Illness and Uncertainty: Situating HIV in Huli Experience of Cultural Change

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“Illness and Uncertainty: Situating HIV in Huli Experience of Cultural Change”

A Thesis submitted in partial satisfaction of the requirements for the degree Master of Arts

in

Anthropology

by

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The Thesis of Kevin Henner is approved and it is acceptable in quality and form for publication in microfilm and electronically:

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Chair

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ABSTRACT OF THE THESIS

“Illness and Uncertainty: Situating HIV in Huli Experience of Cultural Change”

by

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Master of Arts in Anthropology

University of California, San Diego, 2013

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Papua New Guinea’s large landmass and population of 7 million stand out among the scattered islands of the Pacific region. A 2009 estimate by the National Department of Health estimated that 0.92% of the adult population was living with HIV. In the Highlands region, the prevalence is higher—just over one percent. Paul Farmer has written that epidemic disease is not merely a matter of biological transmission, but traces
paths of vulnerability along steep gradients of inequality. I argue, however, that inequality must be understood in ways that are culturally and historically specific. Pacification, conversion, and participation in wage labor and the cash economy led to rapid and significant changes in Huli lifestyle. Furthermore, a thread of Melanesianist ethnographic theory associated with Roy Wagner and Marilyn Strathern emphasizes that the values and precepts of Western individualism can be misleading in a Melanesian context, where higher value is placed on social relationships, and personhood is treated as both multiple and ‘dividual.’ These considerations make metrics of inequality oriented to an individualist value system problematic in the Huli context. In this paper, I propose that a careful extension of Farmer’s theory to include forms of relational and dividual inequality can help us to better understand the course of the HIV epidemic against a background of rapid cultural change. I suggest that attention social uncertainties, indexed by interpretative and diagnostic practice, can reveal these entanglements of disease and cultural change.
INTRODUCTION

Though the first European explorers of New Guinea struggled to match on foot the territorial claims laid out in maps and colonial treaties, another host of uninvited guests made quicker inroads. As Stephen Frankel puts it, “Europeans were preceded by their pathogens.” Even before their first encounter with explorers in 1934, the Huli, a language group living in what is now the Southern Highlands Province of Papua New Guinea, had already suffered from epidemics of influenza, chicken pox, and measles—novel viral infections that indigenous trade networks had carried from the coast and which spread quickly, and with devastating effect, among the people of the highlands (Frankel 1986: 27). This historical overlap of epidemic and encounter tied together Huli interpretations of epidemic and encounter in complex and perduring ways. The rapid pace of cultural and economic change continues to the present, and I argue that understanding this nexus of biological and social uncertainty is critical to building a locally appropriate account of the more recently introduced HIV epidemic.

Since 1987, when the first cases of HIV were reported in Papua New Guinea, the virus has become firmly established in the nation’s population of seven million (Lepani 2012: 21). Estimates from data collected in 2009 put the infection rate at 0.92% for the population as a whole, and 1.02% for the highlands region (National Department of Health: 2010:1). UNAIDS guidelines put the threshold for a “generalized” HIV epidemic—one that could perpetuate itself through transmission in the “general population,” as opposed to being relatively restricted to “high-risk groups”—at a prevalence of 1% among women tested at antenatal clinics (Lepani 2012: 22). Although
these more recent number represents a marked decline from 2004 estimates that put the national rate at 1.7%, limited data on which these estimates were based, as well as the greatly increased number of rural clinics and hospitals included in more recent estimates, makes direct comparison of the figures problematic (Lepani 2012: 23).

The available data does give a few suggestions as to the modes of transmission and demographic distribution of the virus. Katherine Lepani notes that “although data on the mode of transmission are available for only 35 percent of notified cases of HIV infection, the nearly equal distribution of confirmed cases between males and females indicates the importance of heterosexual activity in HIV transmission” (Lepani 2012: 22, National AIDS Council and National Department of Health 2009: 7, 9). There are, however, age-moderated gender asymmetries in infection rates that suggest “the vulnerability of adolescent girls and young women in cross-generational sexual relations with older men who are likely to have increased HIV exposure due to their longer sexual histories” (Lepani 2012: 22-23, National AIDS Council Secretariat 2006:10).

Though these statistical data are central to a broad understanding of the HIV epidemic in Papua New Guinea, they are sparse. Difficult terrain, diffuse settlement patterns, and an unmatched degree of linguistic diversity, as well as a limited and under-funded health service infrastructure, pose major challenges to systematic epidemiological research, especially in the country’s interior (Lepani 2012: 21). Furthermore, many of the existing data point towards a complex and rapidly changing confluence of meaning and practice that requires qualitative social research to illuminate (Lepani 2012: 23).

For the Huli, as for the rest of Papua New Guinea, HIV came more than half a century after the initial waves of introduced viral epidemics. Though the first cases of
HIV in Papua New Guinea were in reported 1987, Tari Hospital in the Huli region of the Southern Highlands Province didn’t start testing for antibodies until 1995 (Wardlow 2006: 221). “Of five tests done that year, all were negative; of thirty-five tests done in 1996, one was positive. By 2004, Tari Hospital had documented eighty HIV+ or AIDS cases in the area.” (Ibid: 221-222). Holly Wardlow notes that during the time of her fieldwork in the mid 1990s, “little was known by the Tari community about the nature of ‘sik AIDS,’ as it was called. … [F]ew people were familiar with the progression of the syndrome, symptoms, prevention methods, means of transmission, lack of cure, or the likelihood that medication would not be available to them should they become ill” (Ibid.). HIV has emerged among the Huli relatively recently, and interpretations of the infection continue to develop even as the course and context of the epidemic shift.

Just as the pre-contact epidemics of influenza, chicken pox, and measles became interpretatively entangled with the strangeness of colonial encounter, HIV has come amidst a continuing process of rapid social, cultural, and economic change. While many of these changes—wage labor and transactional sexual practice, for example—have a direct impact on sexual networks and the biological transmission of HIV, these more proximal risk factors must be contextualized among more distal—but perhaps more fundamental—consequences of rapid change in the patterning of Huli life. As Paul Farmer writes, “an epidemiology that is narrowly focused on individual risk and short on critical contextualization will not reveal … deep transformations [in biosocial systems] nor will it connect them to disease emergence” (Farmer 1999: 53). Epidemic disease must be approached not just as a biological phenomenon, but also as a way that “social forces and processes come to be embodied as biological events” (Farmer 1999:14). Paul Farmer
argues that risk of disease exposure and negative health outcomes (due especially to differential access to treatment, and difficult material conditions) track sharp gradients of social and economic inequality. To understand the HIV epidemic among the Huli, then, we must understand how these inequalities relate to the rapidly changing conditions of Huli life.

