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3. WESTERN MEDICINE AND THE CONTINUITY OF BELIEF: THE MAISIN OF COLLINGWOOD BAY, ORO PROVINCE

INTRODUCTION

> We know there are government and mission hospitals. You young people read and write so you know what is happening. I was told by the white priest that the mission and government hospitals give a different medicine. Our Papuan doctors do the same as those in the hospital. When people get sick they must decide whether to go to the village healer or one of the hospitals. You must go to one of these. You will either be better or you will die. You must show some trust that they will make your son, daughter or wife well.
>
> Adelbert Sevaru, an elder in Uiaku village

An important consideration in the examination of situations of medical pluralism in Melanesia is the overall indigenous response to outside initiatives. Given the diffuse and intertwined nature of beliefs and practices concerning health, morality and religion in these societies, it is frequently the case that initiatives and responses that appear unrelated in type and time to the administrators of health programmes may have important bearings upon each other. Many studies throughout the world reveal that cultural factors influence the ways in which people perceive and deal with innovative ideas and practices introduced from the outside. The nature of the innovations themselves and their mode of introduction are no less important. Anthropologists and other scholars often overlook this latter complexity, writing of "Christianity", "capitalism", and "Western medicine" in vague terms without specifying the usually very attenuated versions of these systems of ideas and practices that are actually offered to or forced upon rural peoples in the Third World.

My present aim is to provide an analysis of Maisin medical beliefs and practices, including their use of Western medical facilities, as a single ethnographic situation. The main theme that emerges from the analysis is that up to the present time the Maisin have successfully encompassed the limited Western medical technology available to them within a framework of culturally grounded beliefs and practices. While the direct effects of the introduction of Western medicine on the Maisin's overall notions of health and sickness have probably been quite limited, the framework as a whole has been sensitive to other innovations influencing the Maisin's experience of the moral and the divine.

The analysis is divided into four parts. I first describe the specific historical circumstances in which Western style health care began and continues to be

S. Frankel and G. Lewis (eds.), *A Continuing Trial of Treatment*. 69–93.

delivered in the Collingwood Bay area of Oro Province. I then examine data collected in a survey to show how the Maisin presently categorize and deal with illnesses. The third section of the analysis deals with each type of curative resort in some detail, showing how they are linked in the course of long and serious ailments into a "hierarchy of resort" (Romanucci-Ross 1977). Finally, I discuss the modality of change in the entire complex of health beliefs and practices.

MEDICAL SERVICES IN THE COLLINGWOOD BAY AREA[1]

The Maisin people live in a series of beach villages along the southern shores of Collingwood Bay in Oro Province, Papua New Guinea. One of several socio-linguistic groups located in Tufi district, they have a resident population of about 1200 with a third more living away in urban centers. Maisin were traditionally gardeners and gatherers, hunters and fishermen; for some time now they have supplemented these subsistence activities with money from sales of beautifully designed bark cloth and remittances sent home from towns by working relatives.

Captain John Moresby made the first recorded exploration of Collingwood Bay in 1873, although there may well have been earlier foreign visitors. Government officers, missionaries and coastal traders began making regular contacts with the Maisin and their neighbors in the 1890s. In 1900, the Administration of (then) British New Guinea created the Northeastern Division and erected a government station at Tufi on Cape Nelson at the northern head of Collingwood Bay. The first Resident Magistrate, the irrepressible C.A.W. Monckton (1922), put a quick and forcible end to inter-tribal raiding, killing some Maisin warriors in the process. The New Guinea Mission of the Anglican Church of Australia also stepped up its activities in the region at the turn of the century. Villagers in the largest Maisin community, Uiaku, accepted Solomon Island teachers into their midst in 1901; other Maisin villages soon followed. European missionaries supervised these "out-stations" from their district headquarters at Wanigela, a village located a few kilometers north of the Maisin area. The first baptisms of Maisin villagers took place in 1911; by the beginning of the Second World War most adults had joined the Mission. Since 1962 there has been a national priest stationed in Uiaku village.

Maisin were not slow to take up such lines of economic advancement as were open to them in the colonial situation. Men routinely left their homes for varying lengths of time to work as plantation or mine laborers, as policemen and as Mission teachers. In 1942 most of the able-bodied men in the Collingwood Bay area were conscripted by the Australian wartime administration following the Japanese invasion of mainland New Guinea. After 1945 the Government and the Mission rapidly expanded educational and occupational opportunities for educated nationals. Maisin were among the first to benefit from these developments. Today many of them number among the country's national elite, working as teachers, businessmen, civil servants, priests, doctors, nurses and dentists. Collingwood Bay, however, remains an economic backwater, accessible to the outside world only by

small planes and the occasional cargo ship. As in some other parts of Papua New Guinea and Oceania, the chief strategy of economic advancement open to the Maisin has been the export of labor (cf. Carrier 1981).

European missionaries and government officers began supplying some limited medical services to the Maisin from about 1900 (see Chignell 1911). From around 1910 the Mission retained the services of a European nurse at Wanigela. The Administration, on the other hand, was able only to provide intermittent medical care because of its poor finances (Gunther 1972). A Government Medical Officer visited the region on infrequent patrols. Native Medical Assistants accompanied patrol officers in the late 1930s and were apparently warmly received in the villages. In 1947 the administration opened an aid post at the eastern end of Collingwood Bay and the following year the Maisin received their own aid post at Uiaku. By 1960 there were nine aid posts in Tufi district, two of them located in Maisin villages.

Health initiatives were not limited to the provision of medical services. Patrol officers had as one of their main duties the enforcement of various regulations designed to improve village hygiene: the burial of bodies in cemeteries outside of settlements, filling in of swampy areas, destruction of diseased pigs and dogs, and regular clearing of refuse from village grounds. These regulations were enforced by the threat of internment in Tufi gaol. Whatever the overall health benefits of these measures, they appear to have done more to demonstrate the authority of the patrol officers than to teach Maisin the rudiments of European theories of sanitation.

From time to time government officers and missionaries tried to counter sorcerers and local healers. In the case of sorcerers they appear to have had the full support of Maisin communities. Maisin elders describe the sorcerers of forty years and more ago as "bad" men who were well known, respected and greatly feared. Sorcerers are described as then having a role analogous to that reported by Hau'ofa (1981) for the Mekeo. They used their power to create and to cure sicknesses as a sanction on behalf of the leaders and, more generally, in support of the indigenous morality. Maisin evidently saw the arrival of powerful Europeans as an opportunity to break the power of the sorcerers. On at least five occasions between 1904 and 1936, villagers invited visiting missionaries or officers to destroy "charms" that had been surrendered in a public place. By giving up all of their magic, Maisin apparently thought they would be able to purge sorcerers as well. On other occasions patrol officers were asked to try or arrest suspected sorcerers. It is common knowledge today that these measures along with conversion to Christianity destroyed the institution of the sorcerer as he had been known to the ancestors.

But misfortunes continue apace and so Maisin suspect that some men still resort to various forms of mystical attack. Villagers worry that not all men gave up their old "poisons" but have hidden them in their houses or passed them on with their knowledge to their sons. These "poisons" are especially worrisome because the antidotes are not generally known or have been forgotten over time. It is said that a greater number of sorcerers have turned to the use of spirit familiars which are less

deadly but harder to detect than the old methods. In more recent times, the increased mobility of the young people has fired fears that novel forms of sorcery techniques purchased in towns are being imported into the villages. The conventional wisdom is that today there are fewer men practicing sorcery than fifty years ago, but the small number who do are virtually uncontrollable.

