

Caring for the Self

HIV and Emotional Regulation

Recall Last Minute Lucy from chapter 2, who had been infected with HIV “at the last minute” (that is, when she had reached the age when women’s sexual activity is expected to end). After many years of living in her eldest brother’s household, she had left in anger after an altercation with him, and gone home with a man she met at a *dawe anda*. It was through this relationship that she was infected with HIV. When her eldest brother learned she was HIV-positive he refused to have anything to do with her. She had eventually given up trying to mend their relationship and now avoided him because of the negative feelings he caused her to have:

My brother’s family has caused me a lot of worry. [How so?] They don’t take care of me, and they gossip about me, and say things like “At the last minute she took her old lady vagina out and fucked around, and look what happened. She got AIDS.” My brother has said this to me in front of other people. And this makes me angry. And it makes me worry. And when I am worried I develop lots of these little sores (she pointed to dozens of small ulcers on her lower legs), and the skin around my eyes turns black, and my eyes are red for no reason. . . . When we were children our mother ran away and married another man, so I became like the mother to my younger siblings. I was the oldest girl, and so I walked them to school, I cooked for them. I wanted to continue going to school myself, but I became a replacement for my mother, and I had to stay home. And my eldest brother used to feel compassion for me. He remembered all I had done for him when he was little, and he was generous to me. When my husband beat me, he would take me in and demand compensation. But now when we see each other on the road he looks the other way (*em pulim nus*). I’m ashamed to run into him because he treats me so poorly in front of other people.

Lucy, like many of the women I interviewed, drew direct connections between experiencing intense negative emotions and bodily symptoms of illness, such as sores, changes in skin color or hair texture, rashes, respiratory infections, and

malaria. Fearing that intense feelings of anger, shame, and worry would “wake up the virus” or would reduce the effectiveness of their antiretroviral medication (ARVs) by blocking pathways within the body, many avoided people and situations that might trigger these feelings. They also developed personal strategies for trying to regulate their emotions, striving for greater equanimity, always in the hope that their ARVs would work best, and that the virus would remain “asleep” or “fenced in by the medicine” if they could keep themselves from feeling “bad” emotions.

Women’s experiences of being HIV-positive varied immensely. A few women I interviewed were essentially homeless, having been evicted by family, one even traveling from one relative to another with a thick, plastic tarp, so that she could sleep outside in their fields with their permission. In contrast, a few women said that they were happier than they had ever been before. Nevertheless, despite differences in age, marital and reproductive history, and family acceptance (or not), they shared a number of characteristics, one of which was that emotional regulation was a key component of their self-care.

The women I interviewed were, on average, an older group than has been typical of much research about HIV, and this surely informed some of their opinions and attitudes, particularly about marriage, which I discuss near the end of the chapter. Twenty of the thirty women fell roughly into the middle-aged and older category; nine were in their twenties or early thirties and had young children; and one was a teenager. Thirteen of the women were widows (their husbands had all died of AIDS-related illnesses); ten were effectively divorced (they had either run away from or been abandoned by their husbands); three were currently married; and four had never married. And, as mentioned in earlier chapters, between twenty-two and twenty-five of them had been infected with HIV by their husbands.

A TALE OF TWO CLINICS

In 2012 and 2013, when I interviewed people receiving care for HIV, patients in the Tari area had a choice of two clinics—one was based in Tari District Hospital, in the center of Tari town; the other was located behind the large Catholic church just outside of town. The hospital clinic underwent the most change over the course of my research. In 2004, the nurse running the clinic showed me the records she kept of HIV-positive patients, and spoke of how demoralizing it was to keep these records, knowing there was little she could do to help them. At that time there was no rapid testing at the hospital, and there were no ARVs in any case. By 2013, however, the Oil Search Health Foundation had taken over the management of the clinic, upgrading the building facilities, hiring many additional staff, improving record-keeping, and providing vehicles for community outreach and the support of a number of satellite clinics. And, being based at the hospital, this clinic was able to refer patients for X-rays and laboratory tests for other

diseases, like TB or malaria. The waiting room was usually full, sometimes with lines out the door, and the clinic often had a frenetic feel to it.

The AIDS Care Centre run by the Catholic Church, in contrast, was a calm oasis. Behind and hidden from the road by a large church, it rarely had more than ten patients in it at one time, and if the benches in the waiting room were full, patients could rest on the plentiful areas of shady grass outside. Most of the patients weren't Catholic; the clinic served anyone who wanted HIV testing or treatment and didn't ask about religion. The staff also had a reputation for being less judgmental than those at the Tari District Hospital clinic. They all chewed betel nut on breaks, and two of them smoked cigarettes, which perhaps accounted for their reluctance to rebuke patients for doing so, even though they knew that abstaining was strongly advised for people living with HIV. Other than these differences, the two clinics were very similar in terms of the counselling they provided to patients regarding self-care, adherence to the ART regimen, disclosing their HIV status to spouses and family members, and abstaining from extramarital sex.

The two clinics had both a cooperative and somewhat competitive relationship. The Care Centre only provided treatment for HIV, sexually transmitted infections, and some opportunistic infections. There were no laboratory facilities, so it referred some patients to the hospital, particularly when it suspected TB. Some of the hospital clinic staff hinted that the Catholic clinic was unnecessary; after all, they said, it was only a short distance away and patients could just as easily come to the hospital. Moreover, and more important, they asserted that it "confused" their records and statistics when they did lab tests or X-rays for patients who weren't registered with them. My decoding of these assertions was that while this probably did make record-keeping more onerous, the larger issue was that the two clinics were competing for patients, and the hospital staff were irked at having to provide care for patients who couldn't be counted in the reports they submitted to the Global Fund, the Health Department, and the National AIDS Council, because these patients had been tested and were receiving ARVs from the Care Centre. For their part, the staff at the Catholic clinic occasionally expressed discontent that the hospital clinic staff, as government employees, had more access to in-service training and professional development opportunities.

POST-DIAGNOSIS LIFE

The women I interviewed expressed profound gratitude for their medication. Most of them had known people—husbands in most instances, brothers or sisters for a few—who had died of AIDS-related illnesses before ARVs became available in Tari. Many said things like, "It came too late for my husband. The medicine became available just a few months after he died, but it came in time to save my life." Knowing that ARVs were keeping them alive generated an affectively intense form of attachment to their medication: many referred to their medication as

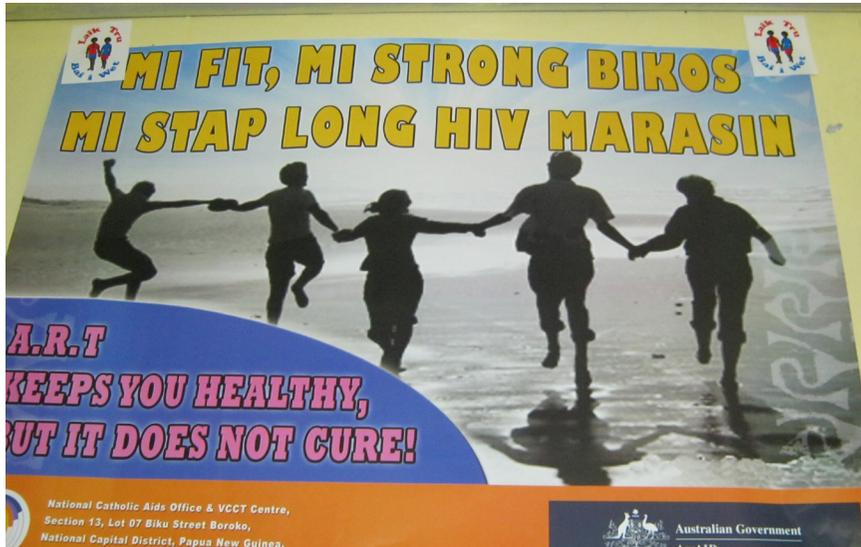


FIGURE 7. Poster inside a health center: “I am fit and strong because I take HIV medicine.” Photo by author.

