Introduction

"We Are No Longer Fenced In"

I sometimes find myself thinking about Julai,[1] and I wonder where she is now. I met her in 2004 when I was doing research in Tari on married women's risk of contracting HIV. Initially an interviewee, then a recruiter of other women for me to interview, Julai eventually became a friend. She is sweet, funny, and frank, and I was drawn to her openhearted, open-minded ways. I often worried about her, because she is generous to a fault. One of her preferred ways of earning money was to buy cartons of cigarettes wholesale and then sell the cigarettes singly for a profit, a very common strategy in Tari. But she was forever giving cigarettes away to her *besties* (close friends), or smoking them herself, and was never able to get ahead.

When I met Julai, she was separated from her husband, who had left a few years before to find work at a gold mine in another province. He had stopped sending money or messages home, but she heard rumors that he was sleeping around, and then learned that he was living with another woman. Enraged at being abandoned and left to care for their son on her own, she had begun having sex with other men. At first motivated by anger and a desire to even the score—"If he can fool around, so can I [*Em inap faul raun, bai mi tu faul raun*]," she said—her philandering came to be driven by other sentiments: feeling flattered by a powerful or wealthy man's interest in her, needing money to pay for her son's schooling, or thinking a man might make a good replacement husband. She talked about three regular partners during the six months I was in Tari in 2004, as well as a number of one-off interactions with other men. I did my best to educate her about HIV, and I gave her condoms, both for her own use and to sell. (Condoms were not readily available at Tari Hospital or in local stores at that time, so I made periodic visits to the National AIDS Council offices in Port Moresby, Papua New Guinea's capital city, and returned with large cartons of them, which I gave to field assistants, friends,

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and people I interviewed.) Julai told me she was an experienced and regular, if not scrupulous, condom user, but I still worried.

In 2013, Julai informed me that she was HIV-positive. Her husband had moved back home a few years before, and although he had been away for most of the previous seven years, he was furious about what he'd heard of her sexual activity in his absence. Julai showed me pornographic images he had sent her by cell phone, images that were intended to insult, not titillate. They showed one stick figure fucking another from behind (mobile phones were relatively new at that time in Tari, and most people's phones in Tari were quite basic, with limited data) and made me laugh, but Julai was deeply offended. She was saving the messages for a possible future village court case. Shaming people in public by talking in sexually disparaging or humiliating ways about their bodies—referred to as *diskraibim* (describe) in Tok Pisin (Wardlow 2006a: 99)—was still a compensable offense in Tari, and although there were contentious debates about whether mobile phone messages counted, Julai was accumulating evidence just in case.

Julai and her husband had had sex during the rare times he visited Tari. They were still officially married (no bridewealth had been returned), and Julai sometimes seemed to hope that they could repair their relationship. She decided to get tested for HIV when she learned that he had tested positive, but she did not know whether he was the one who had infected her or one of her other partners. Despite testing positive at Tari Hospital, she was not put on antiretroviral medication (hereafter referred to as ARVs or ART): her CD4 count—a measure of immune system strength—was too high and she seemed healthy and strong.[2] She said that she had been told to return in a year to have her CD4 count tested again.

I knew that if she had gone to the small AIDS Care Centre, just a twenty-minute walk from Tari Hospital, she would have been put on ARVs immediately. The Centre didn't have a CD4 machine and had adopted the policy of "test and start"— that is, putting everyone who tested positive on treatment. However, Julai firmly rejected my suggestion that she go there. In fact, she was relieved about her results and felt she'd been given a reprieve—if the hospital staff said she didn't have to be on medication and didn't have to return for a whole year, surely that must be good news. She was not going to let herself worry unnecessarily about being sick. A few months later, after I had returned to Canada, clan warfare broke out where she lived, Julai and her son had to flee, and they were now cut off from the hospital. I have been unable to get information about her since.

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When HIV arrives in a place, it encounters a specific political, economic, social, and discursive terrain. It enters at a particular historical moment, and the nature of this moment—whether politically placid or tumultuous, economically thriving or bleak—can shape both how the virus moves through a community and how its spread is understood and acted upon. In the case of Tari, HIV arrived during

a time of immense turmoil and change, from a period of state abandonment, economic decline, and post-election violence in the late 1990s and early 2000s, to the founding of a new province and the development of an immense new liquefied natural gas project in the early 2010s. When HIV arrives in a place, it might also be said to encounter a particular moral terrain, in the sense that infection may be attributed to moral transgressions, and people living with HIV may feel compelled to conduct themselves in particular ways in order to protect themselves from moral judgment or demonstrate their ethical intentions to others.

Among the Huli, the customary cultural group of the Tari area, the fence is an important element of both the physical and moral terrain and is often invoked to explain the spread of HIV: "We are no longer fenced in," many people lamented, when I asked why AIDS was prevalent in the region. Real, material fences are said to facilitate proper moral behavior by minimizing temptation (Wardlow 2006a: 40), and deep ditches and stands of tall trees and bushes often surround family properties. These are said to shield the residents and their belongings from the covetous gaze of others, while also protecting the latter from acquisitiveness and the temptation to steal. Customary rules and prohibitions are conceptualized as figurative fences: by confining people and limiting their behavior, they create a moral space in which they can flourish. Just as fields or pigs need to be fenced in so that they can fulfill their proper purpose of growing and thriving, so people too need to be "fenced in" so that they can properly fulfill their sociomoral purpose of developing, laboring, marrying, and reproducing. The fence in this idiom is at once disciplinary, protective, nurturing, and generative of proper purpose.

In asserting, "We are no longer fenced in," Huli mean that their lives are now less morally ordered, because the customs of the past no longer constrain and compel behavior. Like pigs that have escaped their enclosures, Huli say of themselves, they are now free of their traditional customs, but they lack purpose, meaning, or direction. In particular, they are no longer guided and constrained by precolonial moral knowledge regarding gendered conduct and sexual practice. Because HIV is often perceived through this self-chastising nostalgic lens, Huli discourse about HIV is always also discourse about gender propriety, Huli customs, the consequences of, but also failures to achieve, "development," and the place of the Huli within the nation-state. Fencing in AIDS (that is, preventing its spread), people say, requires more than medicine: it requires fencing in people, which for some means convincing people to be better Christians, and for others means recognizing the benefits of Huli customs and trying to revitalize them. Both of these are seen as increasingly difficult, however, in a context of high mobility, resource extraction, and the failure of the government to provide needed services or to prevent tribal fighting and crime.

In this book I focus specifically on women's encounters with HIV—as pathogen, site of family and governmental discipline, and affective and moral experience. The phrase "the feminization of AIDS" has commonly been used to refer to women's

disproportionate infection with HIV, and it is shorthand for the fact that female sex (specifically, female reproductive physiology) and female gender (a relation of power) interact to make girls and women more vulnerable than men. "The biological make-up of the female body only goes some way to explain the feminisation of the epidemic: the central meaning of the term derives from social and cultural explanations as to why women are more vulnerable to HIV infection," Sophie Harman explains (2011: 2014–15). Globally, these social and cultural explanations include: lower educational levels; less access to paid employment; economic and sometimes reputational dependency on men; less control over money, land, and other assets; less ability to control whether, when, and how sex takes place; and greater vulnerability to sexual and family violence, as well as the inability to safely exit from violent relationships.