The healing techniques presently used in Maisin villages appear to have developed in the 1920s and 1930s as offshoots of the Baigona and Taro cults which made their way through the Collingwood Bay area (see Worsley 1968). Although they considered the actions of healers to be generally detrimental to the good health of the local population, government officers were willing to tolerate them so long as they did not interfere with the maintenance of "order" in the villages. The missionaries' attitudes were more ambivalent. The New Guinea Mission of the Anglican Church was a high church organization led by well-educated bishops who generally were sympathetic to what they saw as the simple values and spiritualism of the Papuan villagers and hostile to plans to "develop" Papua for the benefit of foreign capitalists. Some missionaries viewed healers as the unknowing instruments of God. They advocated introducing some form of Christian faith healing to supplement and then replace the indigenous form. This was never done. Other missionaries were far more critical of the healers, seeing their use of spirit familiars as a type of pagan "worship". These missionaries encouraged the local teachers to preach against the healers and to forbid school children from attending healing sessions. Given its limited resources and power in the villages, the Mission was not able to stop the healers. Nor did the provision of aid posts put an end to their popularity, although one of the objectives of introducing the system was, in the words of the Assistant District Officer of the time, to "stamp out" this "unhygienic" practice (Bramwell 1948).

It is possible to detect some mixed motives in the Mission's and the Government's provision of medical services and sporadic opposition to indigenous practices. The success of European medicine served to reinforce the superiority and authority of the Europeans and their religion, to hasten the acceptance of new forms of thought and behaviour, and to keep the young men healthy for working on the plantations and in the mines. But overall, the provision of medical services played a very small role in strategies of evangelization and "civilization". Health measures were introduced for humanitarian reasons and did not form a strategic part of the missionaries' endeavors to alter and improve the moral and religious consciences of converts or the government officers' ongoing work in preserving and remolding the political order. The irony is that Maisin today, as in the past, strongly associate health and sickness with matters of religion, morality and politics.

Initially, the Administration and Anglican Mission directed much of their medical effort against epidemics, many of which resulted from diseases originally introduced into New Guinea by Europeans. In 1905 the Resident Magistrate in Tufi suspended labor recruiting in the area when villages were struck by an unspecified epidemic. Labourers and coastal traders brought in venereal disease: fifty cases were detected in Maisin villages between 1906 and 1913. Influenza struck in 1923

and 1933, followed by whooping cough and dysentery in 1938. Whooping cough and dysentery broke out again in 1950, leaving thirteen people dead in Uiaku alone.[2]

The 1950s and 1960s saw a tremendous expansion in the delivery of medical services to the rural areas of Papua New Guinea. Maisin gained from this in two ways. First, European medical knowledge began to be made available to students in the community schools and, to a much greater extent, in secondary and tertiary educational institutions. A number trained as aid post orderlies, hospital orderlies, nurses, doctors and dentists.[3] Secondly, the quality and variety of health services available to the villagers improved and increased. The mission provided a district health centre at Wanigela staffed by three nurses. A weekly ante-natal clinic was established at Wanigela hospital and the nurses began making regular patrols through local villages to provide direct maternal and child health services. The administration opened its own health centre at Tufi and sponsored patrols through the region to identify and treat cases of tuberculosis, leprosy and other diseases, to carry out malaria eradication programs, and to provide some dental care. In the towns, hospitals were built or expanded and arrangements made for the transportation of people with serious ailments from the rural areas to facilities under the direct supervision of doctors.

Since the late 1970s the system has deteriorated somewhat. With the exception of increasingly irregular baby clinics, there have been no medical patrols through Maisin villages for several years. The burden of most local Western-style medical care falls squarely on the shoulders of the aid post orderlies who work with little supervision or guidance, often many kilometers from their main sources of supplies and advice.

The Maisin have eagerly accepted whatever European medical services have been offered to them. I found no evidence of resistance to Western medicine either in the past or present. Sometimes a seriously ill person is afraid of being taken away to a distant urban hospital where he may have few relatives and may die. Such anxieties are not unknown in industrialized countries. Given the fact that they know little about Western medical theories and techniques and have almost no control over its practitioners, the Maisin's trust in the introduced system of health care is quite remarkable. As we shall see in the next section, this acceptance of Western medicine has not led the Maisin to abandon their indigenous conceptions of health and sickness. Instead they handle European medicine along the lines of pre-existing categories of diseases and curative practices.

CATEGORIES AND CHOICES

If someone gets sick and the village people cannot make them better they send them to the doctors and they recover. But then when Papuans go to the hospitals and the doctors cannot make them better they must go back home so that the

> local healers can do it. The doctors say, "We cannot find what it is so you should go home and they will cure you there".
>
> Stonewigg Kotena, a healer in Sinipara village

Maisin notions of the cause and treatment of illnesses conform generally to patterns reported in widely spread Melanesian societies (see Burridge 1965, Hamnett and Connell 1981, Lewis 1975, Romanucci-Ross 1977). The Maisin tend to rationalize all misfortunes primarily in terms of their supposed causes and only secondarily in terms of their characteristics. Common misfortunes include sickness, sores, accidents, attacks by wild animals, theft and crop failure. Of physical misfortunes, sickness is considered to be the most threatening, probably because it is the most common cause of death and because the tensions that arise during an instance of serious illness may touch off long-term conflicts within the community. Virtually all villagers attribute most serious ailments to attacks from sorcerers, ghosts and bush spirits. Informants told me that mystical attacks, especially the less deadly ones of ancestral ghosts, may be unprovoked but more often than not an attack is provoked by some moral wrong or slight committed by the victim or his close kin within the community. The study of the ideology of sickness and health in Maisin villages leads inevitably to matters of religion, morality and social conflict.

Towards the end of my fieldwork I undertook a survey of Uiaku and Ganjiga villagers' experience and understanding of various kinds of misfortunes. My intention was to determine the consensus on misfortunes as well as the nature and degree of variations in understanding by different groups of people. I devised a standard open-ended interview schedule in which people were asked about a wide range of misfortunes they might have suffered over the course of their lives including sickness, injuries, infections, violence and theft. The final sample comprised 55 men and women from six age groups.

Inquiries of this nature are always difficult in communities where sorcery beliefs are strong because explanations of misfortune, as Patterson (1974–75) has cogently noted, are often couched in idioms of social conflict. Several of my informants expressed a reluctance to discuss misfortunes in detail because to do so would reopen old quarrels and/or might prompt an attack from a local sorcerer. Most informants gave fairly vague explanations for misfortunes. It is difficult to determine how much of their response derived from genuine ignorance or from fear of being themselves ensorcelled. While the data collected in the survey do not allow the sort of detailed sociological assessment of sorcery accuzations advocated by Marwick (1964), they are revealing of the general structure of Maisin beliefs concerning misfortunes and of the curative options open to sufferers and their kin. As I shall show below, there is a strong consistency in the rationalizations I recorded. While I suspect that some informants held back part of their explanations for particular misfortunes, I have found no reason to believe that anyone deliberately misled me about their experiences or understandings.

The Maisin group all sicknesses, great and small, within the general category of *tatami*. A few ailments are generally referred to by more specific terms. Maisin call malarial attacks, for example, *kororo*, "coldness"; they label manifestations of mental imbalance as *kavakava*; and they identify various types of chest infections as *yaa gaga*, "breath broken". Healers make more specific identifications of diseases; but what these are and whether they form a system I cannot say as I did not investigate this topic. I was able to ascertain that few Maisin show much interest in categorizing types of sicknesses beyond noting their degree of seriousness. On the other hand, other types of physical misfortunes are more specified. The Maisin possess no word that could be accurately translated as "accident" but instead speak about various cuts, scrapes, animal bites and so forth. Sores are often described as a type of sickness, especially when they develop into ulcers. Although there would appear to be an implicit distinction between sicknesses and other bodily misfortunes, the Maisin rationalize all physical misfortunes along the same general lines. Unless indicated otherwise, therefore, the analysis given below of indigenous ideas of the cause and cure of diseases and ailments should also be extended to cuts, bruises, sores, broken bones and other non-disease complaints.