“my life,” “my husband now” (meaning that ARVs were now what protected a woman), or “my bones” (the Tok Pisin word *bun* means bone(s), but is also used to mean staple food or that which is a necessity or is held very dearly). One woman declared, “This medicine is my husband, my mommy, and my army [*man bilong mi, mommy bilong mi, na army bilong mi*].” Rather than keeping their supply at home, most women carried it around with them in their string bags. Some simply felt reassured knowing that their medicine was on their person rather than some distance off. Others feared that a pending tribal fight or lack of money might prevent them from reaching home, which meant that they wanted their medication with them at all times. And, still others wanted to be able to display their medications as evidence of their HIV-positive status, should a man proposition them too aggressively, something I discuss in the next chapter.

While profoundly grateful for their continued lives, many women also articulated uncertainty and discomfort about the degree of dependence created by the daily regimen of taking ARVs. During one period of doing interviews in 2012, because of a countrywide shortage, most of the women had been without ARVs for three months; a few had begun experiencing breakdowns in health, including repeated malaria, respiratory infections, and skin ulcers. The possibility that the drugs might never be replenished, or that they might stop working sometime in the future, concerned all the women. Almost all of them said they had known people who had been taking ARVs but died nonetheless. A few said that these people had started taking the medicines too late or had taken them irregularly; in other words, they put forward plausible explanations for why the ARVs had not worked

as they were supposed to. For most, however, it remained a mystery why the drugs had failed, and this made them feel vulnerable to a similar fate, even after years of thriving on the medicines. Living on ARVs was, they seemed to suggest, like living in a subjunctive, rather than an indicative, state—tenuous, conditional, steeped in both yearning and regret. The perpetual uncertainty about the reliable supply of ARVs, or their long-term efficacy, motivated vigilant self-scrutiny about their own self-care.

The post-diagnosis lives of the women I interviewed varied significantly, and much depended on how their natal families responded to their HIV-positive diagnosis. Compare, for example, the experiences of Gloria and Shelly.

Gloria left school in grade three in order to help her family pan for gold during the Mt. Kare gold rush in 1988. She married a man she met at Mt. Kare, whom she described as a criminal who had many sexual partners and run-ins with the police. Around 2005, noticing that he was losing weight and was constantly unwell, she began to suspect he might have AIDS:

When I asked him about it, he said it was a result of the police shooting him before—that his injuries had never healed and they were making him constantly ill. But I believed that he had AIDS. [Did you tell him this?] No, I locked it in my mind and didn't talk about it. . . . He was diagnosed in 2006, before treatment became available, and died that same year.

In 2007, Gloria herself tested positive, began taking ARVs, and had flourished:

Now my house is bigger and nicer than other people's houses. And I have more pigs than other people. I take care of chickens and ducks. I grow things in the garden. The way I live now is completely different from how I lived with my husband. Now I take care of myself, and I live better than when I lived with him. I travel by myself up and down the highway, and find little things to sell to make money. . . . I live with my mother. She's old, and I take care of her. And sometimes my younger brother lives with us. He doesn't have a job, so I take care of him too.

Gloria's life improved after being diagnosed with HIV and initiating treatment, though, perhaps more to the point, her life improved after her husband died and her HIV-positive status enabled her to move back to her parents' home. She described herself as profoundly happier than when she was married.

Gloria's ability to thrive was made possible by a number of circumstances. First, she responded very well to the medication, and said she never experienced fatigue or any other symptoms that might prevent her from doing a lot of physical labor. Second, her success at farming and making money through small sales had put her in the enviable position of being able to help others, even those who might otherwise have been tempted to treat her badly:

People know my reputation. They know that if they have no money or pigs and they need some, they can come to me and I will help them. So they think to themselves, "She's a sick woman. She has this sickness. If we hit her or do something and she dies,

who can we rely on to help us?” So no one wants to hurt me or insult me. They try to make me happy—they greet me on the road and shake my hand. If they see me sitting alone, they come over and talk to me.

In other words, people in her community, without openly acknowledging her HIV-positive status, demonstrated their acceptance of her by making a point of speaking to and touching her. She was aware, however, that this might not have been the case if she weren't in a position to help others with their children's school fees or bridewealth payments. Finally, her family recognized her as the victim of her husband's extramarital liaisons: they had approved of him when he asked to marry her, because he had helped them pan for gold at Mt. Kare; they admired her loyalty to him as his wife, even in the face of his sexual license and criminal exploits; but they blamed him for her HIV-positive status. From their perspective, she had married appropriately (that is, with their approval) and had been a good wife (even though it turned out badly), and her reputation was therefore sound. Thus, they were happy to take her back when he died.

This was not the case for approximately one-third of the women I interviewed, and a woman's reputation pre-diagnosis often determined how her family would respond to her post-diagnosis. A family's response, in turn, strongly shaped how a woman fared. Shelly, for example, asserted that she had been rebellious when she was younger, had married her husband without her family's permission, and had lived in urban areas away from Tari (that is, in environments considered morally corrupting). Her two older brothers believed that she was the one who had strayed sexually and infected her husband. She admitted that this was, in fact, possible, but that it was unlikely, because her husband had known he was HIV-positive and didn't tell her. After her first two children died when they were babies and she developed sores on her breasts, she sought medical help, tested HIV-positive, and was told to bring her husband for testing:

And he too tested positive. But then I found out that he already knew that he was HIV-positive and had been taking medicine [He already knew?!] Yes, he tricked me. He pretended he didn't know, and he went for another test, but he knew, and he had been taking medicine for a year.

Unhappy with the antiretroviral regimen and unwilling to give up his pre-diagnosis way of life, her husband stopped taking his ARVs, Shelly said, and he died in 2009: “I started taking the medicine, and I had my third baby, and he's still alive. My husband died when I was pregnant.”

Her family refused to take her in, however:

My family yelled at me and called me an AIDS woman in public. They wouldn't take me in—they evicted me, they insulted me, they hit me, they told everyone I had AIDS, they cut me with a bush knife (she showed me a large scar on her shoulder), and forced me out. They said, “You yourself found this sickness. Where you found

it, we don't know, but you have it and you brought it back here. Take it away. You cannot live here."

Desperate, but also furious and humiliated, Shelly responded by exchanging sex for money:

They called me an AIDS woman in public, so I thought to myself, "Fine. You say I'm an AIDS woman, then I will act like an AIDS woman, and go around on the road." That's how I got this baby (her fourth, an infant on her lap when I interviewed her in 2012). [So do you passenger around to make money and take care of yourself?] Yes. [And when you do this, do you tell the men?] Yes, usually I tell them. And once I found a man who was also HIV-positive and I stayed with him for a while. When I was passengering around for money I tried to find men who were also HIV-positive, not normal men. But this is very hard. I didn't want to infect other people, but I had to find a way to get money. (Here her voice suggested irritated embarrassment so I changed the subject.)