I conceptualize the feminization of the epidemic in more expansive terms, examining not only women's vulnerability to infection but also the ways that they are interpellated by AIDS awareness programs as both victims and "unsanitary subjects" (Briggs with Mantini 2003), and how they are perceived by family and community members as harboring unknowable, and perhaps dangerous, intentions after testing HIV-positive. Each chapter shows how being gendered female shapes every aspect of HIV, from being trafficked to landowners at a nearby gold mine, to being admonished for incompetent sexual hygiene during AIDS education workshops, to being considered morally suspect once diagnosed HIV-positive. Elements of Julai's story—her husband's long absence at a mine and his marrying an additional wife while there, her consequent anger and economic insecurity, her quite good access to ARVs once she tested positive, and her determination not to worry about HIV, even if this meant delaying treatment—all speak to important elements of women's experiences of HIV in Tari. The six remaining sections of this Introduction provide important background about HIV/AIDS in Tari: the region's tumultuous recent history, Huli gender ideologies and practices, the complexities and ambiguities of HIV prevalence data in Papua New Guinea, how AIDS has been interpreted and understood in Tari, the research methods and participants, and an overview of the book's chapters.

TARI'S RECENT HISTORY

Tari occupies a special place in both Papua New Guinea's economy and its national imaginary, and this makes it an important site for doing research into HIV/AIDS. Papua New Guinea is heavily reliant on the exploitation of minerals, oil, and natural gas, and Tari is centrally located between world-class gold mines to the north and west (in Porgera and Tabubil), as well as significant oil and natural gas projects to the south (most recently, ExxonMobil's new liquefied natural gas project, commonly referred to as the PNG LNG or simply the LNG). The Huli, one of the largest cultural groups in Papua New Guinea, have a history dating back to
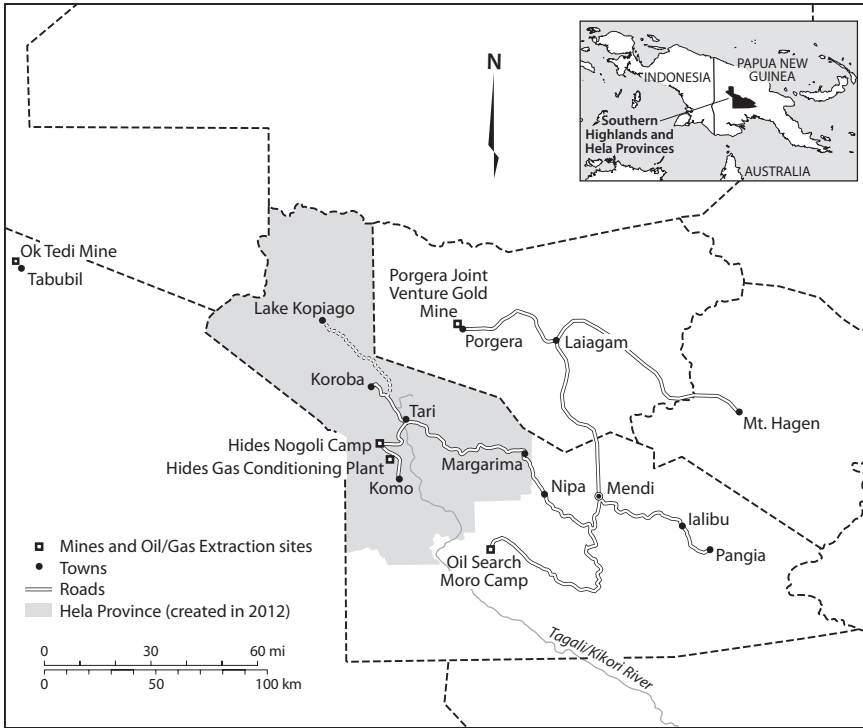
MAP 1. Map of Hela Province and surrounding areas by Bill Nelson.

the 1970s of male migration out of Tari to work on plantations and at mine sites in other provinces (Harris 1972, Ward 1990, Lehmann 2002). Because of this, Huli often claim that they have played an outsized role in the economic development of the nation. Furthermore, they sometimes claim to be the rightful inheritors of Papua New Guinea, destined to rule it. This kind of hubris does not make them beloved in the nation.

As discussed above, fences are deeply meaningful to Huli—materially, metaphorically, and morally—and I have always found that the long, tall fence enclosing the airport is a telling indicator of the state of affairs in Tari. Like most highland towns in Papua New Guinea, Tari began as an airstrip with a few colonial administrative buildings alongside it. It has grown, of course, but the long runway is still in the center, with stores, the main market, government buildings, a police station, and public servant housing on one side, and the hospital, police barracks, and more housing on the other. The runway is long enough to accommodate large commercial planes, and walking its perimeter takes almost an hour. Throughout the day, people walk around it to get from one side to the other—women carrying produce to market, patients trying to get to the hospital, and so on. When I arrived in Tari

FIGURE 1. Woman walking alongside the Tari airport fence. Photo by author.

in 2004, after an absence of seven years, I found the airport fence in a shocking state of disrepair. Sections had been ripped out, goats and sheep often wandered freely around the airfield by day, and at night some people sprinted across it, going through the broken sections rather than walk all the way around. People raucously exchanged stories about the police suddenly roaring onto the airstrip in their four-wheel-drive trucks, high beams on, chasing people back and forth, acting as if they would run them down, and then finally hauling them off to jail for trespassing on government property. "But why should we respect the government's fence?" people grumbled. "Schools and health centers are closed, the police have run away, the politicians are too afraid to come here, and we only ever see the bellies of the planes flying overhead—we have no money to ever go inside one."

This last sentence sums up Tari's plight in 2004. As discussed in more detail in chapter 2, Papua New Guinea's Southern Highlands Province, of which Tari was then a part, had experienced failed elections in 2002. People had been forced to vote for particular candidates, ballot boxes were stolen at gunpoint from the Tari police station and dumped into a river, and violence was widespread, resulting in a number of deaths (Haley and May 2007). Government services had been declining before the elections, and they worsened after them, in part because the failed elections meant that there was no provincial government: public servants weren't paid, government offices in Mendi, the provincial capital, were abandoned and then ransacked, and gradually schools and health centers closed throughout the province as their staffs fled the region.

When people in Tari talk about this period (approximately 2000–2004), they speak of "living in fear"—fear of armed holdups on the roads, of home invasion,

of being abducted and raped by gangs, of being badly injured and there being no healthcare—but they also talk about the people who didn't run away. They remember, for example, which hospital staff continued to work, despite not being paid and running out of essential medicines. And they remember the Catholic nuns, both national and expatriate, who remained when other missionaries and public servants fled. People warmly recall, for example, the tough-minded nun-headmistress of Tari Secondary School, who kept the school open when all other high schools in the province closed, even when a gang of young men drove onto the campus and abducted female students out of their dorms at gunpoint and threatened to kill her and the teachers who resisted.