TABLE 1
Experience of ailments

			Sicknesses				Sores and accidents			
Year of birth	Sex	No.	Unknown	Casual	Spirit	Poison	Unknown	Casual	Spirit	Poison
before 1940	M	18	4	4	4	5	1	4	1	1
	F	17	3	2	7	1	1	2	1	1
1940–1960	M	10	1	1	1	–	1	3	–	–
	F	10	2	–	6	–	4	–	–	–
Totals	M	28	5	5	5	5	2	7	1	1
	F	27	5	2	13	1	5	2	1	1
		55	10	7	18	6	7	9	2	2

As I noted earlier, the Maisin generally attend more to causes than symptoms when distinguishing diseases. Table 1 summarizes the main categories of physical misfortunes and the number of respondents in the survey who at some time of their life had suffered from them. Like the Orokaiva of central Oro province, the Maisin distinguish between three types of infirmities (Williams 1930: 288ff).[4] Maisin refer to most ailments as *amai tatami* and *tamtami rati*, "just sickness" and "little sickness". Such complaints respond quickly to medical treatment of the Western or Papuan kinds or they clear up of their own accord. When pressed, some Maisin will account for these ailments in terms of cold winds, "germs", ghosts and other possible causes. Mostly they are content to see the sickness cured and do not concern themselves with its origins.

The other two categories of misfortune are radically different in that the victim and his kin must delve into the origins of the sickness if there is to be a remedy. These types of ailments are usually referred to as *vavata tatami* and *tatami beiii*, "heavy sickness" and "big sickness". Maisin further distinguish these from the casual kind by using the term *wakki tatami*, "village sickness". This term is apt because such ailments are thought usually to find their origins in breached or troubled relations within the community.[5] The actual work of causing the disease is done by a specialist – a sorcerer – who may either act on his own initiative or at the request of others.[6] (All Maisin sorcerers are said to be male; there are no female counterparts.) As sorcerers create *wakki tatami*, Western-trained practitioners are considered incapable of healing such ailments. Village healers may be more successful because they are familiar with this kind of ailment and the appropriate techniques. But if the sorcerer remains angry no one can cure his prey. It is interesting to note that when asked to recall the serious physical misfortunes of their lives, the 55 respondents reported mostly *wakki tatami* (62%).

Most sorcerers are said to make their attack on other villagers through the agency of bush spirits (*yawu*) and ancestral ghosts (*waa*). Once summoned by a sorcerer, spirits and ghosts stricken their victims by inhabiting their bodies, stealing their souls or both. Spirits may also take the form of dangerous animals such as snakes, crocodiles or wild pigs in order to attack unwary targets. Women and young children are said by Maisin to be most susceptible to attacks from spirits and ghosts because they, unlike most men, are too "weak" to fight off these invisible powers.[7] This assumption would appear to be reflected in the relatively high rate of attack by *yawu* and *waa* reported by women in Table 1.

Healers claim to be able to cure *waa-yawu* sicknesses, but to be helpless against the third and most serious class of ailment.[8] "Poison" sorcery (*wea yammei, beeta*) comes in many forms, all involving the manipulation of magical substances. Some of the techniques said to be employed by the *wea tamati*, "poison man", are familiar from the anthropological literature: the doctoring of fragments of clothes, hair and other materials belonging to the victim; the use of a long bamboo filled with *wea* to secretly poison the victim at night while he is asleep; the attacking of the victim by a group of sorcerers who remove one of his internal organs and replace it with poison (Fortune 1932, Patterson 1974–75). Sorcerers are also said to use more up to date methods, such as a doctored flashlight that bewitches anyone who comes within its gleam. Maisin consider "poisons" to be much more powerful than spirits and ghosts. This assumption may be reflected in the facts that, first, respondents reported fewer *wea* attacks than other sorts of *wakki tatami* and, second, relatively more men complained of this type of misfortune.

Returning to Table 1, we see that informants categorized their own major sicknesses, sores and injuries as of unknown origin, "casual" *(amai)*, "spirit" (*waa-yawu*), and "poison" (*wea*). Table 2 summarizes the curative resorts reported as being sought in each of these cases.[9] There is a clear division here between the *wakki tatami* and other categories of sickness. For the former, the respondents made use of the full range of curative options available. In the case of casual and

unknown ailments they apparently recognized that a visit to the aid post or the use of some indigenous medicines had been sufficient to effect a cure.

TABLE 2
Curative choices in case histories of ailments

Type of illness	No.	Aid Post	Indigenous medicine	Priest	Healer	Meeting	Other
Unknown	19	13	3	–	–	–	4
Casual	20	12	4	–	–	–	4
Spirit	23	3	6	1	14	2	–
Poison	9	4	3	–	3	2	–
Total	71	32	16	1	17	4	8

Note: The sum of the figures in each row does not equal the number of illnesses because some respondents reported more than one curative choice.

From the evidence of this survey it appears that Western medical practices are easily contained within the indigenous framework of types of diseases and curative practices. While Maisin freely admit that Western practitioners treat many ailments more effectively than traditional healers, they classify these particular complaints as "casual" sicknesses. This is the case even when the sickness is serious enough that the patient must be hospitalized for a long period of time. Western medicine can work against *wakki tatami* in the eyes of most Maisin only after the healer has transformed it into a casual disease by removing the spiritual agent. Western medicine, therefore, is not seen as an alternative theory or explanation of sickness. Most Maisin, like the healers whose words open this section, believe that European doctors themselves recognize the limitations of Western medical care when they are confronted by *wakki tatami*.

The statistical data recorded in the misfortune survey clearly reveals a general framework of causes of sickness and curative resources. They may also reflect certain assumptions concerning the ways in which diseases strike different parts of the society. Women and children, for example, appear to be more susceptible to spirit and ghost attacks than men. The fact that it was mostly older men who reported attacks from poison sorcery agrees with the widespread assumption that *wea* is more powerful than *yawu* sorcery (and thus directed at men) and also the notion that the older methods of sorcery have been largely superseded by the malevolent use of spirit familiars.

The survey also revealed important qualitative differences between informants' knowledge of the origins of "village sicknesses". A small number of villagers were able and willing to provide very detailed rationalizations of particular illnesses. In these instances they described the social situation out of which the illness was thought to have arisen as well as the nature of the spiritual agent. Most respondents,

however, were able or willing only to give categorical explanations of major sicknesses. When they explained why a sorcerer, spirit or ghost attacked, they usually told me that they acquired their information from the healer, the acknowledged expert in these matters. As in many other Melanesian societies, knowledge about local spirits in Maisin villages tends to be vague and inconsistent in details. Most people display little interest in cosmological matters (see Brunton 1980, Williams 1930).

TABLE 3
Causes given for reported deaths of adults

	No.	Casual	Sorcery	Unknown	Other
'Old people'	75	75	–	–	–
'Young people'	186	15	137	32	2
Total	261	90	137	32	2
Percent of 'young people'		8	74	17	1
Percent of total		34	52	12	1

Note: Data compiled from a sample of 66 adult respondents in Uiaku and Ganjiga who provided information on the deaths of their siblings and parents. Informants describe the 'old people' as those who are no longer able to vigorously carry out subsistence tasks. 'Young people' in this sample were adolescents and adults who were not completely dependent on other adults and still vigorous.

