Cultural Competency and Rural Disorder in PNG Health Promotion

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Abstract: Health workers in Papua New Guinea strongly emphasise their duty to provide services to the country’s rural majority. Trained to see rural communities as nonmodern and outside government control, they anticipate that rural people will resist, perhaps with violence, if health workers fail to ‘show respect for culture’. Examining cultural improvisation among nursing students on a rural experience practicum in the Eastern Highlands, I show how students and teachers tried to craft culturally respectful health education. However, when difficulties emerged, local people were described as unable or unwilling to harim tok (understand, heed or follow instructions). The capacity to follow instructions, cultivated through education and Christian faith, was cast as incompatible with Highlands culture. Rural health promotion activities, when they fail to foment major transformation, can help reproduce the ideological construction of the people of the hauslain (village, hamlet) as emotionally volatile and ungovernable.

Keywords
Health Promotion; Medical Anthropology; Cultural Competency; Order; Communicability
Introduction

Papua New Guinea is a massively multicultural nation. National common sense acknowledges and affirms that different cultural groups have their own traditional beliefs, practices, and protocols, some of which still have force as sources of social order, and which are distinct from modern or ‘white man’s’ ways. This diversity of cultural orders can be a problem for institutions, like the health system, that are designed to promote universal care and follow culturally neutral institutional and managerial logics. When the supposedly culture-free institutional order rubs up against distinctive local cultural orders, how do health workers manage that friction?

This article considers how students and teachers in a Highlands nursing college interpret the struggles they face in trying to communicate with rural clients, who may be indifferent or hostile to their efforts. The college, as a part of PNG’s public health system, teaches fledgling health workers how to navigate the gulf between modern institutional orders and the cultural worlds in which most patients are thought to exist. The health system in PNG has a strong ideological commitment to the ‘85% rural majority’ as the primary beneficiary of services—in theory if not always in practice. This commitment has roots in the civilising mandate of early government and mission health services, though explicit discourses of civilisation have been largely replaced by discourses of service delivery and community participation. The need for cultural sensitivity is widely acknowledged. Nevertheless, the moral and social transformation of Papua New Guinea into an orderly, unified, modern, Christian nation remains at the heart of most nurses’ sense of vocation. For them, the apparent inability of the majority to become governed is a source of frustration and concern.

During my fieldwork, nursing instructors constantly reminded students to be mindful of their responsibilities to the 85%. I observed students, teachers, and other interlocutors struggling to figure out how to ‘show respect for culture’—how to properly acknowledge custom, protocol, territory, and sovereignty—while at the same time following nursing and bureaucratic procedures ‘in the right order.’ Despite the often very strict rhetoric about the importance of following procedures and guidelines, members of the nursing profession tended to agree that ultimately, showing respect to clients was far more important. This was particularly true in situations where health workers were operating in the difficult interface between the public health system and the ‘hauslain.’ Hauslain, glossed in anthropology as hamlet, is the Tok Pisin term for a residential and kinship grouping within a larger government-designated village. Indeed, the hauslain or ples (village) setting was dismissed, by some professionals, as an intrinsically disordered space, where people did things ‘whenever, wherever,’ unmindful of the rules that made modern life possible. This is somewhat ironic, given that many villages as currently understood were colonial creations intended to make administrative tasks, including hygienic and medical patrols, easier (Barker 1996). Others, more ideologically committed to celebrating grassroots life and improving community health, emphasized that the hauslain had its own rules that health workers needed to discern and abide by. On both sides of this debate, nurses could agree that the people of the hauslain lacked the emotional and cultural reflexivity that ‘educated’ people, like themselves, had learned. Thus, in village
or community settings—or when interacting with people defined as ‘rural’—health workers were often deeply anxious about how their failure to show respect might trigger retribution. Health education and health promotion are always underwritten by an (implicit or explicit) theory of communication that explains how people exchange and interpret health information. Health workers, who have achieved their professional status through specialised education and discipline, evaluate and assess clients in terms of their capacity to understand and follow medical instructions. Briggs (2005), working at the intersection of medical and linguistic anthropology, has called this ‘communicability’: a ranking of medical subjects by their ability to internalise and manifest change. In PNG, communicability is troubled by multiple factors, including multilingualism, growing economic inequality, and regional and class stereotypes that rank citizens as more or less ‘developed’. Moreover, an ethnopsychological uncertainty about the knowability of another person’s thoughts and intentions (Robbins 2008) means that people cannot know that their words have been understood until they see material evidence of action. For health workers, the communicability of rural people is always a problem, and in the Highlands it is believed that, because of local cultural dispositions, saying or doing the wrong thing can have grievous consequences.

In keeping with this issue’s goal of exploring Melanesians’ ‘explicit ideologies of order,’ analogous to language ideologies, my article examines how health workers in Highlands PNG learn to discern and engage with the cultural worlds of their rural clientele. Using the case of a student rural experience trip to a village in Lufa District, Eastern Highlands Province, I show how concerns about the communicability of Highlands villagers shaped their activities and behaviour. In their engagements with this community, the imperative to show respect for culture led students to reject their planned curriculum and institutional regulations in favour of experimental, performative cultural bricolage. This sat uncomfortably with their larger moral sense of what health workers were supposed to do: act as role models of professionalism and modernity, promote healthy lifestyles, and move national development forward.