In addition to the ethnographic and historical challenges posed by this rapid change per se, there is another key challenge to developing an account of inequality that traces local patterns of HIV risk among the Huli. A thread of Melanesianist ethnographic theory associated with Roy Wagner and Marilyn Strathern emphasizes that the values and precepts of Western individualism can be misleading in a Melanesian context, where higher value is placed on the formation and maintenance of social relationships, and personhood is treated as emergent from these relationships—both multiple and ‘dividual.’ However, wage labor is increasingly displacing subsistence horticulture, and a socially atomizing cash economy is increasingly replacing and transforming relationally integrative systems of exchange. Holly Wardlow has noted that with these social and economic changes comes an "incipient individualism" (Wardlow 2006: 19ff.). How do we perceive inequality in this context of multiple and complex value orientations?

In this essay, I suggest that Huli diagnostic and interpretative practice can index sites of disjuncture in the continuity of Huli relational sociality. Attention to these social uncertainties can reveal the entanglements of disease transmission and cultural change without the individualist value assumptions implied by a Western universalist metric of inequality.
THE AUTONOMY AND MUTUALITY OF ILLNESS AND DISEASE

For these changing forms of sociality, personhood, and value, to be relevant to the HIV epidemic, they must be set in a theoretical framework that allows us to perceive the complex interplay between the social and biological. Here, the distinction between human sciences (Geisteswissenschaften) and the natural sciences (Naturwissenschaften) can lead us to initially assume the separateness of social interpretative processes from biological disease transmission. Though we can acknowledge significant differences in productive epistemological approaches to the human and natural sciences, these differing approaches should not occlude a more fundamental continuity and causal entanglement.

In the field of medical anthropology, and in discourses about more broadly, the Geistes/Natur divide takes the form of an analytical distinction between disease and illness. While the former indicates biological pathology, the latter refers to a complex of intra- and inter-subjective experiences and interpretations associated with pathology (Frankel 1986: 5; Mol 2002: 20). Despite these biological and experiential associations, however, there are many cases in which illness is experienced in the absence of biological pathology. Conversely, biological pathologies recognized by medical science are sometimes treated as “unexceptional, or even desirable”—that is to say, independent of experiential illness (Frankel 1986: 3).

Though he acknowledges this slipperiness and cultural contingency of the alignment between disease and illness, Stephen Frankel argues that it would be an error to allow relativistic concerns to wholly displace the influence biological pathology in anthropological accounts of illness. Although “even the most straightforward lesions can lead … to a wide range of social responses … various constants follow from the medical
aspects of the lesion.” If a person’s leg is broken, for example, the condition will, at minimum, have an effect on the length of recovery and the reduction of the injured person’s mobility. “These aspects, which derive from the biological nature of the lesion, clearly pattern the experience of the sufferer and the outcome” (1986: 2).

On the other hand, consequences associated with disease—including illness—should not be treated as merely the epiphenomenon of an underlying biomedical reality. Annemarie Mol argues that though disease refers to something inside to body, “bodies only speak if and when they are made heavy with meaning.” The origins and indications of this meaning are always historically and culturally specific (Mol 2002: 10-11). Gilbert Lewis makes a parallel claim in his emphasis that the circumstances and person make each case of illness unique. Illness “comes at a particular moment in someone’s life. The time and place, the implications for the individual, the other people involved, and whatever else happened just then, all potentially contribute to its particularity” (2000: 1).

Following Frankel, I maintain that it would be disingenuous to wholly reject the results of biological science and their relevance to medical anthropology. However, this view need not be read as in strict opposition to calls for ontological delicacy in discussions of disease and illness (e.g. Law and Singleton 2005, Mol 2002). While the methodologies of quantitative medical research are formulated around (post-)positivist epistemological orientations (Bergman 2011), many researchers hold the position that one need not necessarily accept this philosophical position in order to recognize the pragmatic validity of its results (Johnson and Onwuegbuzie 2004, cf. Bergman 2011). I argue that though biomedical discourse cannot be taken to inform a deterministic
connection between disease and illness, the biological processes and conditions of disease transmission, symptoms,

Like other viruses, HIV does not contain the mechanism of its own reproduction. For the virus to replicate itself, it must co-opt extrinsic productive capacity by inserting its own genetic material into the genome of a host cell. Host cells that do not self-destruct in apoptotic response to infection and are not targeted by immune response are destroyed as the new batch of replicated viruses disrupt cellular function and eventually rupture the cell wall. HIV infects a variety of cell types involved in immune function, and its destructive co-option of these cells’ reproductive capacitites leads to a progressive decline in the host’s immune function. The virus’ host becomes increasingly susceptible to infections and cancers.

For any parasite or pathogen that kills its host—destroys the conditions of its own existence—some means of transmission is necessary for continued propagation. In the case of HIV, organism-scale transmission echoes the co-option of reproductive capacities that occurs on the cellular scale. The virus is carried in semen, mucus, blood, and milk, and its transmission involves sexual, perinatal, or subcutaneous exchange of these substances (Hladik F, McElrath MJ. 2008).

Though these routes of biological transmission do not determine the experiential or social dimensions of illness, their symptoms and patterns of transmission do disrupt a particular field of social practice and draw this field of practice into interpretative association with the disease. Indeed HIV’s routes of transmission resonate strikingly with some historically central themes of Melanesianist anthropology. For those familiar with ethnographic work on kinship in Papua New Guinea, the phrase “exchange of
"substances" is all but metonymy for *The Gender of the Gift*, Marilyn Strathern’s influential study of Melanesian gender and kinship (1988). Here, Strathern emphasizes the role of exchange—including bodily substances transacted in sex, breastfeeding, and certain ritual practices—in processes of social reproduction. Because HIV is transmitted through these same substances, the discourses and dangers that surround the infection ride these contours of social and sexual reproduction. As Katherine Lepani writes, "HIV colonizes the most basic dimensions of human experience, exploiting our fertility and sexuality while gaining velocity through social structures and processes that map multiple routes of transmission" (Lepani 2012: 15).

The meanings attributed to disease and the complex conditions of a particular illness are not simply a dependent variable of disease, but recursively shape the biological course of disease—just as the biological aspects of disease can shape its impact on the social and experiential dimensions of illness. Whether cursory or elaborate, a diagnostic process must precede and condition any purposive act oriented to disease outcome. Even in the absence of direct attempts at intervention, the results of diagnosis can lead to social and psychological consequences such as stigma (Stewart 2012) and despair (Lewis 2000), which can significantly impact health, accentuate forms of social inequality, and put a patient at greater risk for violence and neglect. Furthermore, a meta-pragmatic awareness of diagnostic processes and associated ideologies of morality and risk can have a strong influence on health related behavior (Wardlow 2002b).
As a form of interpretative practice, diagnoses draw on culturally and historically conditioned techniques and categories;¹ these techniques and categories intersect with the unique circumstances of a particular illness to generate contextually situated (Lewis 2000) and indexically complex (Munn 1990) meaning. In this sense, diagnostic and interpretative practices are an important point of articulation between health-related behavior and “a set of ideational resources and habits of mind about morality, gender, sex, and disease etiology,” embedded in a broader cultural and historical horizon (Wardlow 2002b). Just as the biological conditions of HIV’s transmission and effects draw it into interpretative association with a field ideation and practice, changes in that field can shape the conditions of the virus’ transmission.