Finally, mention must be made of a small number of male informants, all of whom have received post-secondary education, who expressed varying degrees of scepticism concerning usual explanations of "village sickness". Only one man, a former dentist, told me that sorcery did not exist (although he suspected that actual poisonings occurred from time to time in Maisin villages). Three other men accepted the reality of sorcery, but insisted that it occurred far less frequently than most villagers believed. Three of the sceptics, all in their mid-forties were respected community leaders. I never heard them express these views in a public forum. Indeed, one of them was widely rumored to have himself been ensorcelled when he suffered a long illness in 1982 and two others were major participants in sorcery meetings that I attended. Their tempered scepticism may be indicative of the mode by which Maisin assumptions about health and illness are presently changing. I shall deal with this topic in the last section of the analysis.

The survey reveals a general agreement among the Maisin as to what it is important to know about sicknesses. It must be kept in mind, however, that the scheme I have sketched in these paragraphs is composed of post-hoc rationalizations. People are rarely certain of the cause of their sickness when they first fall ill. If the ailment comes on suddenly, sorcery will certainly be suspected and the sick person may be taken directly to a healer. But one can never be sure; even serious ailments may respond to Western medicine, thus showing it to be "just a sickness".

When ailments linger victims and their kin begin to move along a sequence of curative options in a pattern that Romanucci-Ross (1977) has described as a "hierarchy of resort". The longer an ailment lasts, the surer Maisin are that a sorcerer is at work. The success or failure of each level of curative resort helps to diminish the ambiguity of the origins of a sickness. As Table 3 shows, death usually removes the last shreds of doubt in people's minds. Almost three quarters of deaths reported to me of vigorous adults in Uiaku and Ganjiga were said to have been caused by some form of sorcery.

CURATIVE RESOURCES

> My eyes are different. I can see the sickness and who caused it. Most people cannot. Most people get sick just from germs. When they get the sickness that belongs to the village, it is village people who must cure it. Others the hospital (aid post) can cure. The hospital cannot cure *wea* or *yawu*. The big hospitals (at Wanigela and in the towns) make those with germs better. It is up to the sick man and his people to try the different ways. He will go to the village healers first and, if they cannot help him, he will turn to the hospital. Or else he will come to the healers from the hospital.
>
> Ida Nancy Sanangi, a healer in Uiaku

The aid post

The Maisin are served by two aid posts, one at Uiaku and another at Airara, about eight kilometers apart. Both are centrally located in the villages, but while the Airara building is made of prefabricated plaster board and has an iron roof with a water catchment system, the Uiaku building is composed completely of bush materials. The respective communities maintain the buildings and grounds. Improvements to schools and aid posts are funded through the Local Government Council at Tufi with money generated mostly by local taxation. Money is limited and there is much competition between villages within the Council area for projects. So people make do as best they can until their turn for improvements comes. Water at the Uiaku aid post, for example, is collected during the rainy season from sheet iron fixed to a platform behind the building or otherwise from a nearby river. It is boiled over a kerosene stove before being used.

Most weekday mornings one finds a small gathering of adults and children in and about the aid post. It is a favorite meeting place. As they wait, men usually sitting apart from the women and children, people share smokes, chew betel nut and catch up on the latest gossip. The aid post orderly (APO) usually completes his treatments within a couple of hours. If asked, he then visits people in the village too ill to come to the aid post.

The APO has a relatively unobtrusive presence in Maisin villages. He simply treats those sicknesses and injuries people bring to him in the best way he knows how. The orderlies I knew did not seek out sick people or take it upon themselves to teach villagers about Western medicine. They simply provided a service.

The Uiaku APO's greatest problem during the time of my fieldwork was in securing regular supplies of medicines. Sometimes these were available at Wanigela, fifteen kilometers to the north, but often the APO had to make his way to Tufi, more than sixty kilometers distant by sea, where he also picked up his fortnightly paycheck. The only way he could get to Tufi was by making a demanding two to three day round trip in an outrigger canoe or by chartering a dinghy at his own expense (this cost 30 Kina for the round trip in 1983). Even then there is no guarantee that all of the needed supplies will be on hand once he arrives in Tufi. Nevertheless, because medicines and dressings were quickly used up in the village, the APO had to make this trip every six weeks or so.[10]

When medical supplies are available, the APO system is an effective means of delivering basic health care to villagers. But there are some weaknesses in the system. These appear to be related to the ways in which the APO role is negotiated between orderlies and the people they serve.

Indigenous professionals, both Maisin and non-Maisin, have lived and worked among Maisin villagers for eighty years. Teachers, evangelists, priests and latterly aid post orderlies occupy a comparable niche in village society. They are specialists who receive a salary from an outside source for their services, who have more education than the bulk of the population, whose living and working quarters are provided and maintained by the villagers, and who live separately from the local people within the village on land that is not owned by any particular clan. Such professionals are in an ambiguous position in relation to the villagers. On the one hand, they are different and apart from the villagers for the reasons listed above. On the other hand, they are often like the villagers in that they come from similar backgrounds, share the same types of concerns, engage in subsistence gardens, indulge in the same cultural activities, etc. This is a situation that easily gives rise to tensions that may interfere with the work of the APO.

When the APO comes to a village as a foreigner, which has usually been the case in southern Collingwood Bay, he tends to associate mostly with the other salaried and educated specialists and with them form an enclave. Like some teachers, the APO may adopt a condescending attitude towards the villagers, considering them to be "backward", or he may simply be unhappy with unfamiliar surroundings. For their part, villagers have less hesitation in accusing an outsider of laziness and profiteering than they do any of their own. During the time of my fieldwork, the people of Airara were frequently complaining about their APO and making their way the eight kilometers up to the coast to Uiaku to go to the Maisin orderly there. The distrust that often builds up between the foreign APO and local people lends itself to a high turnover rate. In Uiaku, for example, twelve foreign orderlies worked for short periods between 1948 and 1965.

Even when the APO is a member of the community, his anomalous role gives rise to certain tensions. The present Uiaku APO, for example, was born in that village. Except for a two year period in the late 1970s he has been in Uiaku since 1965 (having first begun work elsewhere in 1960). I heard occasional complaints that the APO spent too much time fishing or in his garden and that he favored his own relatives over others when medicines were in short supply (charges, incidently, that are often levelled at any villager with public responsibilities involving access to desired goods, services and money). But the APO generally received strong support from the community. The villagers considered him dependable, especially compared to earlier orderlies.

While I sometimes heard grumbles about orderlies' "laziness" and "selfishness", I almost never heard people question their competence. When a treatment given by the APO fails to effect a cure, the sick person and his kin will usually resort to other curative techniques in the ongoing effort to find the actual cause of the sickness. Most of the tensions that develop between orderlies and local people can be traced to social relations rather than medical practice. Maisin, of course, have few resources with which they could evaluate the medical practice of the APOs.

In most cases the aid post, and to a lesser extent Wanigela hospital, serve as the first resort when people are struck by an illness. But aid post orderlies are well aware of the ineffectiveness of Western medicines against *wakki tatami*. The APO at Uiaku, for example, told me how healers had frequently produced rapid cures in patients who had not responded to his treatment. The orderly himself knew no traditional medicines, as he had been away from his village as a young man, but he accepted that they were often efficacious. In his words, the APO is an expert on "the medical side only". He cannot speak about village diseases because they lie outside of his medical training. But health workers, like anyone else in the village, can fall prey to sorcerers. A retired hospital orderly in Uiaku, for example, once confided in me that he had lost both his wife and son because of the attacks of sorcerers.