During the six months I spent in Tari in 2004, things improved somewhat. A caretaker government had been installed until new elections could be held, and, to most people's profound relief, one of Papua New Guinea's mobile squads (special police units assigned to crisis areas and known for their aggressive policing tactics) had been assigned to Tari to restore order. Some schools reopened, there were sometimes nurses working in the outpatient ward at Tari Hospital, and a few small stores sold basic goods, such as rice, canned fish, salt, and soap. A small community-based development project had been established to help families grow and sell coffee and to provide them with chickens, ducks, and water tanks (Vail 2007). The Porgera Joint Venture gold mine (PJV) had opened a small community affairs office in Tari, providing some employment, as well as funds for youth groups and women's groups. There was still no electricity, however, and armed holdups on the roads were common. When I returned for a few weeks in 2006, things were again much better. Schools had reopened, and more staff had returned to the hospital.

This context is important, because it was during this turbulent period—the late 1990s and early 2000s—when many of the HIV-positive women I interviewed from 2011 to 2013 were infected. As I discuss in the first three chapters of this book, many were infected by husbands working at mines in the region, some were infected through selling sex, and a couple of them were infected when raped. The number of women exchanging sex for money increased noticeably during this period, and hospital records also indicate a dramatic surge in sexual violence, which I discuss in chapter 2. Moreover, because of the breakdown in health services, the difficulties in getting any medical supplies to Tari Hospital, and the reluctance of hospital staff to distribute them, there were very few condoms available.

When I returned in 2010, the Tari airport fence had been completely rebuilt, there were now signs at regular intervals warning people not to climb over it onto the runway, and a large area at one end had been closed off and was secured by guards hired to protect PNG LNG construction materials. There was no more running across the airfield at night. PNG LNG managerial staff had taken over every possible hotel and guesthouse in Tari and Mendi and were flown daily back and forth to LNG project sites by helicopter. Eighteen-wheelers carrying LNG supplies drove through Tari day and night, raising clouds of red dust. One

entrepreneurial woman had built a large guesthouse specifically for workers sub-contracted to the LNG project, and although the rooms were small and spartan, they rented for U.S.$100–200 a night; tractor-trailers were lined up nose to tail outside, and the guesthouse was always full.

The construction or development phase of a gas project, particularly in a remote area with little existing infrastructure, is a hugely labor-intensive undertaking. In the case of the LNG, it was expected to have a 14,000-person workforce during its peak construction phase. Roads had to be constructed; compounds had to be built for the laborers who would build the gas-conditioning plant and drill sites; landowners had be identified, compensated, and relocated. Six hundred licensed truck drivers had to be hired to transport heavy machinery and supplies (and, at the start of the construction phase, the whole of Papua New Guinea only had four hundred, most of whom already had jobs working in other industries; the LNG project lured many of them away by offering much higher salaries). And even more local people were hired as cleaners, cooks, launderers, and security guards.

Most spectacularly, the longest runway in Papua New Guinea had to be built near the tiny government center of Komo, at the cost of approximately U.S.$700 million, to accommodate the enormous Antonov AN-124 cargo planes scheduled to bring in the largest equipment and machinery. This runway was to be used by the project for only eighteen months, and then relinquished to the Papua New Guinea government. Given that the project was expected to generate hundreds of billions of dollars, and contracts had already been signed with Tokyo Electric and Osaka Gas in Japan, as well as with Sinopec in China, a $700 million runway that might never again be used was a reasonable expense. This runway took much longer to be built than expected because of unanticipated swampy conditions. As it was cagily explained to me by a high-level manager involved in the project, "the airstrip keeps sinking into the ground." And while the delay created a great deal of anxiety at the national and international levels about whether ExxonMobil would meet its deadline for exporting the gas (it did), it was a source of delight at the local level, because it generated ever more employment and income: new rock quarries had to be identified and acquired, and new truck drivers had to be hired to transport more and more rock in order to build up the sinking runway. It was a tremendously busy and exciting time for Tari, with plentiful employment after a long period of almost none.[3]

As exciting, and largely because of the LNG project, the new Hela Province was being created from a portion of what had been Southern Highlands Province. Huli have longed for their own province ever since Papua New Guinea gained independence in 1975; many speak of it as cosmologically ordained (Haley 2007), and others claim it was promised to them by Michael Somare, first prime minister of the country. Some people literally danced in the streets with joy as they prepared for the new province's inaugural celebrations in 2010. A politician who was key to the negotiations told me that he had informed ExxonMobil executives that

FIGURE 2. Women leaders Veronica Lunnie Payawi, Mary Tamia, and Marilyn Tabagua celebrate the creation of Hela Province. Photo by author.

he would block the LNG project's approval if they did not support the creation of Hela Province in whatever ways they could; thus, the fates of the LNG project and Hela Province were intertwined, and ultimately they were co-creations. The demand for Hela was motivated by a desire to transform Huli territory from a zone peripheral to and remote from state power into its own center of power, with control over resources, opportunities, and services. And what its creation meant most immediately was even more jobs: Tari needed to be readied for its new role as a provincial capital, and international NGOs like Médecins sans frontières (MSF) and Population Services International (PSI), never present in Tari before, arrived to establish humanitarian and development projects.

It was in this context that antiretroviral treatment (ARVs) became widely available in the Tari area. Although ARVs had been available since 2007 at Tari Hospital and the nearby Catholic AIDS Care Centre, the LNG project helped improve access immensely. Oil Search Ltd., the primary joint venture partner with Exxon-Mobil in the LNG project, made HIV education, testing, and treatment in Hela

a prominent part of its corporate social responsibility portfolio, and it invested in training staff, improving data collection and monitoring, and upgrading the network of small health-care centers throughout Hela. In the space of two or three years, HIV-related services went from being available only if you could get to Tari town to being widely accessible.

The LNG project also affected how Huli were viewed by others in the nation-state. The Huli have long had a reputation for being aggressive, and, since the mid 1990s, when I first started doing fieldwork in the Tari area, I have sometimes heard them described by other Papua New Guineans as "primitive," "violent," and "uncivilized." At the same time, I have often also heard the Huli lauded by other Papua New Guineans, usually men, because "they have maintained their traditions when the rest of us have abandoned them." What these admirers usually mean by "traditions" is the Huli practice of gender separation: as they do to a much smaller extent now, in the past, husbands and wives lived in separate houses, sometimes quite far from each other, and men farmed their own sweet potato fields and cooked for themselves. Since the LNG project, however, Huli are more often imagined as wealthy, arrogant, wasteful, and as having abandoned the customs that once made them worthy of admiration. During the construction stage of the drilling sites and gas-conditioning plant, roughly from 2009 to 2013, Huli landowners received large sums of money through jobs, relocation packages, business start-up grants, and various other cash infusions intended to ensure that the project was not derailed by local discontent. Newly wealthy powerful Huli men flew back and forth to Port Moresby to drink, gamble, and maintain their connections with politicians tied to the project. Although these men made up a tiny segment of the Huli population, they were a very visible segment and had a significant impact on how Huli were imagined by others.