**Making Modern Order through Public Health**

Beginning with Foucault’s *The Birth of the Clinic* in 1973, historians and medical anthropologists have demonstrated the centrality of public health institutions to the production of modernist cultural order. While Foucault focused on the role of public health in the European metropole, health institutions were granted even greater powers in the colonized world, where Western medicine and its agents were represented as vital technologies for preserving (white) colonial vigor, combating indigenous population decline, securing ‘native’ obeisance, refuting harmful superstitions, and demonstrating the Empire’s beneficence. Hospitals and clinics were among the first colonial outposts, reliably white spaces in which elements of modernist order—clock and calendar time, the separation of work and leisure, chains of command, clean uniforms, and the keeping of written records—could be cultivated (Anderson 2006; Denoon, Dugan, and Marshall 1989; Manderson 1996).
In her ethnography of Madang hospital, Alice Street (2014) argues that, contra Foucauldian scholars of colonial public health, government health services in colonial New Guinea were never intended to surveil and discipline the indigenous population. In German New Guinea (1883-1914), health services were intended to protect white people and white commercial enterprises from the dangerous tropical environment, not to surveil and discipline the indigenous population. After the transfer of New Guinea from Germany to Australia in 1914, not much changed on the ground, but colonial understandings of the goals of health care did shift with the times. The emergence of the ‘mandated territory’ as a category of colony in the post-World War context encouraged an ethos of benevolent paternalism: ‘Mandated territories were not governed by European powers for the purposes of exploitation but for those of protecting backward people and assisting their development toward self-government’ (Street 2014, 50). This ‘anti-colonial’ mode of colonialism was never intended to cast a ‘grid of control’ over the entire territory, only to create limited forms of enclosure in which modern order could incubate.

The history of public health in PNG illustrates that the health professions have long been deeply imbricated with processes of nation-building and, importantly for this discussion, with the delineation of areas thought to be under and outside of government control. This was accomplished through the production of space—distinguishing between ‘town’, ‘village’, and ‘bush’; or urban, rural, and remote areas—by medical institutions and actors. The closer a place was to a provider of medical care, the further it was along the road to civilisation. For much of the colonial period, government health services were administered through community patrols. Australian medical assistants and other government officers saw mobile patrolling as one of the highest forms of public service, through which they demonstrated their willingness to risk hardship and danger to bring civilization and improve health (Denoon, Dugan, and Marshall 1989).

In the two decades following WWII, with decolonization on the horizon, native health services underwent massive expansion, with hospitals, nursing schools, and aid posts constructed throughout the country. With ‘complete disregard for financial realism’, the Australian administration built ‘what may have been one of the finest medical services of that era in a tropical dependency’ (Denoon, Dugan, and Marshall 1989, 74–75). Nurses, like teachers, were groomed to be the rank-and-file of an educated national class who could mediate between the village and the state, modelling good citizenship and modern behaviour in the undeveloped hinterlands. Ideally, health workers were supposed to want to take their training and expertise back to their home districts, to be cultural brokers with a foot in both worlds, rather than to grow accustomed to the comforts of an urban lifestyle. This personal dilemma remains central to the experiences of trainee health workers, whose self-perception as ‘elites’ is cultivated throughout their secondary and tertiary education.

After Independence, with all administrative positions in the Department of Health filled by Papua New Guineans, health services were decentralized, devolved to the provincial or district level. The results were, by most accounts, disastrous. A 1995 report looking at the impact of decentralization in the Western Highlands showed that health workers had widely divergent opinions on who was responsible for what functions. Access to supplies,
transportation, and staff often depended on the personal influence or whims of the District Assistant Secretaries (Campos-Outcalt, Kewa, and Thomason 1995), and there was limited supervision of staff, especially in rural health centres. The fiscal crises and consequent infrastructural decay of the 1990s further entrenched dysfunction within what had once been considered a ‘model’ third-world health system. The decay of national health systems in the wake of structural adjustment and austerity measures is a global phenomenon; in PNG the situation was made worse by the fact that most services were by definition not in villages but rather in towns, district stations, missions, plantations, and mine sites. The vast majority never had reliable access to care beyond the basic first aid, dispensary, and referral services provided at Aid Posts (Pilang, Gray, and Oprescu 2017).

Concurrent with these reforms, Papua New Guinea and several other Pacific countries signed on to the 1995 Yanuca Island Declaration, a Pacific-oriented response to the World Health Organization’s New Horizons in Health policy framework (Temu and Chen 1999; Ritchie, Rotem, and Hine 1998; Galea, Powis, and Tamplin 2000). Emerging from this declaration was the ‘Healthy Islands’ approach to health promotion and primary care. Healthy Islands initiatives, which remain central to the PNG government’s national health strategy, emphasise community involvement and participation in health promotion and prevention. According to this this framework, “[h]ealth workers and communities need to work together with a focus on preventing ill health” (Government of Papua New Guinea 2010, 2). Nursing students today are taught that part of their job is to work in a participatory way with rural communities to promote healthy lifestyles and environments. However, rural people often feel abandoned by government; they want services, not lectures on lifestyle. The social and cultural divide between educated health workers and their clients can frustrate efforts at participation.