Traditional medicines

All of my informants agreed that many Western medicines are better than their own and can cure ailments that in earlier times were left untreated. I was told that many of the old medicines (*kain*, *bobi*) have been forgotten now that they are no longer needed. On the other hand, several traditional remedies for colds, headaches, sores, and so forth are judged by those who know them to be superior to the European equivalents. These are remembered. In a survey of 75 adults in Uiaku (out of a possible 213) I found that 58 (or 77%) knew some traditional medicines. Some individuals, especially healers of course, know many more than most people.

Knowledge of medicines is a private affair. It is passed down from parents to children, occasionally from mother's brother to sister's son and, much more rarely, from friend to friend. Most medicines are made up of the barks or leaves of

selected plants found in the bush. They may be given to the sick person in the form of a hot broth to drink or bathe in, or the substances may be sprayed over the body of the patient in a bright crimson mixture consisting mostly of chewed betel nut juice. Since particular remedies for some *wakki tatami* are usually known only by the people who have the means to create that sickness, those men who possess many medicines are often suspected of being sorcerers.[11] The APO never finds himself in this position as European medicines are not considered to include "poisons".

The priest[12]

Almost all adult Maisin today are members of the Anglican Church. A national priest resides in Uiaku, serving a parish that stretches to the Milne Bay border and includes several non-Maisin villages. He is assisted by a number of teacher-evangelists, deacons, Church Councillors and Mothers' Union members in the different communities. Church workers tend to play only a minor role in the treatment of ailments. But Christianity has had a major if indirect influence on Maisin thinking about health and disease.

As participants in community life, present day clerics play a part in perpetuating some indigenous notions about health and in changing others. A priest or deacon may act as a third party in village disputes, and so mediate between parties in danger of being drawn into a sorcery feud. Some missionaries in the past spoke out against indigenous healers, seeing them as the representatives of the heathen religion, but many national priests today give cautious support. One priest told me that the healers in their work demonstrate God's power over earthly evil. Because he is seen as an intermediary between God and the people, a priest's encouragement of a healer or a healer's medicines can be a powerful support for the traditional practice of medicine.[13] Indeed, one Uiaku priest, whose father had established a reputation as a sorcerer, was well known for his own knowledge of indigenous remedies.

The priest's chief duty at a time of sickness is to offer prayer and comfort. Very few Maisin admit to praying at home alone. When sick, they or their relatives may ask the priest to come, or one of the other Church workers may report the illness to the priest who then may visit to offer a prayer and perhaps a blessing. The priests I interviewed (two worked at different times in the parish during my fieldwork) saw their duty as one of giving strength to ailing people by encouraging them to have faith in Christ and God. On the one hand, the prayer and blessing offered by the priest may give the patient the courage to withstand the illness and its ultimate cause (when it is considered a "village sickness"). One of the priests always says to those who fear sorcery, "If you trust God this poison won't hurt you." On the other hand, the priest tries to help the sick person and his relatives to accept the illness if it lingers. He tells the patient that God may have a need for him in Heaven. And if the topic of sorcery comes up, the priest may suggest that the kin of the sick person

should not try to take vengeance on the sorcerer; instead they must find forgiveness in their hearts.

Village people, including Maisin church workers, take a slightly different view of the relation between prayer and healing. If one has faith in God, it is said, then one can withstand sickness. One woman told me, "God created everything, so when we ask for His help the sick people get better." I recorded seven cases in which individuals claimed to have recovered from major sicknesses after they had dreams or visions in which they saw manifestations of the Christian divine – angels, Jesus' feet, Jacob's ladder. In other instances, people told me of how God gave them the "strength" (*wenna*) to face the sorcerers who had caused their illness. To many Maisin, then, God represents a source of power accessible through one's faith. Prayer, church attendance and generosity to the Church are among the outward signs of this faith.

God provides a general type of strength to all who have faith, but He is not seen as directly intervening in the social situations that are believed to generate sicknesses. Perhaps because of this, God is rationalized as providing for general well-being but is not usually conceived of as a curative resort for specific ailments. The clergy regularly visit and pray for the elderly and infirm in the villages, but I knew of only a few cases in which they were specifically asked to pray for vigorous adults who had fallen ill. In these instances the kin of the sick person seem to see the clergy's intervention as an ancillary measure of precaution. Significantly, it is the healers who claim to pray regularly for strength from God. Each healer volunteered to me that before they could begin a curing session they had to pray. One healer was a member of his village's Church Council, another belonged to the Mothers' Union, and three had had visions in the past of the manifestation of God's power during which, they claimed, they had received some of their present healing abilities.

Healers

The six Maisin healers that I knew were certainly among the most remarkable people of their communities. Confident, often brash, these individuals showed little of the reluctance in discussing customary things that I experienced in my usual initial encounters with other informants. Healers are far more familiar with traditions than most of their neighbors. At the same time, healers are more concerned than most other villagers that the differences between received traditions and more recent introductions be resolved. We have already seen that healers believe they draw on God's power in their work. They regard themselves as good Christians. In their view the vocation they have taken up is on a par with that of European doctors; it is the ailments that are treated by European and Papuan curers which differ.

Healers are known as *sevaseva* and *kikiki* people.[14] The two women and four men presently practising are all elderly; only two are still capable of gardening. To

my knowledge there are no younger healers practising, training or in waiting, a significant point I will return to in my discussion of change in indigenous medical beliefs in the next section. All of the healers have an extensive knowledge of Papuan medicines and must observe certain dietary restrictions in order to maintain their healing powers. Beyond these general similarities, their methods and styles struck me as both individual and eclectic. Two healers use medicines only, but others have spirit familiars (*yawu*) which they summon during curing sessions by making offerings and singing special songs. Three healers also claim to be able to leave their bodies in order to spy on sorcerers and to recover stolen souls. I heard of one instance in which a healer charged 40 Kina for her services, but most of the time healers are content to receive a small amount of money, about 2 Kina, and gifts of food and tobacco as payment.

Healers have the ability to detect the sources of ailments and to see spirits and ghosts. This allows them to select the right type of treatment and to inform the victim of the identity of his assailant and the reasons for the attack. Most of the sicknesses treated by healers are said to be caused by *yawu*, bush spirits that serve both sorcerers and healers. *Yawu* are said to have the ability to assume many guises, including that of humans. They frequently attack in the form of animals. One female healer in Ganjiga identified three *yawu* that she claimed were among the most common to attack villagers. A snake called *Nanginangi* either enters and curls up in the victim's stomach or wraps itself around their waist. A pig *yawu* called *Goreva* grasps the victim from the back in the same fashion as a single man carries a pig home from the hunt. This sickness is especially "heavy" and very painful. The eel called *Boresu* is said to be eager to have sex with females of all ages. It enters their vaginas when they are bathing and then curls up in their stomachs. The feel of its clammy skin results in coldness and fever. This spirit was often reported as responsible for sickness in little girls. The healers' familiars, which help him or her see these attackers and chase them away, are also *yawu* which may impersonate animals or humans.