Ostracized by her family, Shelly was homeless when I met her:

Sometimes I sleep in people's pig houses (small structures for pigs, normally not tall enough for a person to stand up in). I carry a mosquito net with me and I hang it over the house and make a small fire for my children. [Your family's pig house?] No, other people's pig houses. Anyone who will let me stay. And for a while I had a tarp I could make a tent out of. And sometimes people are sorry for me and they invite me to come stay with them. An aunty lets me stay in her house sometimes.

Gloria and Shelly represent two extremes on a continuum of post-diagnosis well-being: unlike Gloria, most of the women were not better off economically than they had been pre-diagnosis, but, unlike Shelly, most of the other women had places to live, even if they felt that they were at the mercy of kin who might evict them if they caused "trouble" (discussed in the next chapter).

ANTIRETROVIRAL ADHERENCE

The women I interviewed spoke of a range of practices of self-care. The most important of these was acknowledging that "ART has its own laws [*em igat lo bilong em*]." These "laws," as Louise Rasmussen observes, comprise "a set of rules that are defined as central to achieving good treatment outcomes and preventing the spread of HIV" (Rasmussen 2014: 257). First and foremost, of course, is adherence to the antiretroviral regimen, which requires taking one or more pills, precisely twelve hours apart, at the same times every day. In addition, patients should strive to eat a healthy diet, with plenty of protein and fresh fruits and vegetables, while abstaining from overwork, alcohol, and smoking. They are also expected to avoid sex without condoms (unless, following consultation, they are trying to get pregnant), and the health workers at both clinics in Tari often urged patients to

avoid sex altogether, telling them that the “heat” and strong sensations caused by sex would “wake up” or “strengthen” the virus. A few of the health workers who were from the Tari area also drew on Huli conceptualizations of sex as a meeting or confrontation between the different bloods of two people, with one partner’s blood inevitably being stronger than the other’s. If the patient’s blood was stronger, they said, there was a greater risk that she might infect her sexual partner; if her sexual partner’s blood was stronger, it could wake up the virus and make it more virulent. Given these two bad outcomes, they implied that sex was best avoided.

Much of the existing anthropological literature has emphasized the governmental and disciplinary effects of the ARV adherence counselling provided by health workers. For example, Vinh-Kim Nguyen (2013), highlighting historical links between religious institutions and AIDS NGOs in their elicitation of personal narratives about sex, analyzes HIV counselling as a “confessional technology” that works to produce a patient-subject who is “empowered” to live a morally responsible life, and persuaded that the revelation of the self’s sexual secrets to a counselor is crucial for the unfolding of this empowerment. Dominik Mattes, writing of Tanzanian HIV patients, asserts that medical authorities endeavor “to extensively modify [patients’] conduct, ways of thinking, and social interactions toward what is considered ‘appropriate’ and ‘healthy’” with the aim of producing “an obedient and self-responsible patient” (Mattes 2011: 160). To that end, the HIV-care establishment in Tanzania engages in a range of practices that Mattes sums up as “the system of adherence production” (162), which includes: mandatory attendance at three adherence education classes in the company of a treatment supporter, and instilling in patients the concept of ARVs as “a lifelong contract” in which continued access to treatment requires obeying health workers’ instructions. “Ironically, their ‘self-responsibility’ in the sense of adhering to the treatment regime was established through a rigid control system that favored their disempowerment, with mechanisms of stimulus and punishment aimed at their full subjugation to medical authorities,” Mattes concludes (2011:177, see also Rasmussen 2014, Hardon 2012, Burchardt 2014).

To some extent these scholars’ insights apply to the situation in Tari. On occasion (though certainly not consistently) I heard clinic staff inform newly diagnosed patients that it was their duty to adhere to the antiretroviral regime because “foreign donors have made these drugs available to you. The Papua New Guinea government isn’t paying for these drugs. Other countries, because they are sorry for people in Papua New Guinea, are paying for these medicines. So be reliable, don’t waste them, don’t be defiant.” In other words, they attempted to discipline patients by incorporating them into a global biomedical-moral assemblage in which the pity felt by the foreign donor for the distant, suffering other motivated a life-saving gift that had to be repaid through dutiful compliance. However, it should be noted that after treatment initiation, HIV-positive patients in Tari typically only saw health workers once every three months in order to pick up their

next supply of medication. If they reported good health and no adverse side effects, these appointments were often quite short, and staff never made home visits.

Moreover, unlike the sites discussed by the above scholars, patients in Tari were never threatened with treatment discontinuation for noncompliant behaviour. And, although patients were supposed to bring a treatment supporter to their first appointment, some of them didn't, and the staff initiated their treatment anyway, knowing full well that they might not have disclosed their status to family and that they might not have the social support thought to be important for treatment adherence. Furthermore, all of the above scholars emphasize the importance of AIDS support groups in reinforcing clinical disciplinary practices. As Ruth Prince argues, "Support groups are places where the pharmaceutical regime of the clinic meets the humanitarian economy of welfare organized through NGOs. . . . They are imagined as places where people learn . . . to organize their bodies and lives in terms of the requirements of antiretroviral therapy" (Prince 2012: 109). However, there were no support groups in Tari. In short, there was little in the Tari context to suggest that the clinic exerted significant power to produce compliant patient-subjects.

Most of the women I interviewed were, nevertheless, highly compliant with most of the recommended behaviors (the men I interviewed were not). Thus, my point here is not that HIV clinical care in Papua New Guinea does not exert governmental and disciplinary effects, but rather that in analyzing how patient compliance is produced, it is important to consider not only clinical discourses and practices, but also how these intersect with context-specific, gendered expectations and patients' lived experiences in their families and communities. A theoretical framework that overemphasizes the power of the clinic risks obfuscating the role of a patient's family and social networks, or the lack of them (see also Meinert et al. 2009). For example, some of the women I interviewed were profoundly lonely, having been cut off by family and sometimes friends. "I don't have any besties," Shelly said. "My only friends really are the nurses here. I have one friend who is also HIV-positive that I met here at the clinic, but we live too far away from each other. I only see her when we come pick up our medicine at the same time." In this state of solitary abandon, women like Shelly worked to insert themselves into the life of the clinic and to befriend the health workers, often bringing them small gifts (betel nut, a roasted sweet potato). So, while the clinics in Tari did not seem to exert much disciplinary force, being compliant to "the rules of ART" was sometimes framed by patients as an act of deference that they hoped would help build a relationship of care between themselves and the health workers. In other words, the governmental relationship may result not only from clinical disciplinary acts, but also from the accretion of patients' gestures of submission and their overtures of intimacy that gradually entwine their subjectivities with clinical expectations.

This will to comply is also reinforced by gendered expectations of comportment. In general, Huli women's reputations—that is, their moral capital—benefit

from being seen to comply with rules and expectations. Women are praised when they are known to regularly attend church, work in their sweet potato fields, obey their husband's rules (e.g., asking permission to visit natal kin or not touching a husband's belongings), and put others' needs and desires before their own. Thus, many women expressed pride about their rigorous medication adherence. Families also pressure patients to be compliant, in part for their health, of course, but also as a demonstration of their willingness to be "fenced in" by the "laws" of ART. Thus, women are motivated to be compliant in part because of clinicians' governmental exertions and in part to demonstrate to family their moral intentions (a topic discussed at more length in the next chapter).