GENDER AND HIV IN TARI

I originally envisaged this project as a comparison of men's and women's experiences of HIV vulnerability and treatment. However, because so few men were seeking testing and treatment between 2010 and 2013, I did not have enough interviews, conversations, or participant-observation data with men to feel comfortable making many generalizations about them. Moreover, I cut short four of the eight formal interviews I had with men because I felt they were too sick to continue (this was not true of any of my interviews with women). Most of these men had refused to seek help until they were so unwell that others made the choice for them, and two of them died over the course of my research, although none of the women did. The reluctance of men to seek HIV testing, and their typically much later entry into care, is a widespread global problem (Shand et al. 2014), and is attributed to a range of factors, including men's discomfort with hospital spaces, which often feel to them like female spaces, populated mostly by female nurses and patients,

as well as men's aversion to acknowledging vulnerability or dependency. It may also be that becoming an "AIDS patient"—with its expectations of pharmaceutical obedience, absolute sobriety, and sexual abstemiousness—is experienced by them as relinquishing masculine identity, and thus something to be avoided (cf. Mfecane 2011).

Despite my comparatively thin data about men, some clear themes did emerge. For one thing, Huli men were more fearful than women of being ostracized because of HIV and less likely to disclose their status. They feared very material consequences, such as clan members using a man's HIV-positive status as a pretext for trying to appropriate his land. And men were more likely to express deep unhappiness about there being no cure, and thus were more likely to experiment with alternative treatments and to make their own decisions about whether to follow the antiretroviral regimen as instructed. There are, in short, some interesting gendered comparisons to be made. In the end, however, I decided to focus primarily on women, though of course it is impossible to discuss HIV vulnerability and treatment without discussing women's relationships with men (as wives, mothers, daughters, sisters, sexual partners, etc.).

As mentioned above, I've heard Papua New Guineans from other regions, especially men, speak of the Huli with admiration for what they see as their tenacious adherence to tradition, especially the separation of men and women into different sociospatial domains, often underpinned and legitimized by ideologies about the dangers that women pose to men (Glasse 1968, 1974; Frankel 1980, 1986; Goldman 1983; Clark 1993; Wardlow 2006a). When I first began researching Huli women's lives in the mid 1990s, in a rural area north of Tari, many married couples lived in separate houses, sometimes only 25–50 yards apart, but sometimes on clan territories quite distant from each other. A few young unmarried men I knew made a point of growing their own food and eschewing contact with women, even walking alongside of footpaths so as not to tread on female footprints. Nevertheless, even in the 1990s, it was clear that things were changing dramatically. In point of fact, only one-third of married men did not live with their wives, according to a survey done by one of my field assistants, and most men whose houses were old planned to build new, larger houses with the intention of living in them with their wives and children. As reasons for this change, they sometimes said they wanted to be good Christians (Wardlow 2014) or wanted the convenience of living with a wife (e.g., they no longer wanted to cook for themselves). In sum, despite prevailing discourses about the dangers of excessive contact between the genders, most Huli married couples today live and eat together, and people are far more comfortable with heterosociality.

That said, Huli people also regularly debate whether changes like spousal cohabitation are having beneficial or detrimental effects on Huli society. Does spousal cohabitation cause men to become physically and morally weaker? Does it cause more fighting between spouses than in the past? Clearly shaken by it, one of

my male field assistants described the following incident during one of our team meetings in 2004:

> Recently, as part of a bridewealth celebration, I was invited to eat pork in a clan men's house, and I got inside and realized that the men were eating the pig's stomach and intestines (organs traditionally eaten only by women and children). I'd never seen men eating pig intestines before, and I was shocked and disgusted. And I worried that men in my generation are becoming like women.

He added:

> Doing these interviews with men (about their marriages and extramarital experiences) gives me the same feeling—that men are becoming like women. [In what way?] Too many of them talk about being unable to control their desires—desire for sex clouds their judgment and makes them confused. They are impulsive and do things that they later regret. I was always taught that only women and children are like that. Men are supposed to be single-minded; they are decisive, they are self-disciplined.

This kind of concern was expressed often—that spousal cohabitation, and increased heterosociality more generally, have corrupted proper, resolute, self-disciplined masculinity, and that the social order has eroded as a consequence.

Women's increased autonomy (freedom to go to school, to join women's groups, to walk to town and sell things at market) was also subject to critical scrutiny. Men were often unhappy that women used their freedom of movement to spend time with their female kin and friends, whom men often viewed as morally corrupting influences. This is summed up in the Huli aphorism, "The tame pigs follow the wild pigs," which refers to the observation that if domesticated pigs are not guarded carefully and manage to escape the household fence, they will run away, join herds of wild pigs, and lose any domesticated habits they had. Similarly, proper women and girls are said to be easily led by irresponsible sisters and friends into gossip, gambling, smoking, flirting, and worse. Notable here is that men, in their roles as fathers, brothers, and husbands, often see themselves as responsible for ensuring that women behave morally, and physical altercations and punitive violence often result from men's and women's disagreements about female autonomy.

In 2008, Médecins sans frontières established a project at Tari Hospital dedicated to providing surgical, medical, and psychological care for the survivors of family and sexual violence, almost all of whom, not surprisingly, were women and girls (MSF 2011). Though MSF was scrupulous in its reports and clinical interactions to frame this as a project about "family violence"—in part, I believe, so as not to antagonize local men—in practice it largely concerned men's violence against women. That an international humanitarian organization saw family/gender violence in Tari as so problematic that it decided to establish a project about it there came as a surprise to many people, spurring some confusion and much reflection.[4]

Most of the women I have interviewed since the mid 1990s have been hit by their husbands (though the frequency and severity vary enormously), and hospital

records show that women suffer far more severe injuries than men do from family violence. Nevertheless, it is also the case that women are encouraged by mothers and sisters to hit their husbands if they behave in insulting or disrespectful ways, and little girls, like little boys, are encouraged to hit people who take their belongings or who hurt loved ones (Wardlow 2006a). Most of the women I have interviewed are quite proud of their readiness to engage in physical fighting when necessary, including with husbands, and they take great pleasure in giving blow-by-blow accounts of the fights they have been in. "Everyone has two hands and can fight" is a common saying. Thus, people seemed quite divided as to whether the level of violence between spouses was unusual or problematic, as the MSF project seemed to imply. In contrast, many expressed a great deal of concern about what they perceived as an increase in violence between male kin, especially brothers, due to conflicts over land and resource-extraction benefits. In other words, MSF's framing of the situation in Tari as a problem of "family and sexual violence" did not entirely overlap with how people in Tari understood the increases in interpersonal violence spurred by recent political and economic changes.

The issue of gender violence in Tari bears directly on HIV vulnerability. Much of the literature about AIDS in Papua New Guinea has emphasized gender-based violence, especially sexual violence, as being a significant factor in Papua New Guinea's epidemic (Seeley and Butcher 2006, Lepani 2008, Lewis et al. 2008, Hammar 2010, Eves 2010, Redman-MacLaren et al. 2013, Shih et al. 2017). How to theorize this violence has been a troubling question. A number of scholars have pointed to "embattled masculinities" (Jolly 2000) or "troubled masculinities," which Laura Zimmer-Tamakoshi defines as

> men's abject lack of control over the resources they need to achieve both local and global ideals of masculine social and individual power. . . . Unable to achieve community (much less global) expectations, many of today's young men feel unfairly placed in social-psychic pressure cookers of impossible expectations, feelings that may contribute to acts of compensatory violence as well as violent efforts to force others . . . to help them achieve social manhood. (Zimmer-Tamakoshi 2012: 82—83; see also Jolly 2012)

I would add that while Huli men do express anxiety and frustration about their inability to achieve the economic security they need to care for their families and to maintain the respect of their peers, such feelings are also triggered by police violence, corrupt politicians, racist mining personnel, poor social services, and lack of control over extractable resources found on their own customary land. In other words, men's frustrations may have many sources and are not always about the obstacles to achieving hegemonic masculinity. In any case, this analytic framework suggests that gender violence is a phenomenon in which women bear the brunt of men's postcolonial existential distress.