Given certain clues, such as a swollen stomach or a sudden illness following an argument, a person may go at once to a healer. In most cases, however, people turn to healers only when it is apparent that the medicine from the aid post and ordinary Papuan medicines are having no effect. The sick person may be sent off to an urban hospital after seeing a healer, perhaps immediately if the ailment is very serious. To return from town still ill is considered definite proof that the ailment in question is a "village sickness". The ability of the healer to end the sickness at this point is seen by Maisin as being dependent not only on his or her talents but also on the willingness of the sorcerer to desist from appealing to his *yawu* to launch another attack or from resorting to more deadly "poisons". In serious cases the only way to stop a sorcerer is by direct confrontation or appeals from the community as a whole. Such an appeal represents a last resort before death.

Protecting the victim, confronting the sorcerer

When a person has a serious accident, falls ill or dies suddenly, most villagers will assume that there has been foul play. Relations and friends of the victim gather round his or her house during the day, while close kin and affines stay on through the night. This custom, called *gumema*, has a number of purposes depending on whether the supposed victim is living or dead. First, people gather because they wish to show their "respect" for the person. If he is alive, their talk and company cheer him up and give him the strength and desire to recover. Secondly, as the supporters talk they try to discover the possible reasons for the sorcery attack and what their best course of action might be. Finally, they provide a defensive shield around the victim. As he is already in a weakened state his enemies, as well as the sorcerer who originally caused his ailment, might try to add to it and so make the illness even "heavier".

When a victim is reasonably sure of the identity of his assailant, he or his relatives may confront or parley with the sorcerer. This is done in great secrecy. I was told that while sorcerers usually deny any knowledge of the specific causes of a disease or responsibility when they are confronted by victims, they may subsequently remove the sorcery if they feel that their target has been punished enough or that they themselves might suffer retaliation. The practice and threat of sorcery is illegal in Papua New Guinea. Maisin suspected of practising the "black art" are sometimes taken to Tufi by their angry neighbors to stand trial before a magistrate. When I was in Uiaku one man was taken to court on this charge. Such evidence as there is of the actual practice of sorcery consists mostly of veiled threats, gossip and dreams, and much of this is not admissible in court. In this instance, the man was found guilty of threatening behaviour but acquitted of the charge of practicing sorcery. There are obvious dangers in taking an alleged sorcerer to court and few Maisin are brave enough to try.[15]

Sorcerers attack in retaliation for wrongs against themselves or against the community. But sorcery attacks themselves are also wrongs which, in turn, invite "paybacks". Because of this, people in a community feel a growing sense of alarm as an illness becomes more grave, especially in the case of adolescents and young adults. As the sick person begins to slide towards death, the village leaders may call a general meeting, a *totoruga.*

The *totoruga* serves a purpose similar to that of the *gumema.* It is a statement of solidarity behind the victim and also a forum within which the causes of an ailment can be discussed and dealt with. It is an arena of last resort in which all of the differences which divide a village may be aired. The object is not so much to find the sorcerer as to resolve the internal troubles which prompted the attack in the first place. If the difficulties can be resolved, even temporarily, Maisin feel that the sorcerer will call off his attack and the sick individual can start down the road towards recovery. He may still be weak and ill, but now that the cause of the sorcery has been removed his ailment will start to respond to treatment at the aid post or the hospital.

We are now in a position to sum up the Maisin's usual response to health problems. The five choices of curative practices available in the villages fall roughly into a "hierarchy of resort". This in turn corresponds with a division of ailments into three general categories: casual, those caused by ghosts and spirits, and those resulting from "poisons". If an illness responds to medicine treatment from the aid post, Maisin assume that it is casual. When there is no response, people begin to suspect sorcery. They may then turn to healers and perhaps the priest. The *totoruga*, village meeting, is the last resort. When an individual becomes this sick, Maisin strongly suspect that poison is being used. The only way of stopping the ailment is by appealing to the sorcerer.

CHANGING PERCEPTIONS OF ILLNESS AS MISFORTUNE[16]

> We say that we are Christians, but it is us. If we do bad things – steal or something else – we don't live long. People get angry with us and we die. It was the same with the heathens. Our fathers and mothers told us, "If you are good, respect people and help them, you will live to an old age."
>
> Glassio Fisisi, Uiaku

> When I was sick recently, my aunt was saying that it was sorcery. But I was concentrating on the medical side. Sometimes when someone dies I say that I don't believe in sorcery. But then my wife asks, "Why do all of these people keep dying?" If they poison you it is true. But they are not gods who can tell you to become sick!
>
> Franklin Seri, a retired dentist in Uiaku

To many Western educated observers, the sort of medical pluralism described in the preceeding pages seems perplexing, even pernicious. A nurse I was acquainted with once complained to me that healers were fond of sending the hopelessly ill to the aid posts and hospitals to die while seeking as their own patients individuals who were on the mend after treatment by orderlies and nurses. Healers have long been accused by outsiders of exploiting the credulity of their neighbors, but my friend's point was more general than this. She felt that Maisin and others like them employed a double standard. They use medical services provided to them for free but refuse to trust the overall competence of health workers. Instead Maisin cling to their old ideas. Romanucci-Ross's study of medical pluralism on Manus Island sounds a resonant tone of puzzlement as she deals with the problem of why the islanders continue to feel a "sense of loyalty" to "native illnesses" in the face of a European technology "otherwise acknowledged as superior and invested with the

highest prestige" (1977: 483). In an article comparing two instances of medical pluralism in the North Solomons Province, Hamnett and Connell (1981: 497) describe similar situations as classic cases of "culture lag": "What is apparent therefore is that behavioural change proceeds faster than cognitive change; disease aetiology and process are still conceived in traditional cognitive models yet participation in the Western medical system is commonplace." In each of these examples, the coexistence of Western and indigenous medical ideas, practices and institutions is presented as something anomalous, requiring explanation.

But from the perspective of the Maisin there is no double standard and little mystery. Few of them are aware of any contradictions between their approach to illnesses and that which is considered desirable by European specialists. This ignorance is understandable partly in terms of historical experience, namely the inability or unwillingness of the Mission and Administration to present European medicine explicitly as an alternative to the indigenous varieties. Efforts to disseminate knowledge about the intellectual underpinnings of Western medicine began only in recent years in most rural schools and, outside of high schools and higher educative institutions, are still at a rudimentary level. As Hamnett and Connell (1981: 494) cogently note for the North Solomons, the cognitive model of Western medicine remains largely invisible to most of the people who use the aid posts. In such circumstances it is hardly surprising that the challenge of European medicine to indigenous assumptions is muted.

The average Maisin villager's innocence of the contrary assumptions of Western medical practice can also be explained in terms of the ease with which he is able to fit this curative resort within an admittedly flexible framework of belief. Most Maisin see Western medical substances and practices as powerful analogues of their own medicines, useful in the fight against "casual illnesses" and in the aftermath of sorcery-related ailments. It is very possible that with improvements in health following the introduction of Western medical services the instances Maisin have identified as "village sicknesses" have declined. But there is nothing inherent in Western medical care as experienced by the Maisin that would indicate a denial of the reality of sicknesses caused by sorcery. To a remarkable extent, the Maisin have been able to encompass the curative resort of Western medicine within a larger indigenous framework of belief and practice. They have in effect "domesticated" this externally-controlled import.

Maisin today, like their ancestors, understand disease primarily in terms of quality of relationships within the moral order and the nature of the influences of divine entities, including sorcerers, on human lives. The quote that opens this section is an example of a frequently expressed attitude in Maisin villages: the view of sorcery as a semi-legitimate sanction employed to punish those who flout the conventions of the society. Behind this rationalization, revealed in the institutionalized gatherings around the sorcery victim and the crises that provoke them, lies a more complex, darker understanding of sorcery as a secret mode of conflict between those who on the surface must depend upon each other for security. Such moments suggest the danger of the community coming apart at the seams as one

sorcery attack leads to another or provokes physical violence.

