that concerned with sexuality, growth and development. I consider this separately in chapter 7.

The number of occasions when they present an unequivocal view of the specific circumstances that led to the development of the illness is relatively small. Illness descriptions of this sort are addressed to such questions as, Why did this illness occur? Why did it afflict me? Why did it develop now? What did I do to deserve it? Who is responsible? or Which spirit have I offended? The relationships between the answers to questions such as these and the social organisation of the society is the stuff of most anthropological writing concerned with illness. I discuss illnesses with explanations grounded in social relations in chapter 8, and those relating to religious ideas in chapter 9. Illnesses of these sorts will in addition usually be describable in terms of their concepts of bodily processes, and according to the nature of the lesion or symptoms. These features of the illness may also guide aspects of therapy. But in illnesses where answers to the question, Why? are known, responses are likely to be directed to whatever harmful influences the illness is ascribed.

Distinctions of this sort are guided by a number of issues, including the nature of the illness, and the attributes of the sufferer. In their turn, they guide the level of concern, the significance attributed to the illness, and the particular treatment. Before proceeding to the detailed discussion of these interactions I will set the scene from a number of perspectives. Chapter 2 places their present concerns in terms of their historical experience. Chapter 3 describes key features of current social organisation. In chapter 4 the broad themes of their views of health and illness are introduced. Chapter 5 presents various quantitative data concerning the burden of illness, explanations of illness and the selection of treatment strategies.

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Historical Perspectives

The Tari Basin is now traversed by a network of roads that connect to the Highlands Highway, and thus most of the major highland and coastal towns. Many Hulis now spend much of their time away from the Southern Highlands working or visiting, often travelling in trucks driven and owned by Hulis. The air in Tari is filled by the thrumming of twin-rotored helicopters which maintain a constant shuttle to remote oil exploration camps. The bachelor cult through which young men were expected to receive their preparation for manhood is now all but defunct. Traditional healing is now rarely practised. The vast majority of Hulis are at least nominal Christians, and the majority attend church services regularly. These and other aspects of change represent radical departures from traditional experience. Glasse (1968) tells us that in 1959 the impact of the administration and the Christian missions was limited, and that rituals were still practised regularly. The seeming abandonment of traditional practice and adoption of the novelties, such as Western medicine, described here, were thus condensed into two decades or less. In this chapter I describe this remarkable change, first in terms of the development of administrative control, and secondly in terms of the traditional perceptions which have guided their adoption of new ideas and practices. Many of these traditional concerns relate to the Huli's earlier historical experience. Prins (1979) points out the importance of distinguishing 'superficial change and underlying continuity from underlying change and superficial continuity.' The material presented here allows us to make this distinction in relation to the pattern of medical pluralism expressed in the Huli's response to illness.

Administration and development

First contact

On 21 April 1935 the Huli had their first experience of an administration patrol. Jack Hides, Jim O'Malley, ten policemen and twenty-eight carriers emerged from the lowlands and entered Huli territory at a place called Yubaya, some 10 kilometres south-east of the present administrative centre of Komo (see figs. 2 and 3). This meeting was marked by inevitable