Martha Macintyre points out, however, that "aggressive masculine behavior is implicitly valued as both an expression of engagement with modernity and as

an ideal of charismatic self-assertion that is transgressive, audacious and risky" (Macintyre 2008: 180). In other words, demonstrating one's readiness and capacity for violence may actually be an element of hegemonic masculinity, not a reaction to one's failure to achieve it. Macintyre urges scholars to recognize the historical "continuities in masculine embodiment and self-presentation, as both beautiful and dangerous" (181), while also cautioning that such analyses "must be then situated within the contemporary world of increasing economic inequality and mobility, as well as failures of government" (181). Margaret Jolly, for her part, has recently cautioned against making generalizations about Pacific masculinities and violence and instead emphasizes the significant generational and status differences between men, as well as the analytical importance being attuned to how masculinities are "formed and transformed" (Jolly 2016: 305) throughout history and especially in contexts of colonialism and postcolonialism (see also Biersack 2016).

I would also note that national surveys demonstrating high rates of gendered violence in Papua New Guinea date back thirty-five years (see Toft 1985). This means that at least one generation of children has grown up witnessing parental and other forms of interpersonal and gendered violence, suggesting that anthropologists and other scholars of Papua New Guinea might consider engaging with theories about intergenerational cycles of violence. Carrying out research in Tari since the 1990s has allowed me to witness the transformation of young boys traumatized by their parents' fighting—they learned when very young to hide all household axes and knives whenever the fighting started, and they often ran sobbing to neighbors' houses—into young men, some of whom now hit their wives. To my knowledge, most research about gender violence in Papua New Guinea has not inquired deeply enough into women's and men's childhoods, their parents' marriages, or how they understood the violence they witnessed and experienced when young. Finally, it is important to take into account that gendered violence occurs frequently in areas where economic insecurity, social disorder, and other kinds of violence—state and local political violence, for example—are also highly prevalent. Gendered violence is often one element or symptom of a broader environment of precarity and violence.

HIV PREVALENCE DATA IN PAPUA NEW GUINEA

The first questions people tend to ask when I tell them I do research on AIDS in Papua New Guinea are "How bad is it?" or "What percentage of people have it?" I always find myself hesitating about how to answer, because, until very recently, data for Papua New Guinea were scarce and poor. Prevalence—the proportion of a population that has an illness condition—is the primary way we know a disease at the population level; it tells us the extent of the problem. And, when we search the internet to obtain information about a disease, we expect to be able to find a table that at least appears to establish prevalence definitively. However, the numbers in

those tables are not easily achieved—they require health service infrastructure, widespread testing facilities and equipment, trained staff, good reporting systems, and so on. For many years Papua New Guinea did not have much of this when it came to HIV, and so the estimated prevalence has seen some dramatic shifts over time and has been a source of contention.

In 2001, when my colleagues and I were writing the grant proposal that would ultimately enable us to carry out comparative ethnography on married women's risk of HIV (Hirsch et al. 2010), there was almost no population-level HIV information for Papua New Guinea. In the absence of data, we represented Papua New Guinea as having a "nascent" epidemic, while the other countries in the study were categorized as either "concentrated" (that is, concentrated in highly vulnerable groups, such as sex workers) or "generalized" (that is, having spread from highly vulnerable groups to the general population). Within a few years, however, Papua New Guinea was categorized as having a generalized epidemic, apparently skipping the "concentrated" stage altogether. According to UNAIDS definitions, in a concentrated epidemic, HIV prevalence is less than 1 percent in the general population, but greater than 5 percent in at least one highly vulnerable group. In a generalized epidemic, HIV prevalence is greater than 1 percent in the general population. Women attending prenatal care clinics are typically used as indicators of "the general population." The few early epidemiological studies in Papua New Guinea showed a prevalence of 1.35 percent in women seeking prenatal care, and 17 percent in self-identified sex-workers in Port Moresby (WHO 2003, Mgone et al. 2002), which immediately put it in the "generalized" category. As worrying was that other research showed that women in rural areas had very high rates of multiple untreated sexually transmitted infections (Tiwara et al. 1996, Passey et al. 1998), a significant risk factor for HIV. This raised fears that if HIV moved into rural areas, it would spread extremely quickly—perhaps this was already happening, some policy makers said.

At the 2004 International AIDS conference in Bangkok, Papua New Guinea's minister for health, Melchior Pep, said "We're sitting under a devastating time bomb that is exploding as we speak" (Cullen 2006: 155). And Dr. Yves Renault, the World Health Organization representative in Papua New Guinea at the time, asserted that the "WHO estimates that two percent of PNG's population is HIV positive. . . . Our judgment is that, given the current level of infection and the rate of increase, it is possible that the number of infections could reach one million in 10–15 years unless decisive action is taken" (Cullen 2006: 155). Since Papua New Guinea's population at that time was six million, this was a frightening prediction. The 2006–10 National Strategic Plan on HIV/AIDS similarly asserted, "Papua New Guinea now faces a devastating HIV epidemic. If effective action is not taken, HIV will soon take a terrible toll on the people and the economy. It has been estimated that prevalence levels could reach about 18 per cent by the year 2010" (PNG NAC 2006: 14). Many of the factors that had shaped high prevalence in sub-Saharan

African countries were also found in Papua New Guinea: an economy dependent on mining and other extractive industries, high levels of untreated sexually transmitted infections, a highly mobile population, and acute gender inequality, including high levels of sexual and domestic violence.

However, these predictions of a catastrophic "African-style epidemic" (Cullen 2006) did not come to pass. Over time, based on more information from the rapidly increasing number of sites carrying out testing, estimates of HIV prevalence in Papua New Guinea have been continually adjusted downwards. In 2005, there were only 17 prenatal care HIV testing sites, but by 2013, this had increased to 329, multiplying the data for estimating HIV prevalence both nationally and by province. Globally, research showed that data from prenatal care clinics tend to overestimate population prevalence, and so the algorithm used to extrapolate prevalence from such data was changed, which also contributed to the downward adjustment of national prevalence in Papua New Guinea. Thus, the 2008 UN General Assembly Special Session (UNGASS) Country Progress report on AIDS in Papua New Guinea states: "The new estimated prevalence rate of 1.28 percent in 2006 among people aged 15–49, compared to the old estimates of 2 percent prevalence in 2005, does not represent in any way a decrease in the epidemic but the availability of better data and improved estimation methods" (UNGASS 2008: 11). And, in 2010, UNAIDS announced that "approximately 0.92 percent of the adult population in Papua New Guinea was living with HIV in 2009" (UNAIDS 2010). This estimated prevalence of .9 percent of the adult population remained true in 2016.