INEQUALITY, STRUCTURAL VIOLENCE, AND VALUE

The title of this essay is, in part, a play on Paul Farmer’s Infections and Inequalities (1999). Drawing especially from his decades-long experience with advocacy and ethnography in Haiti, Farmer (Ibid) has shown that the global HIV pandemic follows paths traced out by poverty and inequality. Farmer writes that “much of the spread of HIV in the 1970s and 1980s moved along international ‘fault lines,’ tracking along steep gradients of inequality, which are also the paths of labor migration and sexual commerce.” These social inequalities “structure not only the contours of the AIDS pandemic but also the nature of outcomes once an individual is sick with complications of HIV infection” (Farmer 1999: 50, 52). The ways that “poverty and other social

¹ Such practices include well-elaborated practices such as clinical consultation (e.g. Mol 2002: 48), microscopy (Ibid.: 36), and divination (e.g. Lewis 2000: 94ff.), but also more-or-less ad hoc hunches and speculations (e.g. Ibid.: 3).
inequalities come to alter disease distribution and sickness trajectories,” involve “numerous and complicated mechanisms.”

In the case of tuberculosis, for example, Farmer notes that the mechanisms that relate racism and poverty to increased risk of infection include

the fact that the poor are more likely to live together, often in the cramped, airless quarters that once characterized the ‘lung blocks’ of industrializing cities and now describe the urban ghettos in which tuberculosis is endemic. Various institutions designed to serve or contain the poor have in many instances been the settings for amplified outbreaks of tuberculosis. [...] Poverty and racism surely increase the likelihood that one will end up in a shelter, just as these forces arrange the chances that one will wake up in a crack house or a prison. Once infected, the poor are more likely to progress to active disease. [...] Cell-mediated immunity, which keeps tuberculosis quiescent in most persons, may be compromised by malnutrition, HIV infection (or other concurrent disease), or addiction to drugs or alcohol. [...] Poverty and racism increase the likelihood of dire outcomes among the sick by restricting access to effective therapy or rendering it less effective if patients are malnourished or addicted. Poverty clearly decreases the ability of patients to “comply” with demanding lengthy regimens. [1999: 13]

In Farmer’s model, poverty and social inequality are closely associated with structural violence, a concept that Johan Galtung (1969) developed to explicate kinds of violence—especially political and economic—that easily go unseen because they lack the clearly identifiable individual agent associated with direct interpersonal violence. Thus, for example, structural violence is present where "income distributions are heavily skewed, literacy/education unevenly distributed, medical services existent in some districts and for some groups only, and so on. Above all the power to decide over the distribution of resources is unevenly distributed" (Galtung 1969: 171). Galtung defines violence as “that which increases the distance between the potential and the actual, and that which impedes the decrease of this distance. Thus, if a person died from tuberculosis
in the eighteenth century it would be hard to conceive of this as violence since it might have been quite unavoidable, but if he dies from it today, despite all the medical resources in the world, then violence is present according to our definition.” (Ibid: 168).

As Galtung acknowledges, however, this concept of "potential realizations," can be "highly problematic" (Ibid. 169). As with illness and disease, the experiential and social dimensions of violence emerge in complex interaction with the particularities of a historical, biographical, and cultural context. If violence is a matter of disrupted potential, we must ask “the potential of what?” and any answer must be conditioned by these particularities. Though the avoidance of “somatic incapacitation” associated with disease and physical violence has enough general currency in human experience to seem unobjectionable, illness and epidemic, as social phenomena are necessarily more complex than the biological pathologies (or “somatic incapacitations”) with which they are associated. Structural violence, then, is not felt solely by its effects on the body, but more generally in the disruption of anything to which value is attributed.

If, then, we acknowledge that A) patterns of inequality shape the trajectories of epidemic disease, B) these inequalities are influenced by patterns of structural violence, and C) that violence must be framed in relation to some system of values, we must also acknowledge D) the potential relevance of values to the trajectory of epidemic disease.

Building off a long-standing conversation in Melanesianist anthropology, Joel Robbins suggests that “the societies of Melanesia need to be seen as placing primary value not on the [social] whole or on the individual but rather on the relationship and hence might be called “relationalist,” rather than holist or individualist” (2004: 13, 1994). This value orientation reflects a more general Melanesian tendency to regard the person
not as individual, but as a “dividual”—a “microcosm of relations” (Strathern 1988: 131)—and to interpret human action less as “self-determined, than as elicited by the requirements of the relationships that they have” (Robbins 2004: 291; see also Strathern 1987: 295; Wagner 1974, 1986). These conceptions of value, personhood, and agency shape how the disruptive effects of both structural violence and disease are felt, and furthermore, how these disruptions become causally entangled. In a society that places greater emphasis on relational forms of value, we must recognize that disruption of relational social processes is itself a form of violence. Similarly, an account of the harm caused by disease should be attentive to the effects on the patient’s social relationships.

This shift in emphasis from an individualist to a relational value orientation has a significant impact on the epistemological approach appropriate to understanding the intersections of inequality with epidemic disease. While concepts of the “individual” or “social whole” provide discrete units of analysis, a relational model leaves the analyst with an unbounded, fractal, and multiply centered meshwork. While discrete units lend themselves well to abstraction and typification, a relational network is always actual and historical. Because its object is necessarily complex, the grounds for the identification of violence in a relational system, then, are inherently temporal—they cannot assume the eternal abstraction of a Cartesian individual, but must acknowledge person as embodied in time and space.

UNCERTAINTIES OF CONTACT

First Huli contact with an Australian administrative patrol came in April of 1934. After four months of hard travel and short on food, two patrol officers, Jack Hides and
Jim O’Malley, along with ten Papuan constables and twenty-eight carriers made their way across the limestone wastes of the Karius Range into the Tari basin (Frankel 1986:10; Glasse 1968: 15). Though at first the Huli people kept their distance from these strangers, on the second day after their arrival, an impressively bearded man that Hides variously described as “a splendid figure of a man,” an “imperial figure,” and “like a military officer,” approached the patrol. “With his pantomime language,” writes Hides, “I could understand fairly clearly [what he was saying] … he appeared to be telling us that north, east and west were people in the thousands—like the sands he picked up and let fall through his fingers” (Hides 1936: 81 in Glasse 1968: 16). As he continued his gestured discourse, Hides guessed that the Huli man was inquiring after the patrol’s origin. In answer, Hides pointed south-westwards to the limestone barrier they had passed to enter the valley—incidentally the same direction as humbirini andaga, the Huli place of the dead (Frankel 1986: 11).