AIDS AS AN AFFECTIVE DISORDER

The other directive that health workers typically gave HIV-positive patients was that they should try not to worry and should avoid other negative emotions, such as anger. Rasmussen similarly lists "maintaining a positive attitude" as one of the "rules" that patients in Uganda are told to follow. The enjoinder to "live positively" can be traced to the early days of the epidemic in North America, a time of powerful stigma and no treatment (Dilger 2001, Hardon 2012). "Positive living" is wordplay that urges the HIV-positive to come to terms with their sero-status, to maintain an optimistic outlook, and to care for themselves both physically and emotionally (Levy and Storeng 2007, Benton et al. 2017). The wordplay does not work particularly well in Tari, where many patients are not fluent in English, but the intent of the directive—to have hope and to avoid pessimism and despair—remains, and has been translated into the advice not to worry and to avoid negative feelings. Anger and worry, patients are told, can "wake up the virus" (which has been put to sleep by ARVs) or cause their medications to be less effective. Importantly, this advice enters a cultural context that has specific philosophies about emotion, especially anger, and where ethnic identity is strongly tied to a specific affective style.

Avoiding Anger

Huli associate themselves as a group with a very specific emotional style: the ability to move rapidly from one emotional state to another, and especially from anger to cheerfulness. "The most important thing to understand about us is that our emotions fluctuate," a Huli university student told me. To outsiders, this fluctuation or volatility—in which a person can be in a rage one minute and laughing a minute or two later—can be disconcerting and even a little frightening. I have had many conversations with Papua New Guineans recently moved to Tari, or with Peace Corps or MSF volunteers, about their unnerving interactions with Huli people who were shaking with rage and threatening violence, and a short time

later were sheepishly mocking themselves for their outburst. This emotional style may look like volatility, but volatility connotes lack of control, and Huli assert that their affective ideal requires a great deal of control, making it something more like affective suppleness or agility. Edward Schieffelin, writing about the Kaluli, a neighboring group, observes:

A man's temper, or 'tendency to get angry,' is an important feature by which Kaluli judge his character and assess the degree to which he is a force to be reckoned with. It represents the vigor with which he will stand up for or pursue his interest vis-à-vis others, and the likelihood that he will retaliate for wrong or injury. . . . When Kaluli feel strongly about something, they are not usually ones to hide their feelings. Rage, grief, dismay, embarrassment, fear, and compassion may be openly and often dramatically expressed. . . . These displays of affect have to be seen more as declarations of mind, motivation, and/or intention than as mere cathartic expressions of feeling. (Schieffelin 1983: 183–84)

This passage describes the Huli equally well, though their self-representations emphasize also their capacity for joy and jocularly, as much as their capacity for rage. And, the ability to move nimbly between these expressive states is as important as successfully performing the states themselves.

Huli readily acknowledge that not every Huli person can master this affective suppleness. Women, in particular, are often said to be incapable of this ideal, because they are “unable to let go of anger.” Arguably, Huli women have much to be angry about, whether it is domestic violence, denigrating discourses about female inferiority, male sexual privilege, polygyny, or an unfair burden of domestic labor. Nevertheless, many Huli women also assert that affective suppleness is a distinctive Huli cultural characteristic, and an ideal to strive for, and that women are less able to achieve it because of their tendency to feel lingering rancor.

Commenting on the relationship between feminist theory and affect theory, Carolyn Pedwell and Anne Whitehead note that feminist scholars have long pointed out the “critical links between affect and gendered . . . relations of power” (Pedwell and Whitehead 2012: 116). For example, a woman's display of emotion can be used to suggest her lack of rationality and thus to delegitimize and dismiss her point of view (Ahmed 2010, Jaggar 1989, Lutz 1995). Or, women's fitness for positions of political and economic power have been questioned because of their supposed emotional instability due to hormonal cycles. Or, women's presumed innate tender feelings have been used to argue that their proper place is in the home. In short, discourse about affect is often a kind of ideological material for cementing gendered hierarchies. In this case, Huli women's alleged tendencies to be less emotionally nimble than men—and, in particular, to experience stubborn, persistent anger—are decontextualized from the situations and relations of inequality that produce them and are naturalized as an innately female affective deficiency, a quality that makes them “less Huli” than Huli men.

Alongside this ideal of affective nimbleness is an equally strong model that emphasizes the physiological danger of suppressing anger and the importance of expressing it. Huli women describe anger quite viscerally as a powerful and hot sensation that begins in the belly, rises up through the throat, often impeding speech and breathing, and enters the head, causing an intense pressure that can affect vision, hearing, and the ability to think. Anger bottled up causes illness. Theresa, for example, attributed her elderly father's dementia to his habit of keeping his anger bottled up inside:

He's always been a man who talks very little, especially when he's angry. He'll only make his argument once, and then if he feels that he's not being heard he won't talk about it anymore. He doesn't let his anger out. And this has made him sick many times. And now that he's old, it has made him senile (*longlong*).

As one might imagine, these ideas about anger—the feminization of enduring anger, the danger of unexpressed anger—create a conundrum for HIV-positive women when they are told to avoid it: if they experience anger, they might have a hard time letting go of it, and if they bottle it up, they may aggravate their symptoms. Avoiding anger is also problematic because anger is often valued by Huli women as an agency-enhancing emotion—it gives one the energy to respond to other people's affronts. Responding with verbal and physical aggression to violations—such as others stealing from you or hitting you—is actively socialized in boys and girls and considered appropriate behavior for both men and women. Thus, while women are lauded for abiding by gendered expectations, including obedience, this should not be taken to mean that they are rewarded for being passive or docile. Most of the women I've interviewed over the years have spoken proudly of the physical fights they've been in, and women who do not attempt to punish transgressors may be viewed as cowards who are easily victimized. All of the HIV-positive women I interviewed, however, described trying to “fence in,” “lose,” or “forget” their anger, which meant walking away from others' transgressions, a deeply conflicted struggle for many of them.

Martha's story of how she came to be tested for HIV, and her efforts to control her emotions post-diagnosis, illustrates how “fencing in one's anger” poses a challenge. Martha's husband, a civil servant, had been transferred to another highlands town, leaving Martha and their four children in Tari. He had eventually taken a second wife without telling Martha, and upon learning about the marriage from other people, she traveled to this town with the specific aim of beating up the new wife:

I had gone to Mendi because I wanted to beat up my husband's second wife, a Pangia woman. And while we were fighting she said, “I have AIDS and I've given it to your husband, so you better watch out!” [She just said it straight out like that?] Yes, she said it just like that. We were yelling and fighting, and so she said it like that to shock me. She wanted to win the fight, and she hoped that if I were shocked my body would suddenly become weak. And she was right. I was terrified, and my body

lost all its strength, and I lost the fight. Then I went and got a blood test, and it was positive. . . . [How did your family respond when they found out?] They felt sorry for me. They said, “You are a good woman who just stays at home, and you never act like the wife of a civil servant. This was your husband’s fault—you didn’t do this, he did this. But don’t worry, you’ll be fine.” . . . [How have you been about taking your medicine? Have you had any problems?] At first I hated taking the medicine—every pill I took reminded me that I had HIV and that my husband had infected me. I was worried and angry all the time, every time I swallowed a pill, and so the medicine didn’t work very well. My skin turned dark black and my eyes turned yellow. But finally I stopped being so angry, and now the medicine works well. . . . [And do you get along with your husband now? Can you talk to him or do you get angry with him for infecting you?] I stop myself from getting angry with him. If I get angry, my body gets worse. My skin turns dark and dusty. It is the worry and anger that does it. So I’ve given up anger and worry. I’ve schooled myself to give up these feelings. [How do you do that?] When I feel myself getting angry I try to quickly think about something else, or I walk away from the situation. And I tell myself over and over that I need to be afraid of getting angry. Normal people may get angry, but we people with this sickness may not get angry.