The ideological and moral perspectives of health workers today are shaped by these histories. Health workers are driven by an ethos of ‘service’ and ‘ministry’ that is Christian, developmentalist, and occasionally authoritarian. They express the sentiment that their current working conditions are a consequence of ‘cultural mix-up’, incomplete development, and disobedience. As one educator told me, giving her vision of what the health system ought to be:

Directives should flow evenly through the system, and no one should have a different agenda from the government. Everyone needs to do their jobs and feed the system. The private sector, foreign researchers, student researchers, everyone. Everyone needs to sort out their terms of reference, so that forty years down the line we can deliver the services that the government wants. Everybody will tow the line if I was Prime Minister. We need to sort out individual greed, sort out the criminal element, and target what the government wants. We need a PM who is God-fearing, comprehensively educated, who has advisors who put God first and country second. If everyone can turn to the Lord, if everybody just complies, then we will be a very powerful nation.
While declaring the importance of obedience, humility and compliance, nurses still must work in a context defined by irregularity and disorder. Even in the relatively modernized provincial hospitals following the rules can be difficult. Because nothing in the public sector works the way it is supposed to, learning to be a nurse means learning how to ‘brakim bus na wokim’—to hack through the bush and do it, without supervision—while also learning how to disavow and justify one’s own rule-breaking. For the nurses I worked with, hospitals were sites of failed order: supervisors disappearing at crucial moments; broken and missing equipment; patients refusing to follow instructions; expired drugs in the dispensary. Students described these failures as consequences of ‘management problems’, symptoms of a generalized corruption of state institutions and poor relations between staff and management: ‘We complain and the sisters-in-charge say, “How are we supposed to fix that?” We still have to give medication.’

If hospital nursing is challenging, working in rural health centres and aid posts can be even harder. Basic supplies, electricity, running water, and drugs may be nonexistent. The high cost of transport and the lack of amenities outside towns can make living and working in rural communities exceptionally challenging. Rural health workers also have to navigate village, clan, and hauslain politics—the very land on which the health centre stands may be disputed (Razee et al. 2012; Jayasuriya et al. 2012). The fact that nurses, midwives, and community health workers (and the very occasional very idealistic doctor) still sometimes make multi-day expeditions to vaccinate remote villagers or deliver health education is a testimony to their personal commitment. The culturally bound and nonmodern conditions in which the rural majority live are more threatening than the highly constrained, and highly dysfunctional, modern order of institutional spaces. Supervisors at the hospital might write you up for taking shortcuts; the people of the hauslain might do anything.

The spectre of payback is used to discipline nursing students’ interactions with clients. The students I worked with were taught that they must vigilantly police their own behaviour to avoid retribution. Violence against nurses is not unique to PNG or to the Global South—it has been described as ‘epidemic’ in Australia, for example (Kingma 2001; Fisher et al. 1996; Hegney, Plank, and Parker 2003). Despite the global scope of this problem, nurses in PNG linked the risks they faced to failures of national development, including the persistence of an unrefined, ‘bikhet’ (selfish, disrespectful) mentality. Nurses expected people from remote areas—especially Highlanders—to express high emotionality and poor impulse control, to be likely to retaliate out of grief, and to demand compensation if culturally offended (or to use cultural offense as a cover for pecuniary interests). Students were told that they should not expect to be protected by their institution or by the law if they showed disrespect.

The idea that the state is absent in rural spaces is foundational to the ideology of the PNG health system. Services are absent; therefore the state is absent. Many health workers continue to understand their professional ethical ideals in terms of a civilising project (Wardlow 2012, 414). The students I describe in this article will eventually be employees of the state; but their professional training leads them to reproduce the idea that the state and modernity are alien presences in the hauslain. In the classroom, they are taught that villagers are not fully subject to state control or modern forms of discipline. In the hauslain, they
present themselves as guests and interlopers with the capacity to *makim maus bilong gavman* (speak for the government (see Schwoerer, this issue)). Their activities in the hauslain are talked about with the seriousness of a diplomatic mission—students are representing not just themselves and their school, but the health department, the state, and development. At the same time, under the Healthy Islands framework, they are taught that they must try to involve communities actively in the process of building healthier lifestyles. They must learn to collaborate with people who sometimes seem to lack the ability to understand and obey.

**The Threat of the Angry Villager**

While rural people by definition don’t have (enough) government, they are thought to have an excess of culture. In the Highlands, that culture is said to hinge on principles of reciprocity and payback, and the right of the person or kin group to seek compensation for insult. Traditional emotional and psychological dispositions, acquired by growing up in the hauslain, could only be ‘unlearned’ or ‘separated’ from through education, discipline and piety. In the classroom, culture was sometimes likened to an infantile stage that must be overcome for development to be successful. As one student told her classmates, ‘We [health workers] need to separate from cultural ties. Overseas, they balance the spirit and culture. They have firm faith, unlike us, [we are] fifty-fifty or half-half’. Educators told students, ‘Will you show respect for culture? You cannot come from up here and go down to the hauslain and tell them anything. They will chase you out’. In this formulation, public servants can only do their jobs if local people assent, and words untethered from respectful behaviour will be dismissed. Their model of communicability posits that rural people are primarily concerned with actions, not information, and that Highlands culture requires a careful management of other people’s emotional states.

At first glance, the discourse of ‘showing respect for culture’ in PNG’s health sector is not dissimilar from the ‘cultural competency’ taught to health workers in North America, Australia, and New Zealand. For those not familiar with the term, cultural competency¹ is a component of medical education aimed at teaching health workers to recognize how cultural differences can affect patients’ experiences of medical care, and to learn to sensitively accommodate these differences. Medical anthropologists have been among cultural competency’s strongest critics, largely because of how it grants explanatory force to culture in and of itself, concealing structural inequalities and power relations in health settings (Kleinman and Benson 2006; Taylor 2003; Metzl and Hansen 2014). In the global North, ‘cultural competency’ is framed as a way of obtaining compliance in the most medicalised sense of the term—that is, drug or treatment compliance. Providers should show respect for patients’ culture in order to get them to accept biomedical care.