The changing epidemiological estimates necessarily altered the discursive representation of the epidemic, as well as national policy. For example, the 2014 Papua New Guinea Interim Global AIDS Response Progress & Universal Access Report asserts:

> Although it appears that PNG is now experiencing an epidemic concentrated in particular geographical locations and population groups, nearly all of our monitoring, evaluation and surveillance is still based on approaches more suited to a generalised epidemic. It is imperative that size & site estimations be conducted with men and women who sell and exchange sex and MSM in Port Moresby and other regional sites. (PNG NAC 2014: 16)

In other words, with the epidemic suddenly recategorized as urban and concentrated (rather than rural and generalized), there has been a significant shift in intervention strategies towards targeting MARPs (most at risk populations), also referred to as KAPs (key affected populations)—that is, female sex workers and men who have sex with men (MSM), particularly in urban areas and along major highways.

The profile of HIV in the Tari area appears to depart considerably from the current national narrative about the epidemic being concentrated in MARPs. Most of the thirty HIV-positive women I interviewed in 2011–13 had been infected by

their husbands. They did not identify as sex workers, and most had not engaged in "transactional sex." In other words, they belonged to "the general population." Moreover, according to health workers at both clinics where I did research, most of the women registered with them were cases of husband-to-wife transmission. It is therefore important to keep in mind that one nation can contain multiple HIV epidemics, which may have different dynamics, even as they intersect with each other, and a national narrative may not capture a regional reality. The national .9 percent prevalence flattens and obscures significant variability across the country. I suspect that prevalence in Tari is significantly higher than the national average because of the nexus of factors discussed in chapters 1 through 3 that create HIV vulnerability: nearby resource-extraction projects, a period of severe economic decline and political abandonment, and high levels of marital conflict.

I came to suspect higher prevalence in the Tari area in part because five of the thirty women I interviewed had nuclear family members who were also HIV-positive: one's woman's brother had died of AIDS, another woman's brother was HIV-positive, one's woman's daughter was HIV-positive, one woman's sister had died of AIDS, and another woman's sister was HIV-positive. These family members did not have sexual partners in common (i.e., it was not the case that two sisters had sex with the same man), and in most cases they were living far apart from each other and thus not part of the same sexual networks. If prevalence was less than 1 percent, it seemed unlikely to me that a family would have more than one HIV-positive member. However, a sample of thirty is small, and there are, moreover, plausible social explanations for why HIV might cluster in some families. I remain concerned that the current national narrative does not capture the epidemiological reality of Tari, but I examine some of these family clusters and provide potential hypotheses for them in the first three chapters.

AIDS IN TARI'S POPULAR IMAGINATION

During Tari's most turbulent years, from the late 1990s to the mid 2000s, it became quite isolated, particularly in terms of services. The organizations that would normally have promoted AIDS awareness refused to send their staff there, fearing for their safety. Many local health workers fled, and those remaining felt abandoned and cut off from their normal institutional support. There was often no fuel, their vehicles broke down and couldn't be repaired, and in any case they were afraid to travel by road because of crime. So for a number of years, there was no formal AIDS education and no condom distribution. During this time, it was local churches that provided some information about HIV, though the pastors I spoke with said frankly that they had received no directions from their superiors about what they were supposed to tell their parishioners. The dominant ideas that circulated were highly moralistic: AIDS was described as a kind of divine punishment (Wardlow 2008; see also Eves 2003, 2012; Dundon 2007; Hammar 2010;

Kelly-Hanku et al. 2014), and those who died of AIDS-related illnesses were said to have brought this upon themselves through moral transgression, especially pre- and extramarital sex. When an AIDS patient's infant died, it was said to be part of the patient's punishment: the death would intensify his remorse for his sinful behavior and would work to erase his existence into the future. The fewer offspring he left behind, the fewer people there would be to carry on his lineage or remember his name. As one woman said to me, "God wants to exterminate the generations of people who might descend from the sinner. God wants to kill off his whole line so he will have no one to replace him on this earth. So his wife and child must die also. The smell of those sinners is offensive to God" (this was probably the most extreme statement I heard).

This is not to say that people did not know or understand that HIV was sexually transmitted—many people did. But when asked to describe how people became sick from AIDS, most resorted to a language of ultimate moral causality (divine punishment for sin), rather than proximate biomechanical causality (sexual transmission). Moreover, women were more often blamed for the spread of HIV than men. For example, the cause of AIDS was frequently attributed to women who "carry their genitals around and sell them [*karim tau raun na salim*]," a graphic way of describing sex work and transactional sex, and deliberately phrased to suggest an invidious comparison with women who carried around and sold other, appropriate goods, such as sweet potatoes.

By 2010, this morally condemning language had greatly diminished. ARVs had changed AIDS from a fatal disease to a potentially manageable one, making its conceptualization as divine punishment less compelling. Moreover, AIDS awareness initiatives had increased people's biomedical knowledge about modes of transmission, symptoms, and the availability of testing and treatment. People I spoke with in 2010–13 tended to know that the virus was found in blood and sexual fluids, that it was transmitted from one person to another through sex, that it wasn't transmitted through shared clothing or utensils, and that sharing razor blades was another possible means of transmission. HIV-positive people in treatment knew that sex with another HIV-positive person was not risk-free and could in fact have detrimental health consequences.

Such knowledge was often strongly inflected with Huli ideas about sex as a meeting of—or sometimes a confrontation or battle between—two bloods of differing strengths. Men are generally thought to have "stronger" blood than women, although the strength of a person's blood is not tied directly to gender. Rather, blood strength is tied to the force, energy, and charisma of one's persona: gregarious, extroverted, and assertive people have stronger blood. In the case of HIV, blood strength is said to affect the likelihood of transmission, as well as the activity of the virus: a person who is HIV-positive and has stronger blood is more likely to infect others, and a person who is HIV-negative and has stronger blood can "wake

up" the dormant virus in a sexual partner who is HIV-positive and whose blood is weaker. Lucy, a widow ostracized by her siblings, said of her second husband:

> He had all these signs emerging on his body. He lost weight, he had diarrhea, he had sores on his skin. But I was fine. My body was fine, my blood was fine. But he was not all right. I thought it was my blood. I still think it was my blood. [You mean you think you infected him?] No, no. I think my blood hated his blood. My blood is strong, and so my blood kicked his blood. He had the virus, and he gave it to me, but my blood woke up his virus and made him sick.

Sex, more generally, was said to be a dangerous activity for HIV-positive people because of its heating properties: the heat of sexual activity could "wake up" and stimulate a virus, even if the virus was being "fenced in" by ARVs. These statements about battling bloods and sexual heat suggest that it is quite possible for people to possess basic public health knowledge about AIDS—for example, that HIV is found in blood and sexual fluids and can move from one person's body to another's through sex—without that knowledge mirroring a more mechanistic, depersonalized biomedical model. Moreover, such statements show that people are trying to make sense of the incomplete biomedical information they receive. They learn, for example, that HIV can live in the body for years without making a person noticeably sick, and this is translated during awareness talks as the virus "sleeping" in the body. It is not surprising, then, that people want to know what makes the virus "wake up." Similarly, people are told that ARVs "fence in" the virus or make the virus "sleep," again inviting questions about what might make the virus escape the fence or emerge from its torpor. People's solutions to the lacunae in the information they had received tended towards the moral, relational, and affective—they spoke of sexual heat, battling bloods, worry, and anger, issues I take up in chapter 5.