Several Huli who were young men at the time of this encounter contribute their own recollections to the account: Dabure-Puya, the man whose bearing Hides found so impressive, had recently lost a brother, and picked up on a striking resemblance between Hides’ features and those of his deceased kinsman. “Dabure-Puya told the people gathered there that [his brother] had returned, and went off to kill a pig for [him]” Later that evening, Dabure-Puya approached the patrol again and beckoned to Hides. Dabure-Puya “was telling his brother to be on his way and not to kill him” (Frankel 1986: 11-12). Though Hides had hoped to go east, there was no path in this direction, and following Dabure-Puya’s gestured suggestion, he and O’Malley led the patrol northwards (Glasse 1968: 16).
The recollections of Huli witnesses let us imagine the strangeness of this encounter from a Huli perspective. To Dabure-Puya, the appearance patrol officers, with their white skin, steel, and unfamiliar clothing, was well out of the Huli norm. As Hides’ patrol continued north, they met a mixture of hostility and hospitality. They were alternately threatened and fed as they passed across Huli land. Glasse notes that hostility among Huli groups was a common, and that the practices of reciprocal vengeance maintained the possibility of violence even in times of peace (Glasse 1968: 87ff.). Though some Huli men joined with the group to act as guides, none of these were willing risk continuing past the boundaries of their own territory (Glasse 1968: 16-17). The restricted movement of these Huli guides underlines the strangeness of patrol’s mobility. The presence of Hides, O’Malley, the constables, and the porters must have suggested a great potential for something to happen, but their behavior gave few clues that would resolve this uncertainty in a paradigm legible to common Huli experience.

To Dabure-Puya, however, the aberrant behaviors and appearance of these strangers did not put Jack Hides or his patrol “outside” of interpretation. Though the appearance and behavior of the patrol did not fit the typical constraints of Huli life, Dabure-Puya met the patrol with a ready interpretation, and in killing a pig for his “brother,” he acted on this hypothesis. Though perhaps Hides bore a real and coincidental resemblance to Dabure-Puya’s deceased brother, the possibility of this coincidental association was founded on imbricate uncertainties of the kinsman’s recent death and the arrival of Hides’ patrol.

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2 Hides recalls a Huli man pointing out “our white skins, our clothes and steel, and then pointing [questioningly] to the sky,” as if suggesting a spiritual origin. (Hides 1936: 96 in Frankel 1986: 13)
The Huli recognize that in cases of a close relationship, “yearning for the deceased” could be acute enough impact the health of surviving kin. “This yearning is … known as hame, an overwhelming desire for the return of the dead person, and for the help and sustenance that they offered while they were alive (Frankel 1986: 142). While the pain of bereavement could disrupt the lives of those mourning a recent death, the actual fulfillment of this yearning in the spiritual return of the dead could be even more dangerous. Frankel records a case of a man who had been particularly close with his deceased wife, and who complained of sleeplessness due to concern that “his wife’s spirit might return to claim him.” (Frankel 1986: 143). For Dabure-Puya, the loss of a brother’s “help and sustenance,” and the possibility of the spirit’s return would have marked life with a significant degree of uncertainty. Those contexts in which Dabure-Puya might have relied on his brother’s support would present new relational challenges, and after death, the spirit, previously constrained by the limitations of embodiment and social convention, was transformed into a pervasive latent danger.

Despite the historical particularity of such “first-encounter” narrative, Dabure-Puya’s take on Jack Hides has a lot in common with the more general interpretative processes that mediate confluences of Huli belief and practice and the influences of colonialism and global capitalism. Such affinity of uncertainties weaves the interpretative practice surrounding epidemic into the weft of socio-cultural and historical context. Matching contours of incompleteness are powerful evidence for a more profound association between things.

The kind of association Dabure-Puya made between a dead kinsman and a strange outsider seems to be common in Melanesian histories of contact (e.g. Stasch 2009, Scott
2007, Kulick 1992). Rupert Stasch notes, for example, that the Korowai use the same category of laleo (demon) to describe both foreigners and the monstrous dead thought to leave poisoned food-gifts for living kin and occasionally approach dwellings at night. Though speakers increasingly describe this usage as “merely idiomatic,” the significance of the association remains—foreigners, like the dead, are an “intimate other” to living and endogenous humans (Stasch 2009: 69). Though they seem human in many ways, they fail to engage in basic aspects of sociality. Hides, too, may have appeared as an “intimate other” to Dabure-Puya. As a being with apparent social potential, Hides’ presence—and that of the patrol—evoked various possibilities of social interaction, but he did not act in a way that could clearly resolve the significance of their presence.

But what connections can be drawn between this story of encounter and HIV—an epidemic whose effects wouldn’t be felt in the highlands for another half-century? I hope to illustrate a kind meaning that isn’t synchronic in a structuralist sense, but doubly conditioned by temporality: both the anticipatory delay of uncertainty and the historical contingency of its resolution. I argue that both HIV itself and the rapidly changing material and socio-cultural conditions of Huli life are felt as this kind of temporally conditioned uncertainty.

WARP AND WEFT: ILLNESS AND UNCERTAINTY

Aletta Biersack elaborates the application of information-theory to ethnographic material collected during her fieldwork in the Paiela valley—some forty miles north of the Tari basin. Biersack frames “information as a decision between alternatives in which one alternative is selected and the other is rejected as the alleviation of an initial
uncertainty” (Biersack 1980: 21-22). In this model, communication is the transition from an initial “off” state, in which alternative outcomes are anticipated, to an “on” state, in which one alternative outcome has been selected and another rejected.

Learning—“to take mind” (nembo mia), “to see,” “to know,” or “to choose” (anda)—is a two-stage process. In the first stage the Paiela pose the alternatives. But they do so in the interrogative, attaching the interrogative morpheme –pe to the first alternative if not to the second as well, indicating that a choice between alternatives has not been made and that both remain possible. In this stage the speaker describes himself as “confused,” “undecided,” or “uncertain” (na andene) … The sense of both expressions is that he has not chosen. That is why both alternatives remain possible. … The something or someone with respect to whom classification is pending is then said to be “that which makes the learner confused, undecided, or uncertain” or “that which makes the learner unknowing,” “that which is unknown to the observer” (anda na pene) [Biersack 1980: 22]

In the body of Melanesian ethnography, there is pervasive emphasis on contrasting categories of knowledge and uncertainty. As early as Bronislaw Malinowski’s Argonauts of the Western Pacific, these themes—and their relationship to illness and diagnosis—come clearly to light. The Trobriand Islanders greatest dreads, writes Malinowski, were reserved for a shadowy cast of sorcerers, flying witches, and malevolent disease-bringing spirits (1984 [1922]: 72). While mild illness might have been explained by mundane causes, anything severe was attributed to the malevolence of these unseen agents (Ibid. 73. See also Frankel 1986).