For health workers in PNG, ‘respect for culture’ has somewhat different implications. Like cultural competency, it is seen as essential to negotiating compliance. However, compliance

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¹ In health systems of countries with significant indigenous populations (such as New Zealand), the discourse of ‘cultural safety’ has emerged as a challenge to the idea of ‘competency’ (Papps and Ramsden 1996). Likewise, social scientists in the US have countered with the notion of ‘structural competency,’ grounded in a materialist critique of the culture concept (Metzl and Hansen 2014).
in PNG means more than sticking to a drug regimen or agreeing to blood tests: because state actors like health workers are outsiders in village spaces, showing respect is also a strategy for gaining access to territory and mobility, and for avoiding retribution. Instructors at the nursing school told students that their presence in the hauslaim was entirely dependent on how much respect they showed to local people, and how a failure to show respect could end in violence, court summons, or demands for compensation. As evidence, they could point to an unofficial archive of stories and rumours of nurses and doctors who had been assaulted by people angry over some perceived insult. Treatment compliance was not necessarily their biggest concern.

In his ethnography *Illness is a Weapon*, Eirik Saethre documents a similar meaning of ‘respect for culture’ within Aboriginal-white relationships in remote health centers in Australia's Northern Territory. Aboriginal patients, with few other avenues for resisting racism, attacked white nurses, verbally and (sometimes) physically, for failing to respect their culture—for example, requiring an older man to submit to an examination by a younger female nurse. Saethre writes, “‘Cultural violence’ perpetrated by nursing staff—such as the transgression of a community norm—is routinely blamed for precipitating Aboriginal violence’ (Saethre 2013, 115). This dynamic, Saethre argues, is part of the mutual performance of racial difference: nurses enact whiteness through a modernist refusal of Aboriginal concerns about gender and rank, and Aboriginal patients enact blackness by resisting nurses’ efforts to control them and claiming cultural injury (2013, 171). In the process, both parties reify ‘culture,’ transforming it into ‘an agent that prevents us from helping them’ (2013, 13). Obviously, PNG Highlanders have a very different relationship to the state than do Aboriginal Australians. However, cultural explanations for behaviour fall out along similar lines—rural Highlanders, like ‘Aboriginal people living in remote regions’ (2013, 12), are seen as violently sensitive to cultural insult.

The problem, of course, is that educators cannot teach health workers how to show respect for differences that are largely uncodified and very locally specific. This differs from countries like New Zealand, where the health system has systematised and routinised cultural consultation processes, and Māori words, protocols and ceremonies are woven into institutional life. For PNG health workers, it is not always easy to evaluate whether a client’s assertion that ‘this is our culture’ is true or not. There are no certification courses, online modules, checklists or on-call cultural advisors they can consult. Nurses must therefore experiment and improvise, drawing on what they know about local culture from a shared pool of experiences, knowledge, and assumptions. While experienced rural area nurses become adept at managing relationships and avoiding conflict, the students I worked with were still novices who had spent much of their recent lives in institutional environments like schools and hospitals.

Importantly, ‘respect for culture’ was not about using the right words. Respect had to be *shown*: they had to *mekim aksen* (make action), *soim pasin* (display good manners), and *soim hanmak* (show evidence of labour). In Highlands villages, this meant participating in productive labour, doing time-consuming rituals like gift exchanges and ceremonial speeches, and accepting ‘irrational’ and inconvenient taboos.
Fieldnote: Culture in the Classroom

I'm in class with about forty first year Papua New Guinean nursing students. They are learning how to perform last offices—the washing, wrapping, and tagging of a person who has died in hospital. The school's three battered, ancient, pink-skinned anatomical dummies have been brought out of storage and are lying across the students' desks.

A nineteen year old male student, assigned to pack one dummy’s orifices with gauze, gets laughs for pretending to be a father weeping over his son's body, wailing in the Fore language and pounding his head on the desk in mock grief. Another young man, enjoying the joke, lifts off the removable panel from the dummy's abdomen and declares in Tok Pisin, ‘Look Papa, John has no liver/heart. It must have been a sanguma (assault sorcerer).

A female student, perhaps finding the joke in bad taste, encourages the ‘father’ to move away from the body so the nurses can do their work. ‘Okay Papa,’ she says in soothing tones, ‘it's time for us to wrap John up now.’ In fake rage, the 'father' yells, ‘Wrap him then! You doctors must respect patients' relatives, have some respect for me!’ The other students consult their textbook and tie the dummy in a sheet while the young man pretends to tear at the wrappings, still mock-weeping.

Reading down the list of procedures given to them by the teacher, another student asks the pretend father, ‘What time are you going to come get the body?”

‘Next Sunday night,’ he answers. The first student replies that he doesn't think the morgue is open on Sunday nights. ‘But it's our culture! We only remove bodies from the morgue on Sunday nights’, the pretend father exclaims. He then turns to me and, dropping character, explains, ‘That's how relatives act when they come to get dead bodies.’

By now the rest of the group are tired of the joke. Another boy says dryly, ‘John's father must be a sanguma. He must have killed him with sorcery’.

The nursing students' joking performance of aspects of Highlands culture was a commentary on what they had been learning in class for the past two months. Their instructors had repeatedly warned them that failing to pay heed to clients' culture was dangerous and actionable. Had a teacher been watching, they would have almost certainly been reprimanded for joking about the matter. They were taught that as health workers they must always be respectful of patients’ cultural beliefs, even when they interfered with medical and nursing care.