Men's and women's narratives about how they came to be infected also tended to be more complexly relational than standard global health messaging about modes of transmission. Anthropologists have often questioned public health messages' positing of a hyper-agentive autonomous actor capable of initiating and sustaining health-protective behaviors, regardless of socioeconomic context or relations of power. The counternarrative often proposed by anthropologists emphasizes the political, economic, and gendered structures of inequality that can make self-protective behaviors (e.g. condom use) impossible. In contrast to both of these models, the narratives related to me were often at a meso-level, between the individual and the structural, and assumed the causal primacy of the relational—most often family or kinship relations. HIV infection was sometimes ultimately attributed not to the infected person's own acts, or even to the infecting sexual partner, but to others' failures of care.

For example, one young man blamed his parents and his older siblings for his HIV-positive status. He had done well on the standardized test taken in grade

nine—a huge hurdle, and one that dictates whether a student can go on to high school. However, his parents would not pay his school fees to continue. They had already invested in secondary and even tertiary education for some of his older siblings, and so they decided that they had enough educated and employed off-spring to take care of the rest of the family, and that he therefore did not need to pursue more education. He was so angry about this that he left Tari for the highlands city of Mount Hagen without any plans and found himself living in an informal urban settlement. Bitterly remembering this period, he said, "In the settlement, you know, everyone is just taking care of themselves. No one takes care of you." Lonely and struggling, he moved in with a woman there, and only much later learned that she was HIV-positive. He did not blame her for infecting him. Rather, he blamed his parents for not paying his school fees, and his older siblings for not sending him the money that might have put him on a less precarious path: "My life could have been like theirs, but no one in my family would care for me, so it is their fault that I got this virus."

Sometimes this relational notion of causality extended beyond persons to places, which were represented as exerting their own kinds of agentive influence over people. One older woman had been angrily separated from her husband for years, but when he came home during the 2002 election year as part of a politician's entourage—well-dressed, ebullient, and handing out cash—she had sex with him. He was the person who had infected her—"I've never had sex with anyone else"—but she wasn't angry with him, for she also felt that Port Moresby, the nation's capital city, was to blame, and not because it was full of dangerous enticements that might lead men astray, but because returnees carried with them an aura of excitement, a kind of palpable charisma. She could feel it shimmering off of him as he descended from the plane, and she wanted to be part of it, so she agreed to have sex with him. The way she described it, she was less seduced by him than by the nation's capital, which he temporarily embodied.[5]

These examples of what might be called relational causality have a distinctively Melanesian feel to them. In Tari, individuals can, of course, be held solely responsible for their acts having injurious consequences for others or themselves, and yet there is also a willingness to recognize that a person's acts do not emerge only from the lone, interior self, but rather unfold from numerous prior social interactions and relationships. The Huli word for cause or origin is *tene,* which can also refer to tree roots, and just as the tree trunk emerges as a unitary form from a mostly unseen web of tangled roots, an event also emerges from a web of past interactions. Indeed, even persons might be said to appear to be unitary figures while actually being perpetually made and unmade by the gifts (e.g., school fees), substances (parental reproductive fluids), losses of personhood (from illnesses or being severely beaten), and nurturing or disciplinary acts by others. In the anthropological literature about Melanesia, this notion of the person is sometimes

referred to as the "dividual" in order to distinguish it from Western/Northern assumptions about the bounded, singular, autonomous individual. As theorized by Marilyn Strathern, the dividual person is "constructed as the plural and composite site of the relationships that produced them" (Strathern 1988: 13). For the purposes of understanding how Huli often spoke about HIV infection—what I have called relational causality—the implications of dividual personhood are that there was often a presumption that other people played a part in creating the situation in which a person came to be HIV-positive. These narratives did not strip persons of intention, desire, agency, or responsibility, but rather acknowledged that their situations and actions were shaped by their past and present relations, and sometimes by the failures of others to care for them.

Huli people did, however, articulate a notion of ultimate causality regarding HIV infection beyond the relational. This was the idea that it was excess freedom—and especially the loss of custom as a protective moral "fence"—that had led to a multitude of social ills. "We are no longer fenced in" was a regular refrain, and AIDS was typically offered as proof of the problems caused by excess freedom. As it was explained to me, sociomoral rules, like fences, confine, but they also protect the self and others; they restrict, but they also enable moral development and flourishing. Describing yourself as having "jumped the fence" can be a way of saying that you are a rebellious, free spirit, but having "no one to fence you in" is also a way of saying that you have no one to care for you. Thus, when my interlocutors asserted that they were no longer fenced in as a people, they were decrying a loss of moral discipline, but they were also lamenting the sense of not being cared for (by the nation-state, for example).

The idiom of the fence to refer to moral discipline and care had multiple ramifications for HIV. For example, condoms, and sometimes even ARVs, were described as allowing people to "break the fence." The fear of being infected with HIV was said to be like a fence that prevented people from engaging in pre- or extramarital sex. Condoms, by allowing people to protect themselves from infection, and AIDS medications, by allowing people to recover from debilitating symptoms, broke the fence and tacitly gave people permission to behave in sexually transgressive ways with no repercussions. Some women I interviewed even spoke of HIV itself as a fence that forced them to behave in morally upright and constrained ways. Fear of infecting others, they said, made them careful about flirting with men or agreeing to spend time alone with them. And Lucy said that she used her ARVs to control her own movements: unlike many women who carried their medicine around with them, she deliberately left her supply at home so that she would have to return to take her evening dose and couldn't be tempted to stay out at night. As she plaintively put it, "I have no one to take care of me, no one to fence me in," and so she had to rely on her medication to assist her with this sociomoral work. Here we see that the relational and moral models of AIDS

causality are intimately entwined: for women especially, kin have obligations of both discipline and care, and their failures leave women vulnerable to both moral waywardness and illness.

THE RESEARCH

This book is the culmination of two research projects, carried out over six periods of fieldwork between 2004 and 2013.[6] The first project, which entailed six months of fieldwork in 2004 and one month in 2006, was part of a multi-sited, comparative project investigating married women's risk of HIV in Papua New Guinea, Mexico, Nigeria, Uganda, and Vietnam (Hirsch et al. 2010). This research employed multiple methods, but at the center were semi-structured interviews with married men and women of different generations about their experiences of courtship, marriage, extramarital relationships, and mobility and migration, as well as their understanding of HIV/AIDS. For this research, I interviewed the female participants and trained four Huli male field assistants to interview the male participants, based on the assumption that men would be more candid about some topics, such as their extramarital liaisons, when speaking to another man. Each of my assistants completed at least ten interviews, so by the end of the research we had interviewed fifty-four married men and twenty-five married women.[7] A semi-structured interview guide, shared between all five field sites, was used for this research (see Hirsch et al. 2010, Appendix II), although it was adapted to each site. The interviews I did with women were done in Tok Pisin (Melanesian Pidgin) with Huli words and phrases thrown in when appropriate.