All very rapid and violent diseases, more especially such as show no direct, perceptible symptoms, are attributed to the mulukwaurasi, as they are called. Invisible, they fly through the air, and perch on trees, house-tops, and other high places. From there, they pounce upon a man or woman and remove and hide “the inside,” that is, the lungs, heart and guts, or the brains and tongue. Such a victim will die within a day or two, unless another witch, called for the purpose and well paid, goes in search and restores the missing “inside.” [Ibid: 76]
Even the sorcerer, the only human figure among these supernatural threats, must practice his art stealthily. He prepares his spells and charms in the dense jungle, where he cannot be seen. He hides behind a shrub or house as he points his magical dagger at a victim, or, staying hidden behind the wall of a dwelling, inserts a deadly ensorcelled bundle through the thatch in order to bring harm to an occupant (Ibid.: 75). The human sorcerer might motivated by personal grievances or be paid by a third party to use his “black art” against a victim. In these cases, there is a clear association between the uncertainty of disease—its etiology and prognosis—and the hidden aspect of its cause.

Nancy Munn (1990) and Pierre Bourdieu (1972) have both observed the inevitable risks of social exchange: that in appeasing one exchange partner or fulfilling one social obligation, one is always potentially neglecting some competing obligation. The tensions of display and occlusion cast this problem in sharper light. To make something visible is to elicit desire that might linger as dangerous malevolence if left unconsummated (Wardlow 2006: 30ff.).

A gift seen by many but given to one must have what Munn calls a “covert negative potential” (Munn 1990). A specific observer does not need to be present for negative potential to be anticipated. It can be "virtual observer" who "'favors' a transaction with his notice, giving it a known identity beyond the spacetime location of the transaction and the participant actors" (Munn 1986: 222, see also ch.5). The possible negative inclination of such anobserver "is implicit in all transactions, standing ready, as it were, to subvert the transaction" (Ibid.). In any exchange, then, the positive reciprocation of an anticipated counter-gift is shadowed by the possibility of malevolent counter-attack by those excluded from the exchange. Recalling the pervasive Melanesian
orientation towards the multiple and relational construction of personhood, then, this suggests that a person is not merely a microcosm of positive or productive relationships, but also, in part, the occluded and uncertain “negative potentials” of those relationships. These negative potentials occupy the same occluded and uncertain conceptual space as the hidden or invisible agents of sorcery and disease.

Bourdieu elaborates the critical role of time in gift exchange: it is, he argues, the uncertainty that inheres in the interval between the presentation and return of a gift that give the exchange significance. “This uncertainty, which finds its objective basis in the probabilistic logic of social laws, is sufficient to modify not only the experience of practice … but practice itself, in giving an objective foundation to strategies aimed at avoiding the most probable outcome” (1972: 9). That is to say, no matter how likely an outcome is, in objective terms, the possibility of alternatives can profoundly shift the orientation of those actually involved in a given interaction. “In dog-fights, as in the fighting of children or boxers, each move triggers off a counter-move, every stance of the body becomes a sign pregnant with meaning that the opponent has to grasp while it is still incipient, reading in the beginnings of a stroke or a sidestep the imminent future, i.e. the blow or the dummy” (Ibid. 11).

More generally, a great deal of ethnographic work supports the strong association between seeing and knowing (e.g. Robbins 2004: 138ff., Kulick 1992, Eves 2000a). Knowledge is assured by direct observation, rather than through second-hand communication. Eves notes that “Sight is considered the most reliable means of obtaining knowledge, because people may either disguise their meaning in some form of veiled speech or simply not speak the truth at all” (Eves 2000a: 463).
In cases of illness, a diagnosis or cure will typically require the revelation or interrogation of the hidden aspect of the illness in relation to a known interactional history of the victim (e.g. Munn 1986, 1990, Wagner 1967 ch.2, Lewis 2000). In this sense, patterns of uncertainty condition the diagnostic search for cause. For example, Lewis (2000) gives us an account of divining practice in the Sepik region. Following the death of a young girl, a piece of bamboo is suspended such that it swings against the men’s house slit gong in response to names of culprits and their villages or origin. "As some names were suggested, there were jeers or dissent: 'No, not him, he's in gaol!'; 'No, he's too old!' (Ibid. 95). As the names of possible attackers are drawn into common context, their own uncertain potentials are fitted against the uncertain cause of Maisimbel’s death. They do not need to know that some suspected sorcerer was at the scene of the crime, but rather that he could have been. The objections: “he’s in gaol!” “he’s too old!” eliminate candidates based on constraints to the potential of their movement and capabilities.

“RISK” AND AGENCY

In epidemiological terminology, the word "risk" refers to the statistical correlation of "a specific behavior or other factor" with increased "relative odds of infection" (Brookmeyer and Gail 1994: 23). The statistical metric of "risk" is applied as the criterion of a "risk group," which can be defined as "all those individuals belonging to the set with the characteristic that is associated with increased relative risk or relative odds" (Barnett and Whiteside 2002: 80-81). Barnett and Whiteside note that the translation of 'risk' into everyday language loses the ostensible objectivity of its statistical criterion and is readily
associated with blame and stigma (Ibid. 81). As Katherine Lepani puts it, "the subtexts of moral and social deviancy invoked by categories of risk derive in part from historical representations of people marginalized from positions of power—prostitutes, homosexuals, the poor, and people of color" (Lepani 2012: 17). Lepani argues that even in their usage within expert epidemiological discourses, such surveillance categories can be problematic. "Risk groups," "core transmitters," "risk behaviors." and "epidemiological hot spots," all fit into a system of discourse that tends to externalize risk and emphasize individualist models of behavior change (2012: 16-17).

These models, conventionally used for predicting and modifying behavior in relation to risk, are referred to as "social-cognitive" in the health psychology literature. The "social" is generally represented as a measure of individual agency responding to various external factors, rather than the relations between social actors, whereas "cognitive" is represented as an internalized struggle between risk and reason. The emphasis of behavior change is on rational intention—the individual, armed with factual information, setting out to achieve goals. [Lepani 2012: 16]

Drawing on ethnographic fieldwork among the Huli, Holly Wardlow makes a strong case that behavioral and epidemiological "risk group" categories of prostitution and sex work are a poor fit for the kinds of multiple-partner sexual practice that actually occur in the region. For both men and women, sexual and marital practice has been profoundly transformed by men’s participation wage-labor and the cash economy.

In part because sexual contact carries such connotations of risk to a man’s health, beauty, and social effectiveness, “Huli men often interpret acute sexual desire as the subversion of one’s own self-determination by the object of desire, perhaps with malevolent intentions and through underhanded means, such as magic” (Wardlow 2002a: 15). While the idea of female pollution has persisted, the institution of the ibagiya
bachelor cult has disappeared. The traditional conceptions of a sexually disciplined masculinity still exist, but in increasing competition with “newer constructions of masculinity [that] frame extramarital sex … as an exciting conquest and as a (temporary) means to escape the strictures in which sexuality is traditionally embedded” (Wardlow 2002a: 15).