Here Martha draws a direct connection between her family’s assessment of her moral character and how they responded to her being HIV-positive. Her character is sound because she was sexually faithful (“you are a good woman who just stays at home”) and because she has never “acted like the wife of a civil servant” (that is, as if she is superior to others); thus, her family was willing to take her in when she left her husband. Also important is the distinction that she draws between “normal” people and HIV-positive people: normal people can feel anger without considering the health consequences, whereas the HIV-positive need to “school” themselves not to feel it. Thus, Martha self-monitors and disciplines her anger, and even deliberately mobilizes another emotion—fear (that is, the fear of her ARVs failing and of dying)—to control her anger.

Feminist scholars’ engagements with affect theory are useful here for thinking about the implications and consequences of the instruction to avoid anger. Scholars like Erin Rand have emphasized “the epistemological function of affect and emotion in public discourse” (Rand 2015: 173)—that is, the way that authoritative directives to *feel* a particular way about an experience both shape what we are able to *know* about it and work to foreclose other ways of knowing. For example, Sara Ahmed argues that the cultural imperative to be happy about heteronormative ideals works to silence critical questions about those ideals (Ahmed 2010; see also Cvetkovich 2012). In the case of HIV-positive women, the instruction to avoid anger has both disciplinary and epistemological effects: it shapes both how women behave and how they know and experience their condition of being HIV-positive. For one thing, this directive guides them to think of their emotions as internal, privately owned feeling states whose most vital connections are to their own

individual immune systems and viral loads. In other words, it directs them to look inward towards assiduous self-monitoring, rather than outward towards shared experience. As such, it reinforces the idea that women should *know* their HIV-positive status as an individual, rather than a social, condition.

Furthermore, because this directive frames anger as an individual health concern—pathologizes it, in a sense—it occludes the possibility of experiencing anger as a shared sociopolitical diagnostic or impetus to action. Feminist scholars have long pointed out that emotions, rather than being idiosyncratic, nonrational sensations, can be seen as somatic indices of inequality or as “indications that something is wrong with the way alleged facts have been constructed, with accepted understandings of how things are. . . . Only when we reflect on our initially puzzling irritability, revulsion, anger or fear may we bring to consciousness our ‘gut-level’ awareness that we are in a situation of coercion, cruelty, injustice or danger” (Jaggar 1989: 167). More recently, Geraldine Pratt and Victoria Rosner have observed that, “For many feminists emotion can be a potent analytic tool for discerning social injustices. . . . In this context anger has been of special importance” (Pratt and Rosner 2012: 5). Telling HIV-positive women to “fence in” their emotions, eschew anger, and to walk away from situations that cause upset is thus telling them to give up an important epistemological tool for seeing the structures of inequality that have made them vulnerable to infection. Indeed, some, like Zoli, come to distrust and denigrate their own feelings of anger.

Zoli had a 6th grade education and was in her mid forties when I met her. She had a daughter who was also HIV-positive, likely infected by her policeman husband. When young, Zoli had married a Huli man and moved to Mt. Hagen, where he worked. Over time they had five children together, and because his employer provided housing, they were able to save money to buy a small house and rent it out. She recalled:

But then he made a lot of money from renting out this house, and his salary increased, and so he married another wife. He didn't think about me, and he didn't give me money. He didn't give me money for the children. He just dropped us, and he didn't take care of us anymore. And he kicked us out of the company house, so he could live there with his new wife, and he sent us home to Tari. . . . [So when he did this, what happened? I think you must have been angry.] Yes, I was very angry. I passengered around. I wanted to show him that if he wanted to go around, I could go around too (*em laik raun, mi tu bai raun*). I passengered around in Mt. Hagen. I left my children and went to Port Moresby and passengered around. And finally I came back to Tari and lived with my mother. But then she died. And I went crazy. My thinking became confused (*tingting bilong mi faul*). My husband left me, my mother who took care of me died—my thinking completely crashed (*tingting bilong mi krash olgeta*). So I left my children again and went to Madang. I passengered around in Madang. Then I met a Huli man there who said he would take care of me. And I thought it was a good idea—he could help me take care of my children. But it turned out he was sick. That's how I got this sickness.

When I asked how she was sure it was this man in Madang who had infected her, given her many other sexual partners, she replied, “It’s true I had sex with a lot of men—in Mt. Hagen, in Port Moresby, in Madang. But I used condoms. The only reason I didn’t use a condom with the man in Madang is because I thought we were going to get married”—an explanation that echoes a wealth of research demonstrating that women often use condoms with transactional sexual partners or customers, but that more intimate, trusting, longer-term relationships are marked as such through foregoing condoms (Varga 1997, Tavory and Swidler 2009).

When her family found out about her HIV-positive status, “They said I had brought this problem on myself. And it’s true that I left Tari in anger, and then I crashed. That’s how I damaged myself (*mi kros wantaim na mi go, na mi krash nau. Olsem na mi bagarapim mi yet*).” Here, Zoli ruefully suggests that her family was not wrong in their judgment of her: her own anger, she said, was responsible for her HIV-positive status. It was anger about her husband’s behavior that drove her to act in the sexually reckless manner that ultimately resulted in infection. I reminded her that by her own account she had been infected when she was attempting to behave as a “good” woman, trying to forge a new marriage. However, the fact that she now considered anger to be a “bad” and unhealthy feeling that could worsen her HIV-positive condition led her to conclude that anger was also responsible for her infection in the first place. In other words, her new understanding of anger led to a rethinking and negative reevaluation of the role it had played in her past.

Feminist scholars have debated not only the epistemological role of emotion in how we come to know our own experiences, but its role in political life, asking whether the labile, unpredictable, multiplicitous nature of affect enriches our understandings of humans as political subjects, and indicates that subjectification/subjectation is never total, or whether, in contrast, affect is a powerful means through which domination is exercised, through, for example, attaching subjects to nationalist or to racial ideologies (Sedgwick 2003, Ahmed 2010, Koivunen 2010, Bargetz 2015). Influenced by Spinoza, and his conceptualization of affect as a force that can increase or decrease our capacity to act, scholars have debated the nature of specific emotions for agency. Rosi Braidotti argues, for example, that feminist political action should be grounded in “an ethics of joy and affirmation” (Braidotti 2002: 13). Sara Ahmed, in contrast, asserts that anger is key to political mobilization: “Crucially anger is not simply defined in relationship to a past, but as opening up the future. . . . As [Audre] Lorde shows us, anger is visionary, and the fear of anger, or the transformation of anger into silence, is a turning away from the future” (Ahmed [2004] 2015: 175). Ahmed cites Lorde’s analysis of her own anger about racism: “Anger expressed and translated into action in the service of our vision and our future is a liberating and strengthening act of clarification . . . Anger is loaded with information and energy” (Lorde 1984: 124, 127). And, in her

2010 book *The Promise of Happiness*, Ahmed posits the feminist “killjoy” as a marginalized but crucial political voice whose anger is necessary for identifying oppressive social structures and galvanizing action against them (Ahmed 2010: 20).