These themes are ancient and widespread throughout Melanesia. But in Maisin communities, as elsewhere, villagers have had to contend with new circumstances and new answers even as they have asked the old questions (cf. Zelenietz and Lindenbaum 1981). Informants uniformly insist that the sorts of "village sicknesses" people face today are very different from those of the past. In the past when a person's survival depended completely on close kin and their allies, ghost and sorcery attacks were the expected form of conflict within and between the multi-clan villages. The most powerful sorcerers were well known, feared for their ability to bring sickness and valued for their knowledge which allowed them to undo their spells. It is said that at this time misfortunes could be explained, acted upon and controlled.

The elders go on to explain that with the coming of the Europeans their ancestors learned that these forms of mystical retaliation were both wrong and unnecessary. One of the most interesting developments was the decline in importance of ancestral ghosts as a source of power. Informants told me that unlike the older "pagan ghosts", recent ghosts are Christians who are unwilling to linger around villages. At their funerals they listen to the prayers of the priest and go obediently to Paradise. The elders also tell how most of the old-style sorcerers gave up their poisons when the Maisin converted to Christianity, or let it die with them. The sorcerers who have replaced them are thought to be few in number, but much more secretive, vicious and hard to control – true criminals. The older forms of curative resort, described in the previous pages, appear to prove less and less capable of dealing with this changing threat. Maisin, however, find some comfort in Christianity as they understand it. For it is said that the good Christian man of faith will be given the strength by God to withstand the attacks of the sorcerer. The adoption of Christianity has encouraged many Maisin to see the crises of "village sicknesses" as battlegrounds between the forces of the microcosm and those more powerful ones of the macrocosm. As the Christian divinities are known to be the most powerful, the outcome is seen not so much as a contest against God and local sorcerers but as a test of the victim's faith.

There is a certain element of myth in the oral accounts I have summarised. The reader may be forgiven for suspecting that the older sorcery crises were as ambiguous to participants as those of the present. At the same time, the testimonies show that villagers are not "clinging to old ideas" but actively making sense of the implications of Government and Mission actions, Christian teachings, and the changing circumstances of their lives.

Let us inquire further into these changing circumstances. Oral testimonies and documents reveal a contact society very similar to others reported in this part of Papua (e.g., Young 1971). Maisin lived in multi-clan villages in a permanent state of tension with their neighbors. They recognized no transcendent political (or divine) authority. Outside of the narrow confines of his "security circle" of close kin and affines, to employ Peter Lawrence's useful phrase, each person joined in unstable alliances with various influential men. The colonial authorities acted in

various ways to eclipse the power of these men. At the same time, the Mission and Government laid the basis for the formation of new contexts of political action by introducing and supporting local schools, churches, councils, aid posts and cooperatives.

Since the end of the Second World War, Maisin have simultaneously experienced massive out-migration, a growing dependence on money and commodities and aspirations for local economic development. They have come to some extent to recognize kin loyalties as inimical to the greater needs of the people. At the village meetings I attended, both elders and younger educated leaders enunciated an ethic that emphasized the need for and values of community solidarity. They pointed out how such divided loyalties encouraged gossiping and conflicts and in general aborted efforts to form a united work force that might improve the material conditions within the community. This contrast between the promise of community solidarity and the problems of intra-community divisions finds a remarkable resonance in the characterization of sorcery attacks as contests within the souls of participants between a saving faith in the forces of the macrocosm and the conflicts that exist in the microcosm. Indeed, informants sometimes spoke as if the conditions for economic and physical health were one and the same.

Unfortunately there are little reliable data on how Maisin conceived and responded to "village sicknesses" in the past so we cannot know the effects of these changing circumstances and understandings. The implications of the various innovations, however, are clear and consistent. While none deny the reality of "village sicknesses", all act as impediments to action. First, the common assumption that sorcerers have become more secretive suggests that it may be even futile to try to identify and stop them. Further, speculations and inquiries to find an elusive sorcerer may work against the aims of community solidarity by provoking a climate of increasing conflict. Community leaders are keenly aware of the dysfunctional aspects of sorcery fears and frequently caution those closely involved in the sickness not to "gossip" amongst themselves and only to bring an accusation forth if they have enough evidence to take the sorcerer before a magistrate. The indigenous rendition of Christianity also dissuades speculation and action in the event of a serious illness. The Christian view continues to link morality with physical well-being, but it shifts the concerns of the victim from his relation to the sorcerer to his relation with God, for it is ultimately the supreme being who decides whether a person will live or die. The injunction to forgive one's enemies also encourages an other-worldly focus during times of illness.

This brings us to the Maisin "sceptics" mentioned in the earlier discussion of the misfortune survey. I noted that these men privately criticized some aspects of sorcery beliefs but publicly acted in ways that supported the premises of the same beliefs. My impression is that they are not so much working against the given framework of assumptions as influencing from within the way that framework is applied to particular instances of sickness. One striking instance of this process occurred following the death of a little girl in the village, probably from untreated tuberculosis. Soon after the death a Maisin health officer working in Popondetta

made a trip to the village concerned to tell the people that it was fruitless to try to find a sorcerer for this was not a case of "village sickness". They should not mistake tuberculosis for *wakki tatami*. Such initiatives, combined with the impediments noted above and the successes of European medical treatments, have in all probability narrowed the range of illnesses the Maisin identify and act upon as moral crises.

If this analysis is correct it indicates that while the Maisin continue to view major sicknesses within a moral and spiritual framework, they are becoming more willing to tolerate ambiguity. This may explain why there are no apparent replacements for the aging healers; the unique gift of the healers, their ability to explain an ailment in terms of present social conditions, is becoming less relevant and convincing than it once was. In my opinion the Maisin are already making close to maximal use of the limited Western medical facilities available to them, so it is difficult to see how changes in their view and approach to "village sickness" will affect this aspect of behavior. On the other hand, the historical process in which the immediate moral and spiritual context is becoming less important in the explanation of sickness as misfortune portends the day when Maisin assume the focused and amoral understanding of disease now common in industrialized societies.

CONCLUSION

The most striking theme emerging from this case study, in my opinion, is the degree to which Maisin have successfully appropriated the provision of Western medical facilities and integrated it into their general conceptions of disease. European medicine has not only added powerful options in the range of therapies available to the villagers but has also become an important factor in the diagnosis of sickness; for today ailments are identified as "village sickness" with the most certainty when the aid post orderlies, nurses and doctors are seen to fail. As in many other non-Western societies, Maisin view major illnesses as misfortunes grounded in moral and spiritual realities. They accept Western medicine as a type of technology appropriate for certain types and moments of sickness, but they are for the most part incognisant of its intellectual foundations. Whatever its effects on actual health, Western medical services have had a muted impact on Maisin ideology. Changes in the consensus regarding the etiology and appropriate response to sickness appear to have been more directly affected by larger changes in the society: conversion to Christianity, incorporation into the cash economy, extensive out-migration, to name a few.

In the analysis I have tried to identify some of the cultural and historical factors which can in part account for this type of medical pluralism. The specifics are, of course, peculiar to the Maisin people, but many of the generalizations made in this study hold true for people in other parts of Melanesia and beyond. Melanesians in general are renowned for their "pragmatism", whether this is shown in their willingness to experiment with a wide range of garden magics or to attempt to cure

physical complaints with sequences of visits to the aid post, local clergy and indigenous healers. In the Collingwood Bay area, the colonial presence of poorly financed and understaffed Government and Anglican Missions, which prided themselves on a relatively tolerant philosophy of the "white man's burden", created benign conditions for the incubation of a pragmatic combining of therapy processes drawing upon both indigenous and European resources with little resulting conflict or contradiction. One of the most interesting developments has been the degree to which the Maisin have invested their vision of Christianity with implications for sickness and health. The early missionaries would certainly have been surprised, although not necessarily disapproving. The situation bears some close resemblances to that of another Anglican mission in east Africa, described recently by Terrence Ranger (1981).