Following Kamala Kempadoo’s critique of the “canon” in prostitution studies (1998: 13), Wardlow notes the tendency to privilege “western categories and subjects” at the expense of under-theorized Third World lives and experiences (Wardlow 2006: 140). Wardlow orients much of her attention towards the figure of the “passenger woman.”

[Tok Pisin: pasinja meri, Huli: pasinya wali]

“Passenger woman,” a term used widely in Papua New Guinea, may derive from the fact that women who sell sex can be found at roadside marketplaces where public buses stop as they traverse the Highlands Highway (Hughes 1997). In other words, passenger women are the women who provide sexual services to passengers on public buses. Among the Huli, however, the term has somewhat different meanings: people say that passenger women are called by that name because they jump on buses and run away from their families; that is, a pasinja meri is literally a female passenger—a woman who will not stay put, either physically or sexually. [Wardlow 2006: 139-140]

Applying the labels “prostitute,” and “sexworker,” to Huli pasinja meri, however, is problematic. These women, she notes, “do not depend on the money they gain for survival, and in general they do not consider what they do ‘work’” (Wardlow 2002a: 14). Though the identity of pasinja meri, carries significant stigma, this is not because of emotional breaches of gender propriety, but because it implies the abandonment of kin obligations for the purpose of personal profit … In accepting money for sex, passenger women are sometimes said to ‘eat their own bridewealth’ or even to ‘eat their own vaginas.’ Implying that they have disrupted the proper transactional flows for wealth
and women by appropriating the means of social reproduction for their own aggrandizement. (Wardlow 2002a: 14)

For both men and women who participate in such transactional sex, it constitutes a rupture in, or escape from traditional forms of sexuality. “Proper transactional flows for wealth and women” embed sexual exchange in a broader process of social reproduction. “A marriage—specifically the acts of giving and receiving bridewealth—is considered an act of collective agency,” writes Wardlow, “during my fieldwork both men and women would sometimes take me aside, point to a child, and boast in a delighted and wonder-struck tone, ‘I gave (or accepted) two pigs for that child’s mother and look what we’ve created!’” (Wardlow 2002a: 19).

If individual, transactional sex is a negation of this kind of collective social reproduction, however, this does not mean that it should be understood only in terms of individual agency. Based on the life-histories collected from pasinja meri during the course of her fieldwork, Wardlow observes that the decision to leave the control of their male relatives and engage in transactional sex is a “refusal to participate in social reproduction when one’s structural position becomes untenable” (Wardlow 2002a: 7).

Wardlow gives an example of such a case:

Ogai had two children and had suffered through a difficult marriage for a number of years before she began to “raun long laik” (literally, go around as I please, which implies promiscuity when applied to women). Her husband worked in the mess hall of a mine site in another province, but he rarely gave her money and rarely came home. He once promised to take her to Mt. Hagen during leave from work, but he took his girlfriend instead, and she later found naked photos of this woman in his pockets when she did his laundry. Nevertheless, it was only after she was raped and her brothers and husband refused to do anything about it that she decided to leave him. It was after this incident, she said, that she abandoned him and their children and began exchanging sex for money. [Wardlow 2006: 135-136]
The absence of collective agency does not mean its irrelevance. Ogai—and many other Huli women—feel such absence acutely. Indeed, “it is precisely because women are so defined by bridewealth that their sexuality becomes an important instrument of retaliation when they feel betrayed or exploited by kin” (Wardlow 2006: 25). Though their reactions constitute what Wardlow calls an “incipient individualism” this individualism, and the freedom of action and mobility that it entails stand in sharp tension with the relational values of traditional social reproduction.

Cash allows alienation and anonymous transfer of items whose exchange might otherwise be restricted relationally productive channels like bridewealth and death compensation. As men have become more involved in wage labor, the production of wealth and resources with a constrained relational function has been increasingly replaced with the acquisition of cash—defined by its unconstrained exchange potential.

As Katherine Lepani writes:

To be effective within contexts where the cultural imperative for social reproduction involves complementary constructions of sexuality and fertility, HIV communication must move beyond essentialist binaries and the individualist premise of behavior to engage with a diversity of meanings and intentions in sexual and reproductive agency. [Lepani 2012: 100]

The case of the *pasinja meri* demonstrates that the “individual,” as categorized in a "risk group," or "risk setting" is not necessarily an appropriate or effective locus of intervention. This emphasis on categorical criteria by which to direct behavioral interventions is a symptom of the scientistic tendency emphasize what something or someone *is* as an epistemologically necessary and sufficient pre-condition to making judgments about what something or someone *does.*
AN INTERPRETATION OF “GONOLIA”

Emphasizing the importance of a processual approach to the study of illness interpretation (Wardlow 2002b; see also Farmer 1990: 6, Lewis 2000), Holly Wardlow details how a Huli woman’s representation of her illness changed over time as she selectively drew on discursive resources related to “long-standing ‘beliefs’ about the relationships between personhood, social reproduction, moral violations, gender and health.” The way she managed these discursive resources continued to transform as she “entered a new social organization of knowledge and as these resources failed to account for new information” (Wardlow 2002b: 155). This woman, whom Wardlow calls Yerime, was married to Alembo, who plays an important role in the illness narrative.

...Yerime and Alembo were a fairly typical young Huli couple ... He had episodically engaged in wage labor, as had many Huli men, and she spent her time tending sweet potato gardens and raising pigs. She had never been outside Huli territory, while he had for short periods of time. Both grew up attending the same Catholic church, and she was more devout, as are most Huli women, and he was more dubious, as are most Huli men. They married in a fashion that was frowned on, but typical: he courted her by giving her trade store foods, such as rice, biscuits, and canned mackerel, and then, when it appeared that she might be married to another man who was able to provide the requisite bridewealth first, he sexually molested her, forcing the marriage. [Wardlow 2002b: 158]

Wardlow notes that Alembo, who was her host during her first year of fieldwork, would occasionally “become very ill, hide out in the communal clan men’s house, and refuse to go the health center.” After treatment with antibiotics, he would recover “within a week or so” (Wardlow 2002b: 151).

Yerime … was convinced that these were episodes of gonolia, the Huli term for all sexually transmitted diseases (STDs), a condition she considered chronic in his case because he refused to get himself properly diagnosed and treated at the nearby health center. According to her, his
recalcitrance on the issue stemmed from his fear that documentation of an STD in his clinic book might give her leverage in a future divorce case. [Ibid.]

During these episodes of illness, Yerime “would refuse to bring him anything he asked for and would stand outside the men’s house on the road, shouting to him and anyone passing by that he was a ‘gonolia man’” (Ibid: 152).³ Yerime hoped that if she could obtain medical evidence of Alembo’s gonolia, she could gain support in ending her marriage, which, after five years, had not produced any children.