Reading the HIV clinic’s admonition to avoid anger in light of this theorizing suggests that it has both governmental and anti-political effects. It not only translates anger into a health condition that requires monitoring of one’s interior self, it also encourages women to fear it. Fully experiencing anger about HIV stigma, for example, might generate shared narratives about living with HIV, which might in turn pave the way for other affective possibilities, such as fellow feelings of solidarity, hope, or determined resolve (Berlant 2011). The taboo against anger arguably turns women away from this future. I should be clear that I do not think that this is the intent of health workers. On the contrary, their intent is both to help patients live longer and to enhance the quality of patients’ lives by giving them permission to remove themselves from the affective rough-and-tumble of everyday life in Tari. They know that patients can be objects of fear and suspicion, and one of their aims is to give patients a good reason *not* to respond to others’ aggressions.

AIDS and Worry

Although HIV-positive women considered anger dangerous to their health, the emotion most associated with HIV/AIDS in Tari was worry. Indeed, a dominant model of AIDS before the arrival of antiretrovirals was that it was worrying that killed infected people, not the virus (Andersen 2017, Hinton and Earnest 2010). Some of the evangelical churches in Tari promoted this construction of HIV/AIDS and asserted that being “born again” was the only solution to fatal worrying: putting one’s faith in God and trusting in his divine, if unknowable, plan allowed one to lay down one’s worries. With the arrival of ARVs in 2007, this model lost most of its purchase, since patients were seen to recover their health without being born again. Nevertheless, the ruinous effects of worry remained a compelling concern for patients.

When I asked clinic staff about this concern, they said that patients used two Huli words to talk about their worries: *genda*, which refers to a feeling of heaviness, and *mini purugu*, which refers to thinking compulsively about a situation. Patients and clinicians alike described both kinds as lodging inside the body and causing physical damage. Patients worried about a range of things: being abandoned, dying and leaving their children with no one to care for them, being hated by spouses and children for “bringing AIDS into the family” (a worry expressed more by men), having land stolen by avaricious and scheming kin, and, for those without children, leaving no lineal trace of themselves into the future. A very common worry was malicious gossip, which one patient described to me as “when you know that people are spreading rumors about you, and especially saying ugly things about your sick body, or about how you will die soon, or about the bad things you must have done to get HIV.”

The patients I interviewed often spoke in great detail about the worries they tried not to have: “You imagine your family and friends living on without you. For example, you will all be around a fire talking, and then suddenly you’ll imagine the same scene, but you are missing, erased from the picture. And you try to go to sleep, but now you can’t stop picturing this.” Here, the person living with HIV experiences a moment of reflection that removes her from being in the moment and forces her to imagine a typical family tableau in the future, without her. And once she has imagined this, she finds it difficult not to imagine other family and community gatherings in the same way. Another elaborately detailed worry that a few women described themselves as trying not to experience was:

You compare yourself with friends who don’t have HIV. For example, you see someone you grew up with, and before you were on the same life path. And then she went to school and you didn’t, or you had to drop out because no money. And now she has *more* money, she has a family, she is thriving, and you feel that you have lost all of those things, or never had those things. If you had money, it is now gone, and no one will give you anything.

This is an affectively dense and layered form of worry that combines loss, envy, anger, and despair. It sums up life circumstances that can put one on a path to HIV infection, as well as what can happen afterwards. It also constitutes a kind of rebuttal to the still dominant public health model of HIV causality, which focuses on individual risk behaviors rather than the intersecting inequalities that propel behavior or put one in the path of someone else’s behavior. It might also be seen as one of Pratt’s and Rosner’s (2012) affective analytic tools for discerning social injustices: it is a distressing feeling that causes its experiencer to reflect on how different life circumstances—for example, having the funds to attend school or not—can lead to stark differential outcomes, such as being infected with HIV, which, in turn, can lead to a cascade of social and material losses. However, worry does not afford as much potential for action as anger does.

We might therefore think of “worry” in this context as similar to one of Sianne Ngai’s “ugly feelings”—that is, feelings that are “minor and generally unprestigious . . . *noncathartic*, offering no satisfactions of virtue . . . nor any therapeutic or purifying release” (Ngai 2005: 6, emphasis in original). Much like the affect theorists discussed above, Ngai is influenced by Spinoza’s conceptualization of emotions as “waverings of the mind” that can either increase or diminish one’s power to act—that is, she grapples with the relationships between affect and agency (2). However, rather than focus on the noble feeling-scapes typically analyzed by literary scholars, such as tragedy, Ngai instead mines films and novels for scenes characterized by affects that are “experientially negative, in the sense that they evoke pain or displeasure,” as well as “semantically negative, in the sense that they are saturated with socially stigmatizing meanings and values” (11). Such scenes, she says, often convey “ambivalent situations of suspended agency” (1). In other words, ugly

feelings obstruct a protagonist's ability to act, move forward, or be transformed. For Ngai these include envy, irritation, and anxiety. Worry was similarly described by women living with HIV as a paralyzing feeling that could impede their ability to care for themselves and others.

EMOTIONAL REGULATION AS A PRACTICE OF SELF-CARE

As suggested by the narratives of Martha, Zoli, and Shelly, the women I interviewed took to heart the injunction not to worry or get angry, and they had developed a range of strategies for managing negative feelings. Some of these were aimed at modulating one's interior emotional life, and some were aimed more externally at limiting one's exposure to people and situations that might cause upset. I separate these into four categories: religious faith, emotional diversion, social avoidance, and rejecting remarriage.

Religious Faith

In the face of hostility from kin, a determined faith that they had a place in God's unknowable plan was sometimes the only thing that enabled women to leave the house and persevere. Over the course of my three years doing these interviews, I myself was sometimes used to illustrate the rightness of refusing worry and having faith in God: at the end of an interview, when compensating interviewees for participating in the research, a few women said something along the lines of, "You see? I came to pick up my medication this morning, knowing that I did not have money to buy food in town or even for the PMV fare home, but I refused to worry because I know God will take care of me. And then you were here, and we talked, and you gave me money."

Faith that God would provide not only gave them emotional comfort, but also the bravery to take risks, such as hopping on a PMV without knowing if they would be able to get home at the end of the day, a finding that reinforces the importance of examining faith not only as a cognitive matter of "belief," but also as an affectively rich state of mind that provides far more than solace. Although some ethnographic research suggests that heightened religious zeal may motivate patients to abandon their ARVs in the faith that God can heal them (Burchardt 2014), the small acts of courageous faith by the women I interviewed were often for the sake of self-care: to get the next three months supply of ARVs, no matter what, or to find food and company.

Emotional Diversion

Diverting oneself to drive worries from one's mind was also a common strategy. A few women, for example, spoke of going regularly to Tari's large main market in hope of running into friends and family who might engross them in banter or

news about disputes and village court cases. Arguably, they were lonely and seeking out company and social interaction, and yet they often framed this as a quest to divert themselves from negative thoughts that might otherwise preoccupy them. If they stayed at home, they said, there would be nothing to prevent them from dwelling on their worries, but at the Tari market they were likely to run into people who would take a moment to share gossip or make them laugh. Family members also sometimes helped with this strategy of emotional diversion: some women's sisters, for example, said they would send their young children to entertain them because "children say and do funny things that make grown-ups laugh, and we don't want her to worry."