I can say little about the effects of this medical synthesis on the health of the Maisin, for I did not investigate this question. Nor do I have the case material that might indicate whether Maisin, or specific sections of the Maisin population, are more likely to go first to aid posts and hospitals or to healers in the sudden advent of a serious illness (cf. Romanucci-Ross 1977). I did hear of and note some occasions when very sick villagers remained home among relatives and healers instead of going to the health centre at Wanigela (I was told that they did visit aid posts). It is possible that some deaths could have been prevented had such people been taken to Wanigela. I also knew of patients whose illnesses grew worse and who died while in the care of aid post orderlies, nurses and doctors. In many, perhaps most of these instances the decline was inevitable, but some patients may have been saved given better training, supervision, facilities and supplies. There are a great number of ambiguities that must be included in a consideration of the reasons why people faced with the crisis of a major illness or accident elect to follow one course of therapy over another, especially in places where Western medical facilities are rudimentary. No simple answers will suffice.

It should be said, however, that the present situation presents some risks to the Maisin along with the benefit of improved health. Like the community schools and churches, they have incorporated the aid posts into their social lives while being content to remain in ignorance about institutional purposes and potentials, leaving such concerns in the hands of outside experts. This innocence, on the one hand, makes the Maisin vulnerable to dangers from incompetent health workers.[17] In the long run it leaves them with little or no voice in the deployment of scarce medical resources. The analysis presented here suggests that given the secularizing trends attending the incorporation of villagers into larger economic and political systems, the rural Maisin are approaching a philosophy of disease more or less compatible with that of Western medical science. This promises greater local understanding of the aims and difficulties of rural health delivery and, in time, a fuller participation in the management of medical resources. Ironically these changes are coming at a time when the international economic crisis is forcing cut-backs in rural health care.

NOTES

The research on which this paper is based was carried out between November 1981 and August 1983 in Port Moresby, Popondetta and Collingwood Bay. Financial support was provided by the Social Sciences and Humanities Research Council of Canada. I would like to thank the staff of the Native Archives of Papua New Guinea and the Right Rev. David Hand for their assistance and permission to use the archival materials that appear in this study. To those Maisin who acted as my assistants, informants and friends, my deepest gratitude. This piece is dedicated to Sister Helen Roberts who has given almost four decades of her life to the health care of the people of Collingwood Bay.

1. This section is based upon archival materials in the Anglican Archives located in the New Guinea Collection in the Library of the University of Papua New Guinea and patrol reports deposited in the National Archives of Papua New Guinea. The materials for a more extensive historical study of health care in the Collingwood Bay area were tragically destroyed in a fire at the Wanigela health centre in 1982.
2. I unfortunately did not have access to recent health statistics for the Collingwood Bay area. I was told by health workers in the area that malaria and tuberculosis accounted today for most deaths. The *Oro Provincial Handbook* (1980) states that the province has the second highest rate of malaria parasite infestation in the country.
3. A patrol report of 1968 listed 16 of the 78 Maisin individuals either employed or in professional training to be in medically related fields (Mendaris 1969). At least four Maisin men have undergone training to be dentists and two have graduated as medical doctors, including Dr Wilfred Moi, presently Head of the Mental Health Services and the first Papuan graduate in Medicine and Surgery from the Fiji School of Medicine (Moi 1976).
4. A similar distinction between *sik nating* and *sik belong ples* is reported for the North Solomons by Hamnett and Connell (1981).
5. While my informants were usually exact about the general differences of types of illnesses, their explanations of individual cases were often full of ambiguities. Informants would often begin describing an instance of sickness as the result of an unprovoked attack by an ancestral ghost or a *yawu*. After further discussion they usually indicated the presence of a living man lurking in the background of the spiritual attack. Instances of sickness that could be traced back no further than spirits and ghosts were always relatively minor and usually involved women and children.
6. Although the distinction between the "spirit" and "poison" methods of attack is important to their etiology of disease, Maisin tend to use the terms "*yawu* men" and "*wea* men" interchangeably regardless of the nature of a particular attack. Indeed, there is little to distinguish the culteral representation of these attackers beyond the difference in methods. It is, therefore, appropriate to identify both as sorcerers.
7. For a discussion of the measures that are taken to protect unborn and newly born children from spirit and ghost attacks see Tietjen (1984).
8. As I noted earlier, healers blame this situation on historical circumstances: the revival in the use of traditional "poisons" without accompanying antidotes and the introduction of unfamiliar "poisons". But Williams (1930: 239–94) also observed in the 1920s that Orokaiva curers declared their helplessness against anything but spirits: "it remains the general rule to impute this cause [material sorcery] for the more serious complaints. Further than this, it is imputed as cause especially for those complaints which cannot be cured. Thus when a doctor has tried his methods on a patient without success he is likely to set the case down as a hopeless one of sorcery and discontinue his treatment; and, indeed, if he be astute enough, he may decide to have no truck with any case that seems too far gone. For it is generally held that sorcery sickness cannot

be cured by the ordinary methods of the healer. ... Sorcery is, in fact, the native's exegetical last card".

Orokaiva notions of the cauzation of disease, according to Williams's account, varied in one significant way from those of the Maisin; the Orokaiva apparently believed that attacking spirits operated independently of any human agents.

9. Figures given in Table 1 for each category of ailments are of the number of people in the sample who reported that complaint one or more times. Table 2 records the aggregate number of cases of the different ailments. The tables are, therefore, not directly comparable. Figures from sicknesses, sores and accidents have been combined in Table 3.
10. The aid post was often out of supplies. During these periods my wife and I provided villagers with simple treatments for colds, malaria and sores.
11. Women inherit medicines and may become healers but they are never sorcerers. A few Maisin admitted to me that it was possible for a woman to pay for a sorcerer's service, as men are often supposed to do, but they knew of no instances where this had happened. Men whose fathers were sorcerers are themselves often suspected of carrying on the craft.
12. Village Christianity was the focus of my research. The points made in this section are examined and documented in greater detail in Barker (1985).
13. The priests are not always aware that their actions are being interpreted in this way. When the priest says a prayer or blessing for an ailing healer this may be taken as approval and enhancement of the healer's art upon his recovery. Some healers interpreted the priest's blessing of the congregation during the Mass as a source for their personal curative powers. I heard of only one occasion when indigenous medicines were deliberately blessed. Clergy do offer prayers for patients in the care of healers. The priest also routinely blesses the aid post each year.
14. *Kikiki* has a wide range of meanings, including "story", "myth", "traditional custom", "clan emblem", and "origin". *Sevaseva* is a term heard throughout Tufi district in reference to healing seances, also known as *kaara* to the Maisin. *Tamatari* means "men".
15. It is usually, but not always, the village councillor (in the past the village constable) who is asked by other villagers to take the alleged sorcerer to court. I heard of only three other instances of this happening in the recent past. On each occasion the defendant was gaoled for short periods or fined. In none of the cases was the sorcerer said to have made vengeance upon his accusers following his return to the village.
16. The historical developments described in this section are discussed and documented in much greater detail in Barker (1985).
17. A small example of this is the propensity of aid post orderlies to give injections of penicillin for even the most minor complaints.