Eventually, however, Yerime herself “became very ill with flu-like symptoms and little sores around her mouth. The local health center referred her to the regional hospital STD clinic, where she was diagnosed with syphilis” (Ibid). Despite this diagnosis and the fact that the symptoms quickly subsided after treatment with a course of antibiotics, Yerime initially refused to acknowledge the possibility that she had gonolia, insisting that the clinic had made an error. The reasoning behind this denial “drew on both symptomological and etiological understandings about gonolia” (Ibid: 159).

First, Yerime’s experience didn’t match the typical symptoms of gonolia—though Huli usage of the word encompasses multiple sexually transmitted diseases, most of these diseases include abdominal pain as a primary symptom, which Yerime did not experience. (Ibid) Furthermore, Yerime’s case did not initially seem to fit Huli etiological beliefs about gonolia.

³ Wardlow gives a striking example of such a tirade: “Your little stinking gonolia is eating little holes in you, and you’re becoming old and smelly. A little piece of trash like you, you think you can do anything worthwhile? It’s absolutely right that I shame you in public. I say you are gonolia and you have no shame. You little, useless, left-over scrap. You and your mother are both little demonic slugs with skinny, weak legs—all your relatives are like this—just hanging around for no reason and talking about nothing. Everybody come and look at the man who has been eaten by gonolia!” (Wardlow 2002b: 152)
On an etiological level, gonolia is thought to be the result of individual moral violations; it is caused primarily by one's own sexual transgressions—specifically, extramarital sex—not by transmission from someone who has the disease. Thus, as long as one engages in sex only with one's spouse (regardless of what one's spouse is doing), one cannot contract gonolia. This notion of disease causality has both moral and biological components. [...] Sex that takes place outside of the project of social reproduction [...] is a moral transgression that can cause illness. [...] On a biological level, and more specific to gonolia, one's own sexual transgressions (meaning all pre- or extramarital sex) are dangerous because they expose one to reproductive substances that have not been socially regulated through the exchange of bridewealth gifts or the utterance of protective spells. [Ibid: 159]

After the initial denial, however, Yerime concluded that the sores, though perhaps not gonolia, were related to her own behavior. Yerime had not had sex with anyone other than Alembo, but she located her actions in cultivating a relationship with a potential second husband on the same dangerous transgressive axis as sexual contact (Ibid. 160). Yerime had “accepted money from a former boyfriend and used it to buy pork, which she had eaten by herself in secret. … [S]he knew that this man’s overtures were ultimately of a sexual nature, and so her acceptance of his gift counted as a moral violation” (Ibid).

Before she shared this theory with her female relatives however, they set out some related hypotheses, “most of which implicated Yerime’s own behavior, and none of which implicated Alembo. The central theme in all of these explanations was that the sores were a manifestation of sinful or polluting consumption.” (Ibid). These alternative theories, Like Yerime’s own explanation, relate to the “covert negative potential” (Munn 1990) of the excluded other in relational exchange.

One aunt reminded Yerime that Alembo had almost married another woman instead of Yerime: the other woman had planted sweet potato on Alembo’s land, and when she had left, Yerime had harvested and eaten it. Perhaps the woman was jealous of Yerime and had cursed those sweet potatoes, or perhaps she was a pasinja meri who had transmitted gonolia
to Yerime. […] Or perhaps [Yerime’s] former suitor was jealous and angry that she had married Alembo, and so he had poisonim (done black magic on) a gift of food for her, which she had then ingested. She should never have accepted gifts from a man who was not a brother. [Ibid: 160-161]

When Wardlow suggested that Alembo could have transmitted the disease to Yerime through sex, the Huli women told her “that this could not be so.” In this insistence, these women were drawing on a discourse of health, gender, and pollution that “represent men as the epitome of a powerful but fragile purity,” and women as dangerous, and polluting (Ibid: 165; Frankel 1986: 55).

Though contemporary Huli constructions of masculinity increasingly “emphasize a more conquest-oriented sexuality and … define the modern man as nonchalant toward, and dismissive of, more traditional sexual prohibitions,” Huli masculinity traditionally placed great value on “self-disciplined and reproductively oriented sexuality” (Wardlow 2002b: 166). Men were deeply concerned with their health and physical appearance, the aesthetics of which were strongly associated with social effectiveness (Frankel 1986: 55, 97). To achieve this ideal masculinity, men young men would “receive formal training in ibagiya, the bachelor cult, which centered upon special houses hidden in the forest of each clan territory.”

Each of these was run by a specialist in the lore, spells and techniques that help a young man care for his hair and his body, ensure his health and beauty, protect him from the causes of premature ageing, give him the power that causes others to be generous in their dealings with him, and that causes his pig herd to grow rapidly and without disease. [Frankel 1986: 103]

The instruction and lore provided in these bachelor cults put a great deal of emphasis on sexual discipline. In order to conceive and for men to avoid dangerous
exposure to female contamination, “sexual intercourse should take place on the eleventh, twelfth, thirteenth, and fourteenth days of the woman’s menstrual cycle.” (100) The threat of female pollution was pervasive and held significant dangers for men. It is not just in sexual intercourse that puts men in at risk of such pollution. “Women can be dangerous to men in other ways too: by stepping over a man’s food for example, or by looking at him while she is menstruating.” It is during sexual intercourse, however, that a man is most intimately exposed to her destructive essence, her 'heat' (pobo). This heat travels to the conjunction of the base of the penis and the colon, the area said to be joined to the umbilicus. The effects of this heat, and the taint (ngu, literally 'stink') of the woman, include a blackening of the intestines, and their twisting and tangling. The umbilicus will also blacken. At this stage the sufferer will be aware mainly of abdominal pain, and perhaps black diarrhea. The taint also travels up his spine, causing his neck to weaken and so his head to droop, as well as backache and headache. As the illness progresses his intestines will tangle so firmly round each other that they will knot and then the colon will burst. Symptoms are said to begin in months rather than days after exposure, and result in death a few days after their onset unless proper measures are taken. [Frankel 1986: 105-106]

The threat of such deadly illness is an important pole in the continuum of deleterious effects that improper avoidance can entail. This background framed Yerime’s beliefs about the possibilities of transmission between men and women.

Yerime and her female kin … conceded that perhaps gonolia could be transmitted from women to men, but they were adamant that men did not give women gonolia. [...] A wife could not get gonolia from a husband. [Yerime] still believed that [Alembo] had gonolia, but he had probably contracted his through sex with pasinj meri, while she had contracted hers through the consumption of a sexually illicit gift. That Alembo could have made her ill violated both the moral component (one’s own extramarital sexual acts cause gonolia) and the directionality component (men can contract it from women, but not the reverse, except in the case of pasinj meri). [Wardlow 2002b :162]
Although Yerime eventually accepted the possibility that Alembo could have transmitted gonolia to her, the only way she could initially make sense of this was as a malicious perversion of the productive capacities of marriage and sexuality: "He's fed up with children. He doesn't want me to give birth to children. He wants me to give birth to gonolia" (Ibid.).