What might be called cell phone sociality also had a very important role to play in this strategy of emotional diversion. Almost all of the women who owned mobile phones had long lists of "phone friends." The "phone friend" phenomenon has been described as "a uniquely PNG response to the communicative possibilities of the mobile phone" (Andersen 2013: 319). It is the calling of, or accepting a call from, unknown phone numbers with the aim of forming a friendship or romance with a stranger that will likely exist only by phone and may endure for one phone call or for many months. Most people I knew in Tari had phone friends, and many of these were romantic partners who would flirt, confide woes, offer sympathy, and sometimes send each other phone credit. The HIV-positive women I interviewed had both male and female phone friends, and while some of these connections were romantic or flirtatious in nature, most women said that they spoke to these friends late at night if they had a sudden attack of worry. When they found themselves *tingting plenti* (thinking a lot), *wari wari* (worrying a lot), or *busy tumas* (very busy, but it can also mean overly preoccupied with or perseverating about something), they would call their phone friends, who could calm or distract them with teasing, chatty, or comforting talk.

Phone friends were, in effect, affective regulators, helping the women to modulate their anxious thoughts and emotions (Wardlow 2018). They were especially important for women like Last Minute Lucy, who had been shunned by natal kin and were living alone. Indeed, when I spoke with Lucy a year after I first interviewed her, her phone had just been stolen and she was distraught. Because she had not actually met any of her phone friends face-to-face, had not memorized their numbers, and had no other way of contacting them, they were all lost to her. "My thoughts (*tingting bilong mi*) are fucked up," she said over and over. "All those phone friends, in Port Moresby and other places. They would send me credit, and we talked all the time, every night, and now I don't have a phone and I've lost all those numbers. My thoughts are fucked up."

Social Avoidance

The strategies described above are specifically aimed at preventing worry, not anger, which for some women was a more difficult emotion to manage, because its

instigation was less under their control. Whereas worry was usually triggered by their own thoughts about a situation, anger was more often triggered by interaction with others. For women who had been rejected by their families, it was running into them and enduring their slights, insults, or refusals to help that caused anger. Like Martha, some “schooled” themselves to walk away from inflammatory encounters, not easy in a context where, as noted above, summoning up a splendid rage and standing up for oneself verbally and physically are highly valued.

Others, wanting to avoid the possibility of anger altogether, cut themselves off from important social spaces. Much Huli socializing takes place, not in people’s homes, but more publicly, whether on the road or on church premises or in the marketplace or a community area for playing sport and hearing village court cases. Some women said that they took great care in trying to avoid many of these spaces because they never knew whom they might see there: an unexpected run-in with a past nemesis, a husband’s other wife, or relatives who had cast one out might result in an argument or altercation, which could negatively impact one’s health.

Rosina, for example, said she now avoided going to weekly women’s basketball games because of an incident in which she had been shamed in public. As she described it, there had been a dispute about the game she was participating in, and women from both teams, including herself, had begun insulting each other. Then a woman from the other team, who had recently divorced Rosina’s brother and knew she was HIV-positive, pointed at her and yelled, “the AIDS germs inside her are making her say all kinds of things. Let’s just drop it and leave—AIDS has made her crazy.” She found herself yelling back,

Those germs aren’t making me do anything. I didn’t go out and find these germs; my husband gave them to me. And why are you talking about my germs in public?! Do you think you can shock people here and shame me? Everyone here knows. I have not hidden this—I have told everyone in my community about this. So why are you trying to shame me in public?

The insults back and forth escalated, and then the yelling turned into a physical fight between the two families, with other people joining in. In the end, the woman had to give Rosina K200 for “calling me an AIDS woman in public.”

Notice that Rosina makes a point of establishing her own unblemished moral character: she asserts that she herself did not “find” HIV—that is, her infection was not due to her own illicit sexual behavior; rather, she was an innocent party, infected by her husband. She also asserts that lest the insulter believe that she is conveying some shocking revelation by announcing Rosina’s HIV status to everyone at the basketball game, in fact Rosina has made a point of disclosing her status to her whole community, an issue I expand upon in the next chapter in connection with the ethical challenges and imperatives of living with HIV in Tari. Since the national HAMP (HIV/AIDS Management and Prevention) Act of 2003 makes it unlawful to stigmatize a person because they are infected or

affected by HIV/AIDS, and because Huli custom allows people to demand compensation from those who publicly insult them, the insulter's family had to give Rosina compensation.

Although Rosina was vindicated by this experience, she felt she could not risk that kind of altercation again. So she stopped participating in, or even attending, community basketball games. This was in part because she did not want to embroil her family in any more conflicts regarding her HIV status, but it was also because she was afraid of the anger she had experienced. She acknowledged that getting angry during this basketball game, and feeling her family get angry with and for her, was, in fact, a pleasurable experience, but she worried that any similar affective assaults on her immune system might make her ill. In short, the effort to prevent anger can lead HIV-positive women to remove themselves from the daily fabric of social life.

It is also worth noting that in forsaking anger, HIV-positive women are not only forsaking valued, and even relished, modes of social interaction, but also sometimes justice. Last Minute Lucy, for example, said that she had been raising nine chickens, but a neighbor's dog killed a few and some "marijuana faces" (young men who are known to smoke pot) stole the rest. "They weren't outsiders," Lucy said.

They were from my community. I think they thought that an HIV-positive woman doesn't deserve to be successful raising and selling chickens, and that I wouldn't be able to do anything about it. I wanted to take all these people to village court and demand compensation. But I dropped it. I don't want to get angry, and if I take them to court, they will lie and insult me and make me angry. So I dropped it.

Village court cases can be unruly public events, where tempers are lost, lies unleashed, and insults exchanged. Anticipating that her feelings would be riled by the denials and slurs of the people she accused, Lucy decided not to go forward at all. Similarly, Shelly—who, as noted above, was homeless and sometimes slept under a mosquito net in people's sweet potato fields—said this about how she responded when her family evicted her:

They kicked me out and they harvested what I had planted. [And did this make you angry?] Yes, but I could feel the anger making my sickness worse. If I worry and get angry, then my body will lose weight. So I had to let go of my anger. I must fence myself in (*banisim mi yet*) so that I don't get angry and I don't worry (*mi noken kros, noken wari*). . . . So, you want to steal my food, fine. I'll just leave.

Zoli too said that she and her HIV-positive daughter had been evicted from her father's land:

They wouldn't let us stay. They took everything—the blankets, the mattresses, our land, our house. They broke the walls, tore down the house, stole everything. So now we live on my mother's land with my sister. . . . I work hard—I wash all the plates

and wash all the clothes. But sometimes they are unhappy with me. I try to humble myself (*mi trai na hamblim mi yet*) and work hard and not worry. . . . Problems come, but I try not to worry. If I worry too much, I might die. Sometimes I find myself thinking, “I haven’t seen my daughter in a while—I’m worried about her” or “My brother hit me” or “My sister’s husband is mad at me and might kick me out.” But I try not to think about these things. If I think about it too much, I am killing myself.

In short, avoiding anger sometimes meant letting others infringe upon one with impunity or humbling oneself and hoping for others’ tolerance.