In the sections that follow, I describe episodes in which students and teachers improvised respectful practice in a village in Lufa District, Eastern Highland Province. Having listened to many lectures on the importance of following procedures and the chain of command, students found themselves forced to adjust their practices to follow ‘pasin bilong ples’ (the ways of the village). Hyper aware that the rules were different in a village context, they improvised respectful ways to achieve their curricular goals.
Rural Experience

As stated in the introduction, the term hauslain is used by health workers to refer, firstly, to the hamlet as a kin-based residential unit; secondly, to denote a particular way of living and seeing the world that is outside or beyond modernist order. Hauslain indicates ‘village’ or ‘traditional’ lifeways, typically found in rural and remote areas. Urban villages were also classified as hauslain by my informants, suggesting that kin-ordered residential communities, whatever their location, are seen as sharing certain nonmodern qualities. Bundled with this nonmodernity are social practices—collectively described as *pasin*\(^2\)—associated with traditional culture.

Rural experience practicums are an important component of the nursing curriculum in PNG. In the school where I conducted fieldwork, these practicums were sometimes described as part of the ‘Healthy Islands’ approach to community health promotion. In the first two years of the nursing diploma program, students stay, with their cohort, in rural communities for up to a month, learning some of the negotiation and cultural translation skills so essential to their future careers. While many, if not most, students have spent some time living in villages before, these programs allow them to experience the hauslain as outsiders, as representatives of the government and cultural go-betweens. They learn, often through crisis management, how to bend the normal rules of modern order to show respect for ‘culture’. In what follows I describe some of the impromptu cultural work students did to show respect in a rural setting.

*Arriving in the Village*

The first-year rural experience trip in Lufa district took place over three weeks in September. As students understood it, their performance on the trip would be graded on the basis of two assignments: a hygiene construction project, in which they would collaborate with their hosts to build a latrine or other amenity essential for community health, and an educational presentation that would teach villagers about a significant health issue. They were to bring a message of self-sufficiency and primary prevention, encouraging people to look after themselves so that they wouldn’t have to travel all the way to Goroka for health services. It was expected that their work would be needed and appreciated by a community that lacked government services.

The village was a little over two hours drive from Goroka. Leaving town, the road took us to a junction with the Highlands Highway that turned onto the vast kunai grasslands of Henganofi district. The grass was yellow and dry at this time of year, sparsely dotted with charred patches from brushfires. After an hour or so on the road, the kunai thinned out and tall trees reappeared. The flat plains slowly rose up to a higher elevation as the terrain and vegetation changed.

Our destination was a group of hauslains on the road to Lufa station, the headquarters of the district of the same name. As rural communities in the Eastern Highlands go, this place was not actually very remote—the road that ran between the different hauslains was paved, and

\(^2\)Related to the English word ‘fashion’, *pasin* can be translated as a way of doing, behavior, manner(s) (as in good or bad manners as well as manner of doing something), style, or tendency.
buses ran to and from Goroka several times a day. Shortly before our departure, I had spent ten days in an extremely remote fly-in community in the far southwest corner of the same district, where the nearest vehicular road was a gruelling three-day hike from an airstrip serviced only by missionary aircraft. In comparison, our current destination was practically ‘town’, with a large primary school and Lufa Secondary School within walking distance, a vibrant local market held several days a week, and coffee buyers in fancy new Land Rovers going door-to-door during coffee season. However, it was also far enough from Goroka to be decidedly rural—an agricultural community where nearly everyone grew their own food and accessed cash solely through smallholder coffee production, selling vegetables at the market, or hawking wholesale goods in small trade stores.

The hauslain where we disembarked at the end of the two-hour drive was right off the road: a group of about ten bush material houses, set apart by wide, dusty clearings. In the clearings between the houses, pulped coffee beans dried on tarps in the sun. Women and children smiled and greeted us, but there were few men to be seen. As we disembarked, the two tutors who had accompanied us, Sister Kopou and Sister Urara, urged patience: we were to wait for the vice-principal to arrive before unloading anything. (Teachers did not want the villagers to see the store goods we had brought with us for our daily meals, lest they become jealous or demand a share.) A smiling woman came up and told us that we would be staying in houses that belonged to her and her husband, Michael, but that he was away at the moment trying to sort out a ‘little dispute’ with leaders of the other hauslains. We waited.

Two students in the group had grown up in the same subdistrict and thus had some familiarity with the cultural and social milieu. The beliefs held by the people of Lufa district that were most important for students to be aware of were the same ones emphasised in classroom discussions of Highlands cultures in general: that female sexual fluids were polluting and could cause illness in males, that relationships entailed obligations and must be handled with care, and that personal property and bodily wastes could be used to target their owners with sorcery (Meigs 1978; Hayano 1973). These cultural features were common enough in the Highlands that they did not really need to be explained, though students would be intermittently reminded about them. Because the majority of students were young women, they were advised to keep a close eye on their laundry and wastes, to be mindful of where they stepped, and to avoid acting supercilious or flirtatious. The young men were warned not to interact with unmarried girls, as this might be misinterpreted as a courtship gesture. Any exchange of gifts with villagers, in general, was to be carefully managed and restrained, lest intentions be misread and obligations spiral out of control.

Several hours later, the vice-principal appeared in the college’s car, along with Michael and a few other local men. They shook hands with the tutors and introduced themselves, explaining that they had been busy with village business. Michael showed us the three houses that we would be staying in and urged us to unpack our cargo. The girls’ houses were adjacent to the house he and his wife and children would be sleeping in, as was a large fire pit for our cooking needs. We gathered as Michael gave a brief speech of welcome, introducing us to our security team—four local men who had been assigned to protect us—and assuring us that this was a peaceful village and that we would be safe there, provided we treated people with
respect. ‘Nothing will happen to you here. This is your place, but you must follow the ways of the place. We can’t welcome you properly today because we are busy taking care of this little problem, but don’t think that is because we don’t respect you. Tomorrow we will show our good manners (soim pasin bilong mipela) and welcome you properly.’ The class captain, Apoga, spoke for the group and thanked Michael and the rest of the village for their welcoming words.