As news of Yerime’s diagnosis became public, however, her interpretation continued to change. Other women who had also been diagnosed visited her, and explained that they hadn’t had sex outside of marriage either. Some of these women had been repeatedly infected with various STDs, and the nursing staff had explained a model of germ theory—“that their husbands’ (or other men’s) semen might contain tiny binatang (parasites, insects) or pipia (dirt) that could cause disease and infertility” (Ibid: 163).

Yerime’s transforming interpretation of her illness demonstrates an important point about Huli diagnostic practice. Yerime and her female relatives diagnostic hypotheses index points of disjuncture in Yerime’s relational milieu. Though, after exploring a series of other possibilities, Yerime accepted the possibility that Alembo had transmitted gonolia sexually, she nonetheless ultimately contextualized this possibility with a broader frame of “men’s moral dissolution.” As Wardlow puts it, “it seems to women that men have given up the self-disciplined work of being men, and gonolia is symbolic of this abdication” (Wardlow 2002b: 165). This, like Yerime’s earlier interpretations, points towards a model of disease that emphasizes relational uncertainties—aberrations from the norms of social reproductive practice—as the ultimate cause of disease. Traditionally, men valued strict discipline of their sexual
practice—the limitation of their sexual energies to socially productive channels that could be further moderated by proper protective magic and socially visible bridewealth exchange. As in Lewis’ account of divination practice, where the men who were too old or in jail were limited in their mobility, and thus rejected as possible attackers, so to did the traditional social strictures on male sexuality, and the accompanying ideologies of purity and pollution, limited the role of male sexuality in disease etiology. The dissolution of these controls leaves men’s sexual practice uncertain—increasingly contaminated by the possibility of dangerous and non-productive sexual contact.

CONCLUSION

In Papua New Guinea, HIV, as a purely medical phenomenon, is largely invisible. Testing is unavailable, as are the anti-retroviral treatments that can reduce and even eliminate symptoms and transmission rates. Diagnosis of HIV, furthermore, is done almost wholly in the context of antenatal care. Because treatments are not available, testing is done in service of epidemiological surveillance goals, rather than for the benefit of the patient. If the biological “disease” remains elusive, however, the epidemic itself is highly visible—even in locations with few or no reported cases (e.g. Eves 2002a, Lepani 2012: Ch.1).

What, then, is an appropriate response to a hidden danger? As in the kinds of curing rituals common throughout the diverse populations of Papua New Guinea suggest, to reveal what is hidden is the first step in arriving at a possible cure. Such revelation is not a matter of cutting and categorizing, but of drawing together into common context. The bounded categories suggested by epidemiological models of “risk settings” and
“behavior change” are especially problematic in Papua New Guinea, as are more general sociological categories of “individual” and “society.”

Ethnographic research on AIDS has clearly demonstrated this movement away from "culturalist" orientations. Instead this work tended to "emphasize political economy, in particular, the ways in which local actors--especially female actors--are precariously positioned by global inequities over which they have no control and that often leave them vulnerable to HIV” (Wardlow 2002b). Wardlow attributes this movement, in part, to the concern that the "etiolization" of culture would further obscure these neglected structural determinants (Wardlow 2002b: 153-4. See Farmer 1999, Farmer 1992).

Merill Singer writes that "approaches have tended to focus attention at the individual level, treating the targets of intervention as if they were independent beings and not members of families, peer groups, communities, and the broader society. Prevention emphasis has been placed on cognitive and motivational variables, including how individuals interpret behavioral information, how they value that information, how capable they feel about using the information, and how prepared and committed they are to personal change" (Singer 1998: 13-14).

Though the "families, peer groups, communities, and the broader society" that Singer cites have been the traditional focus of anthropological work, a reductive model of culture threatens to elide these complexities by framing them as epiphenomenal to a synchronic, and bounded cultural system. Critiques of this cultural etiolization, like other critiques of culture, have been framed against these obsolescent qualities of the culture concept, rather than against a nuanced understanding of the complex flux of human experience that “culture” might index.
As Wardlow writes, "although it is necessary to critique essentializing and etiologicist notions of culture, it is still important to hold onto the fact that people do deploy different logics about disease causality and that these logics can shape health-related behavior" (Wardlow 2002b: 154). Part of what is needed, then, is a concept that allows us to acknowledge the important role of the cultural in shaping health behavior without resorting to models of culture as bounded or essentialized. Avoiding culture altogether threatens to re-inscribe an assumed boundedness of culture through its explicit absence—a thing that can be categorically avoided is necessarily a categorical thing. For political and economic approaches that emphasize individuals and aggregates of individuals as their object, cultural variation appears as a sort of “irrational” residuum around the edges of “rational” behavior.

Searching for a way to account for variation in the logics of disease causality that "can shape health-related behavior," without recourse to reductive or static models of culture, Holly Wardlow suggests that "rather than 'the X believe Y, and so they do Z,' we need something more like 'among the X, A, B, C, and D, exist as discourses that can be drawn on consecutively or simultaneously to make sense of various health-related predicaments" (Wardlow 2002b: 154).

The phenomenology of symptom is insensible without intimations to the past and future. Some of these can be parsed into a discourse of syndromes, exposures, vectors, risk factors, case histories, contagions, and prognoses, but many more slip their biomedical traces and make for the fields of the historical, the social, the biographical, the affective, and the contingent. With these paths spread across such vast and complex territory, how do we begin to make sense of them? Even if it were possible to trace each
trajectory with perfect accuracy, we would find ourselves in the same trouble as Borges’ cartographers. We would find ourselves just as lost *within* our map as we might have been in the territory we had hoped to describe. In this case, where we bump against the limits of objectivism, I suggest that we can turn to the diagnostic and interpretative practices of the Huli themselves for guidance.

This paper is about the AIDS crisis in Papua New Guinea. This *about* specifies an object, but it is also the circuitous *about* of “roundabout,” and the approximate *about* of “just about.” This isn’t a hedge, but rather an outline of the broad approach necessary for a deeply biosocial understanding of HIV in the rapidly changing cultural context of the Papua New Guinea highlands. I argue that an approximate and inferential approach is a necessary component in our understanding of these complex and transdisciplinary systems. Though discrete categories mesh well with established quantitative epidemiological methodologies, the categorical variables required for these methodologies prefigure the kinds of results they can produce and the kinds of interventions they can warrant. Though the neatness of categories can *increase* the validity of results, it also threatens to *decrease* the scope and depth of inquiry. As the scope and scale of complex global systems extends and accelerates the networks of contact and contagion described in this paper, we must be willing reciprocally slow our analysis—to increase the interval between question and conclusion and allow a greater share of this complexity to be felt. We must slow our rhythm to let other voices be heard between the strokes of question and result. To do so, we must be open to a significant degree of approximation and uncertainty in our work.
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