Rejecting Remarriage

Thirteen of the women I interviewed were widows and ten were divorced, and almost all of these women had received one or more marriage proposals since being diagnosed HIV-positive, typically from men who didn’t know them, but who had learned that they were available (in the sense that all widows and divorced women are considered available). All but one of the women rejected these proposals by informing the men of their HIV status and asserting that they didn’t want to risk infecting them. In other words, they let the men believe that it was only their HIV status that prevented them from accepting the proposal. However, when I asked whether they wanted to remarry, most of them replied with an adamant no. This was my exchange with Gloria:

I don’t have worries and I’m not afraid. If got married again I would start worrying again—I would worry about food and about money. But the way I live now I have my two hands and I can take care of myself and not worry. . . . I want to be faithful to the medicine. (Here, Gloria was deliberately playing on the command to “Be faithful” from ABC prevention messages: being faithful to her husband had not prevented her from being infected with HIV, but being faithful to her medication kept her alive and happy.) [What have the nurses told you about remarrying?] They have said that I can. But. I don’t want to (*mi les*). . . . Here—Highlands men, they are no good. If you have a little money, they’ll say, “I’ll boss it,” and then they’ll just take it—they’ll go into your string bag and just take it. That’s how they are. I was already married, and I know what it’s like. We physically fought all the time, and he slept with lots of women, and caused me a lot of worry. And now I’m not married and I’m happier than ever. I’m relaxed. So, why should I go around and look for another husband? I’m not interested.

Lucy, for her part, used concerns about excess worry to leave her second husband:

Even after we tested positive he continued to passenger around and get drunk with his friends and go to *dawe anda*. I tried to control him, but I couldn’t. I told him he needed to stay at home, eat better food, get enough sleep, and wash every day, and he just wouldn’t. And I was worried he might infect someone else and there might be “trouble.” (Recall that “trouble” is a euphemism for compensation demands, retaliatory violence, or tribal fighting.) It was causing me too much worry and pressure, and I felt myself getting worse because I was worrying about him and his behavior.

I told him, “We are patients. That means we are a different kind of person now. We have to behave differently.” But he wouldn’t listen. So finally I explained that he was causing me too much worry and that it would be better if we lived apart. So we divided up everything fairly—the chickens, the pigs, the bedding, the pots and pans, the clothes. And then I left. I told him to call me when he got really sick. I said I would come see him. And he did get really sick, and a nurse called me, and I came. He said, “I am dying, and you are still alive. But that’s okay.” And then he died.

When I asked if she wanted to remarry, Lucy replied:

I have seen my own marriages and other people’s marriages, and I have seen how men behave when they marry you, and really I hate them (*mi save hetim ol*). They control you—tell you you can’t go to the market or that you have to cook something for them. And then they are quick to get cross or hit you if you disobey. So really I hate them. I’ve had HIV-positive men ask me if I will marry them, but I think married life is no good. It just causes anger and fights and worry. If I thought a man would care for me and not get angry, then maybe. But I haven’t seen any men like that.

Many women suggested that one had to choose between marriage and a healthy life. The one benefit of HIV stigma, such as it was, was that many people viewed the HIV-positive as unmarriageable. Showing men their ARVs or clinic books was therefore an expedient way for women to deftly decline proposals. Thus, while public health practitioners have sometimes conceptualized marriage as a state that can protect people from HIV, the women I interviewed saw their HIV-positivity as a state that protected them from marriage.

Their desires to avoid marriage contrast markedly with findings elsewhere. Kathryn Rhine, for example, found that HIV-positive women in Nigeria wanted to marry and have children; they participated in AIDS support groups largely to find potential mates (Rhine 2009). This difference speaks, I think, to the strife-ridden nature of many Huli marriages. However, it is also important to bear in mind that, compared with Rhine’s interlocutors, the women I interviewed were, on average, much older and already had children. They had thus already fulfilled their womanly obligations to bring in bridewealth for their natal families and bear children for their husbands’ families. Had my sample been younger, I believe more women might have expressed a desire to marry.

CONCLUSION

The advice to avoid negative emotions was a health message that most of the women I interviewed took to heart, more even than instructions about nutrition or stopping smoking. Being attentive to their feelings and trying to regulate them became an important form of self-care, and many spoke of AIDS almost as an affective disorder, in the sense that one’s emotions could play an outsized role in whether the virus remained “asleep,” or “fenced in,” or “woke up” and “broke out

of the fence.” This construction of AIDS resonates with Marian Burchardt’s findings in South Africa, in which “infection emerges as a psychological disease, as an affliction that impairs life by constantly reminding the infected person of possible future suffering” (Burchardt 2014: 63). In both cases it is the affective dimensions of being HIV-positive that are sometimes experienced as so corrosive that they can cause biological death. And the women I interviewed often read their own bodily signs, such as skin ulcers and fevers, as indications that their emotions had gotten the better of them.

Some women were more concerned about anger because they felt less able to control the external circumstances that could incite it. They anticipated, for example, that if someone insulted them on the road, not only would they feel anger about the insult, but this anger would also be intensified by the humiliation they experienced when they forced themselves to walk away without responding. Not all women were successful at walking away from others’ emotional assaults, of course, or even tried very hard in some cases. Peony, for example, had been living with her husband in 2012, when I first interviewed her, but wasn’t in 2013; between the two interviews, her husband, who had infected her, abandoned her and married another HIV-positive woman he had met at the clinic. Smiling somewhat sheepishly, she said she began working on not feeling anger *after* she burned down his house. More women were concerned about worry, however. And although some women described elaborate worry scenarios—such as imagining themselves as entirely absent from future family gatherings, or imagining their orphaned children at the mercy of neglectful or abusive kin—others did not even want to talk about their worries, for fear that talking about them would bring them to mind. “I don’t worry,” a couple of women said, abruptly putting an end to that line of inquiry.

Worry can be seen as one of Ngai’s “ugly feelings”—dysphoric emotions that suspend agency. The bodily heaviness of worry, or compulsive thinking about problems, paralyzed some women. In these cases, the clinical advice to try not to worry did seem to help them, and indeed motivated some of them to seek out company, talk, gossip, and laughter. For others, it motivated a redoubling of religious faith, which they found consoling, and sometimes even revitalizing.

The advice to avoid anger, on the other hand, often posed some problems. Recall Edward Schieffelin’s observation about the neighboring Kaluli that emotions such as anger “may be openly and often dramatically expressed. . . . These displays of affect have to be seen more as declarations of mind, motivation, and/or intention than as mere cathartic expressions of feeling” (Schieffelin 1983: 183–84). In other words, a display of anger is often an assertion about oneself—that one is not the kind of person to tolerate others’ insults or offences, and that one intends to take serious action should the offense continue. The performance of anger can thus be important for maintaining others’ respect and one’s own sense of dignity, and among the Huli, this is true of women as well as of men. Moreover, as noted

by feminist scholars of affect and by Huli women, anger can enhance one's sense of agency. As Audre Lorde put it, anger can be a "strengthening act of clarification. . . . Anger is loaded with information and energy" (Lorde 1984: 124, 127).

In some cases, the advice to avoid anger led to a kind of self-exclusion in the name of caring for the self, with women withdrawing from social venues and activities with the aim of protecting themselves from potential upset. As important, the directive to avoid negative emotions often motivated a turning inward of attention, and it fostered an understanding of emotions as private feeling states connected to one's own personal bodily condition, rather than as shared responses to experiences held in common. In other words, it furthered an individualization of the experience of being HIV-positive. This individualization, along with the lack of support groups in Tari, meant that there was little sense of collective experience, let alone solidarity, between women living with HIV.