Almost immediately, tutors realised that their plans for the students would need to be adjusted. The village, it turned out, was not backward enough: it had running water and good latrines, recently funded by the European Union. This was the origin of the ‘little dispute’ that had delayed Michael’s arrival—only four of the hauslains had been given taps connecting them to the supply. This was problematic for a couple of reasons. Firstly, the major participatory hygiene project on which students would be assessed was no longer possible because everyone already had the necessary amenities; students worried that they might fail because the village was too developed. Secondly, their duty to ‘makim maus bilong gavman’ (speak for the government) had been compromised. If the EU could provide better services than PNG, then what were they even doing there? The water project was somewhat embarrassing—it made their well-meaning efforts to improve rural health look bad, further delegitimising the health system. How could they salvage this situation?

**Working Respectfully**

In these unexpected circumstances, tutors and students had to improvise new ways to achieve their tutelary goals. They did so by transforming the space of the hauslain in ways that, they felt, would convey an important educational message. On rural experience trips, students were supposed to work with their hosts to build items that would promote health, such as latrines and dish racks. Confronted with a village that already had these things, some students instead decided to plant flowers and *tanget* (*cordyline fruticosa*) to demarcate the boundaries between houses.

A few days into our stay, after a morning of clearing weeds and planting *tanget* around a pastor’s house, I pressed four students to tell me what making flower gardens had to do with the learning objectives set out by the curriculum. At first, they seemed confused by my question—the importance of the work was obvious to them, and they assumed it was to me as well. ‘I’m really not clear on this,’ I said. ‘This isn’t my country so I don’t know how you do things here.’ Finally Andrina explained, ‘If we come here and just talk, they won’t heed our words. We have to do some actions (mekim aksen) first and after that we will talk.’

Beautifying the areas around houses, she explained, was a performance that conveyed messages about healthy living. It also helped students to redeem their, and by extension, the government’s, reputation in the eyes of the villagers. In interviews, students described this cosmetic work as a kind of *tok piksa* (allegory), a material demonstration of a general hygienic principle. Students were showing their willingness to ‘come down to the level’ of the villagers; they were also sending a message about the connection between orderly domestic spaces and community health. In ‘Better Homes and Gardens,’ her essay examining
Tubetub Islanders’ missionary-prompted shift from elaborate longhouses to single-family homes, Martha Macintyre reminds readers that even subtle changes in the organization of space can index much larger ideological transformations, especially when these changes are explicitly marked as Christian by those who perform them (Macintyre 1989, 169). There seemed to be a similar intent behind the flower gardens and cordyline fences: people would see the ‘straightened’ houses and be inspired to live more orderly and hygienic lives. In this sense, the activity was entirely consistent with their understanding of the Healthy Islands concept, without requiring much active participation from the villagers.

However, some students found that their host families had trouble seeing the connection between their talk and their labour, assuming that the work, not the message behind the work, was why the students were there. In one case, a group of young women was asked to help their hosts prepare the soil in a freshly cleared swidden for planting pineapples. The students, unable to explain the difference between planting a flower garden (communicative work) and planting a food garden (real work), had to defer to their hosts’ desires: as one of them put it in our interview, ‘We had a hard time talking to them so we just went and cleaned the garden. We just followed them and worked.’ By doing work that changed the village’s appearance, students were trying to stimulate residents’ excitement about development—their work was not supposed to be the everyday, humdrum work of maintaining crops and running a household, but a large, transformative collective effort.

By straightening the gardens, students had found a way to fulfil their competencies despite not being able to do, strictly speaking, what was required by the curriculum. They simultaneously transformed the physical space of the village, provided a service on behalf of the government, illustrated the principles of hygiene and disease etiology laid out in the educational lectures, and showed their respectful intent. It was now up to the people of the hauslain to receive and acknowledge their efforts. Would they get the message?

*Enacting ‘Hauslain’ Gender Roles*

‘*Pasin kilim ol,*’ Sipe and Enoch remarked with admiration as they watched young men piling firewood, sweet potatoes, and meter-long stalks of sugarcane on a sheet of plastic in the middle of the hauslain. It was dusk, seven days after our arrival in the community, and with the ‘little problem’ Michael had mentioned now fading into the background, the local men had finally organized a formal presentation of welcome gifts to the students. Women brought string bags full of watercress and other greens, which the men carefully arranged under the dark red sugarcane. This was proper village behaviour, the boys’ approving comment said: their good manners were overwhelming. While the display was small, it was appreciated. Students took it as a sign that the community was finally recognizing the group’s hard work and good intentions, and doing so in a culturally appropriate manner.

While the display was being assembled, a group of about ten students quickly organized themselves to perform a traditional Mt. Hagen dance and sung ballad. As the senior women of the hauslain sang and waved target branches behind the food display, the students responded by linking arms, performing the dance to acknowledge their hosts’ *pasin*. That
particular dance was chosen not because most students were from Mt. Hagen (they weren’t), but because Hagen dances had universal cachet and were particularly aesthetically impressive. Emically, they were performances of order and unity (Strathern and Strathern 1971); etically, they were icons of traditional ‘culture’ at its most spectacular.

On occasions like this, students did their best to show respect for culture despite not always knowing the details of local protocols, beliefs, and politics. They made assumptions, some of them grounded in the personal experiences of students from Lufa district, and acted in ways consistent with what they thought villagers wanted. This focus on what was culturally acceptable bled into how students conducted themselves as a group, even when villagers were not present. Worried about what the villagers would think, students started relating to one another differently than they did in the school, hospital, and dormitory in specific gendered ways.

While both male and female students were officially supposed to cook on their allotted days (they had drawn up a schedule), at around 5 pm, the time when preparation of the evening meal was supposed to start, the boys would silently disappear, retreating to their house down the hill. The first time this happened, the girls, annoyed, went ‘on strike’, refusing to cook. Eventually, the boys emerged to complain that they were hungry, and Nelly, a female student in her thirties, laid into them with a blistering diatribe. Teachers sided with the young women, saying, ‘Young men also need to know how to cook. We aren’t living in the time of the ancestors’. Nevertheless, after a few days it became clear that the boys were not going to help with this particular chore—they didn’t want villagers to see them doing women’s work—and the teachers could not compel them to do so. Moreover, the young men wanted to reciprocate their security team and build friendships with local men by giving them leftover biscuits, sugar, and tea after morning meals, but the women insisted that the surplus should be held back as ‘insurance’.

Late one night, after a series of text message threats sent back and forth between the two camps, a small group of boys stole rice and tinned meat from the collective stores while everyone else slept. When the theft came to light early the next morning, an angry argument ensued, with the girls demanding an apology and compensation. One of the most vociferous of the girls shouted at the ringleader: ‘Am I your sister, or mother, or affine that I have to give you food? You’re no relative of mine. Bring me a six-pack of beer [as compensation].’

While the boys, as a group, eventually apologized, bad feelings lingered for the rest of the day. Finally, two male students who had not been involved in the theft went to collect wild greens from the forest, an act that won them effusive praise from the girls. ‘See, when there’s cooperation, work will go easy’, Nelly commented. Unlike chopping vegetables or cooking rice, this was culturally-appropriate work for young men in rural Highland communities. This finished the conflict.

If similar things had happened in the dormitories or in the college classroom, students would have been immediately reprimanded or even suspended, chastised that this was not the way educated professionals should behave. There was an explicitly articulated sense that this behaviour—rigid gender separation and antagonism, and favouring kinship-based over institutional/professional identities—was appropriate to the village context. While things
went too far in this case, the principle behind their behaviour was that they were supposed to ‘respect the culture of the village’. It would have felt unseemly, even offensive, for them to follow a gender-neutral cooking roster under the eyes of the hauslain. Similarly, the young women took on the task of doing their male classmates’ laundry while in the village, something they never did in the dorms, and policed their own adherence to menstrual taboos, even when villagers were not watching. One Eastern Highlander, after being reminded by a classmate not to touch the food they were cooking (she was menstruating at the time), snapped irritably, ‘I know that, I'm not a coastal woman’.³ Though she had a similar background as the villagers she was trying not to offend, her classmate knew that the social and mental transformation that came from education could lead people to forget that ‘things are different out here’.

A Respectful Lecture

A third example of experimentation surrounded an educational lecture (*skul toktok*) about the dangers of drugs and alcohol put together by a small group of students. Throughout the preparation process they put in a huge amount of effort to tailor the lecture to the presumed linguistic capacities of the villagers. Their textbooks were all written in English, and most of the presentations they had given in the classroom had been entirely in English as well. Though all students were fluent in Tok Pisin, some, especially those from Port Moresby, habitually used a prestige sociolect that they called ‘mixed English’. Rehearsing their health talks, students became aware of just how ‘mixed’ their Tok Pisin was. They assumed that villagers would be familiar only with a basilectic Highlands variety of Tok Pisin and would have trouble understanding them. Edna, a 19 year old woman who had grown up in Gordon’s Police Barracks in Port Moresby, had only rehearsed two sentences of her presentation on drugs and alcohol before stopping herself and lamenting (in perfectly grammatical, if urban-sounding, Tok Pisin), ‘Mi sa had long tok pidgin ia! (I have trouble speaking in pidgin).’ She was struggling to put together sentences that followed the conventional rules of ‘pure’ Tok Pisin grammar, and as she continued, showed increasing anxiety about translating medical terms and referring to bodily states, like high blood pressure, that (she thought) would be unknown to people without medical education.

When Edna was done and it was Enoch’s turn to rehearse his speech on alcohol, he realized that the Tok Pisin term for liver, *lewa*, did not necessarily refer to the anatomical liver but could index the heart and other innards as well. He tried to solve this problem by incorporating the local language, Yagaria. Enoch called over some men from the security detail who were having a smoke nearby. ‘How do you say “liver” in your local language?’ he asked. The men pondered for a minute, then asked for clarification: ‘This liver that you cook and eat, like in a pig, or the other liver that sits above it?’ Enoch showed them the anatomical drawing in his textbook, and the men began to discuss amongst themselves. After a few minutes of animated debate, gesturing as though they were butchering a pig, the men settled

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³ Coastal cultures were thought to be less preoccupied with menstrual taboos.
on hagamopa. Satisfied, Enoch began crafting a narrative about cirrhosis, using hagamopa to stand for the liver. However, the physiological connections also needed to be spelled out, and the function and structure of the nervous system described. Trying to explain how alcohol affected the mind, Enoch asked, ‘The backbone, inside that bone, there’s a kind of “grease” inside. If you break the backbone of a pig or something…’ A man spoke up: ‘We call that sua.’ This was exactly the kind of participatory engagement with the community that Healthy Islands initiatives encourage. Students did it untutored, in response to their (maybe disproportionate) concerns about the linguistic abilities of villagers.

Enoch prepared a beautifully culturally respectful discussion of the effects of alcohol that eschewed imposing a Western anatomical understanding of the body in favour of one that seemed more indigenous. Sprinkling Yagaria works into the lecture—anatomical terms like sua and hagamopa, as well as the greeting detenae (good afternoon) and friendly terms of address like soko bade (good man)—was part of a respectful linguistic praxis of ‘listener orientation’. By using Yagaria words, Enoch was demonstrating that students knew they were on someone else’s territory and that they were willing to do the extra communicative work required to properly acknowledge their hosts’ cultural difference. He didn’t use words like ‘spinal cord’ or ‘nerves’ that would be foreign and confusing, speaking instead of a ‘special grease’ that God had put into the body to convey messages between parts.

After hours of careful preparation, the presentations went smoothly. After each student had said their piece, a man in the audience, who had been sitting against a tree with a bottle of beer, spoke up:

Our community needs your lecture. You come and live with us and see how we live and tell us how we are failing. And still we’re failing! You’re teaching us to have some sort of standards, so that we can make the country better. Still, Papua New Guinea, you know… we’re not whitemen yet. We’re still like black men—some of your talk we will obey and some we won’t. This is a good lecture you’ve come given us. I too am a drunkard, so when you say these things I worry. It is a true to life talk you’ve given us. So thank you very much.

Despite his polite words, the man’s message was (to students) clearly hostile and impertinent. Stunned, they reckoned afterwards that after all their hard work to craft a culturally and linguistically respectful lecture, the villagers still didn’t fully grasp their good intentions. The man stated explicitly that ‘some of your talk we will obey and some we won’t’. They didn’t mean to imply that the community members were failing at being like white men, but that was the message at least one man had heard.

The ideologies of order taught in nursing school included a communicative aspect that linked higher education and professional training to an improved capacity to act humbly and follow instructions. Rural clients, who presumably lacked that education, could neither fully understand the health workers’ messages nor take that knowledge and use it to live more

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4 In this article I follow students’ spelling of the Yagaria terms, which may not correspond to the orthography used by linguists working on the language.
disciplined and orderly lives. The Tok Pisin expression *harim tok* (lit. hear language, heed my words) links the capacity to understand with the capacity to obey (Andersen 2017). Discourses about the people of the hauslain often included claims about their inability to harim tok—their refusal to obey the directives of more knowledgeable people and their resistance to change. As one student told me in an interview, discussing the challenges of rural health promotion:

> If they feel sick, they run to the hospital. And once they go home, they do whatever they want. Like village people, how they cook, get food and eat, how they look after themselves and that kind of thing, like... village people. They just stay as they are.

**Conclusion**

Taught to be vigilant about the dangers of offending their rural clients, student nurses experimented, improvised, and modified their practices in ways they thought would be culturally respectful. They had received little explicit training on how to do this, relying instead on their collective knowledge and assumptions about how villagers thought and what they valued. The misunderstandings that ensued, despite their efforts—as with the food gardens the girls were asked to plant, and the lecture that came across as arrogant—reinforced for them the difficulty of communicating with the people of the hauslain. In interviews and casual conversations back in town, many seemed to despair that it would ever be possible to convince the rural majority to live healthier lives—as long as they stayed in the village, they would never be able to suppress their bikhet. As one student told me, recalling an incident where an instructor offended the locals during a different rural practicum:

> At that time I was afraid. Because we were in a strange place, so it was an experience where I felt there was no hope in life. If anything happened it would still happen to us, and I was on high alert. They would come and beat us or—[pause]... this kind of thought was with us. It was an experience I had that made me a little unwilling to do rural experience. ‘Why did we go so far away? Why didn’t we stay at school and go out nearby, go to a settlement [in town] and give health education? Why did we do this?’ I thought.

For the students and teachers I worked with, education was the road to an orderly and stable modern world. Without education, individuals would remain willful, emotionally immature, and dependent; communities would stagnate and fail to develop; countries would regress into barbarism. At the heart of this construction is a close linking of education with obedience and order—modern, developed, advanced societies were also places where people had learned to control their emotions, follow the rules and behave. Truly educated professionals should be rule-abiding and humble, putting others above themselves. If Papua New Guinean professionals did not always live up to these expectations, it was because (nurses said) their education was not up to standards, their attachment to culture was still too strong, and their faith was only ‘half-half’.
The idea that health workers need to respect and understand culture in order to be ethical and effective has been strongly promoted in much of the English-speaking world since the 1980s (Kirmayer 2012). In Papua New Guinea, everyone knows that cultural diversity is a real and accountable matter. Health workers are acutely aware of the risks of insulting people’s cultural sensibilities, yet many also feel that those cultures are at the root of the problem. Some assert that rural health promotion is futile, because the culture is not an alternative order of meaning but a state of incomplete development. ‘We’re not whitemen yet,’ the drunkard said; no one had to ask him what he meant.

One nurse educator I spoke with was critical of the Healthy Islands approach, saying that it had ‘flopped’ because it did ‘not belong to PNG’. ‘We are a colonised country, people have lost their indigenous knowledge,’ she explained. In the same utterance, she noted that ‘PNG societies have certain cultural boundaries you have to work within. Healthy Islands is the best concept for the country, but it must be handled with care’. The notion that communities could be deprived of indigenous knowledge but also bound by culture may seem contradictory; however this is quite consistent with the view of rural communities reproduced through nursing education. Rural difference was not primarily a matter of knowledge or even language. It was about a communicative gap between the educated, who had learned how to obey instructions without taking things too personally, and the majority, who would not obey words that weren’t backed up by actions.

References