Tari proved to be a particularly challenging place to carry out the team's planned marital case-study methodology in which I was supposed to interview a married woman and a male field assistant would separately interview her husband. Huli men wanted to be interviewed first, and, once they knew the interview questions, many refused to give permission for their wives to participate in the research. Their objections included that wives might disparage husbands when interviewed, that talking about sex might arouse a wife and motivate her to be unfaithful, and that, as husbands who had given bridewealth for their wives, they were entitled to know how a wife had answered certain questions. I was loathe to make a woman's research participation contingent on male permission, but I ultimately concluded that interviewing the wife of a man who had already participated in the research but objected to her participation would entail far more risk of physical harm for her (through being punished by him) than she would encounter in her everyday life, and that there was little I could do to mitigate this risk. I was also concerned that her uncountenanced participation would be hazardous to me and my research assistants. Indeed, my field assistants were so distressed by the angry reaction of some of their peers to the request for their wives' participation that they informed me very early on in the research that they could not make such requests any more. In the end, we interviewed men and women who were married, but not to each

other. This approach allowed individual women themselves to give or withhold informed consent and to hide their participation in the research from their husbands if they so chose. These interviews took place in a wide range of venues—at my guesthouse (I rented two rooms—one for myself, and one for interviews), in an empty trade store, in empty offices at the hospital, and in people's homes when they were alone. I came to know many of the women I interviewed quite well, because they would come back and visit, or I would run into them in town.

For the second project, carried out through fieldwork periods of six to ten weeks every year from 2010 to 2013, I investigated the lives of HIV-positive men and women who were in treatment. This research likewise entailed multiple methods, but primarily entailed clinic-based, semi-structured interviews with men and women (mostly women) about how they thought they had come to be HIV-positive, their decisions to seek testing and treatment, their experiences of disclosing their HIV-positive status to others, and their subsequent relations with friends, family, spouses and sexual partners, and community members. I rarely approached these women directly. Instead, clinic employees would inform women who had come to pick up their next three months' supply of ARVs that I was in a nearby room and interested in interviewing them if they were willing.

The women I interviewed were, on average, an older and less educated group than has been typical of much anthropological research about HIV: twenty of the thirty women fell roughly into the middle-aged and older category, and seventeen of them had no formal education or just a few years of primary school. Only one had completed high school. Thirteen of the women were widows (in every case their husbands had 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. The nature of this sample—and especially the average older age of the women—has some bearing on my findings, particularly women's reluctance to remarry, discussed in chapter 5. These interviews were also done in Tok Pisin with Huli words and phrases thrown in when appropriate.

The clinic-based interviews were limited in the sense that I only came to know those few women who lived near Tari town, and so never observed most of the participants in their households or communities. I did not visit any of the women who lived farther afield, in part because public transport was unpredictable, and in part because I did not want to draw undue attention to my research participants, even if many of them claimed that everyone in their community knew they were HIV-positive. I was able, however, to interview some of the women two or even three times, because the research took place over the course of four years. Thus, I learned how some of their situations changed quite dramatically from one year to the next.

AN OUTLINE OF THE CHAPTERS

I think of this book as having three parts. The first three chapters examine HIV vulnerability, and focus on the economic, political, and social factors that have

produced some of the pathways through which women become infected. The last two chapters focus on women's experiences with their families and communities once they have entered treatment for HIV. And a chapter in the middle analyzes how the issue of gender is taken up in AIDS education workshops.

Chapter 1 examines the ways in which two resource-extraction projects near Tari, a gold mine and an oil-drilling operation, make women vulnerable to HIV. That mining towns are places of HIV risk is hardly a new finding. The social psychologist Catherine Campbell is perhaps best known among anthropologists for investigating and poignantly writing about the connections between migrant labor, the hazards of underground mining, masculinity, and men's relationships with sex workers at South African mines (Campbell 1997, 2000, 2003). In this chapter I argue that while Papua New Guinea's mining environment aligns with some of these findings, there are features of mining policy and practice in Papua New Guinea—in particular, "commuter mining" and the creation of a "landowner" class—that produce a unique kind of mine site and thus unique HIV vulnerabilities. For example, men who are designated as owners of the land leased to mining companies become wealthy and powerful patrons, and are able to demand fealty from their clients, including the "tribute" of wives. This has resulted in the trafficking of young rural women to mine sites, some of whom have become infected with HIV by their landowner husbands.

In chapter 2, I examine in greater depth the period of sociopolitical turmoil that Tari experienced from the late 1990s to the mid 2000s. This was the period in which many of the women I interviewed became infected, and I analyze these years as a time of abandonment by the state, characterized by flagrant crime, intensified warfare, the flight of public servants, and the evaporation of economic opportunities. I focus primarily on the increase in sexual violence during this period. Although my descriptions of sexual violence are not graphic, the reader should be warned that I closely examine cases of rape in which young women's accounts were questioned and they were publicly humiliated, resulting in suicide in one instance.

In chapter 3, I focus on gendered contestations over the meaning of marriage in Tari. A significant shift is taking place, with many younger people asserting the importance of marital choice and affective intimacy (Hirsch and Wardlow 2006). Nevertheless, men continue to aspire to polygyny as both a marker of and means to socioeconomic success. Thus, for many women, what began in youth as a companionate marriage founded in love and romance becomes a polygynous union in which they must sacrifice their own desires for intimacy, as well as the power that women can sometimes exert through being a man's sole partner. Often the emotional intimacy they had with their husbands was forged through years of shared strategizing and cooperative work devoted to getting ahead economically, making the material and affective dimensions of marriage deeply intertwined. When an additional wife comes into the marriage, often emotionally and physically displacing

the first wife, the resulting bitterness and resentment play an important part in wives' decisions to engage in extramarital sex.

In chapter 4 I use a week-long AIDS education workshop as a case study for examining AIDS-awareness activities in Tari. Gendered inequalities, such as girls' and women's lesser access to education and employment, fuel the epidemic globally, and so AIDS awareness workshops often allocate a significant proportion of time to gender consciousness-raising, which typically includes discussions about gender stereotypes and gender-based violence. I analyze how the concept of gender was taught to the participants in this workshop, while also demonstrating that the workshop itself became a space where gendered tensions erupted and gendered inequalities were reproduced. AIDS educators must sometimes work hard to navigate and manage the gender inequalities and anger that emerge during AIDS-awareness activities, and this can spur "translational activism" (that is, the deliberate transformation or censoring of educational content) as they wrestle with material they find problematic.

Chapters 5 and 6 analyze the experiences of HIV-positive women who are on antiretroviral treatment. Chapter 5 discusses how women work to care for themselves; chapter 6 analyzes the steps they take to protect others and to demonstrate that they are ethical persons, not social threats. Chapter 5 focuses especially on the centrality of emotional regulation in women's self-care practices. Women living with HIV are counselled by health workers to avoid or "fence in" their negative feelings, such as anger and worry, which are said to "wake up" the virus or enable it to escape "the fence" that ARVs have built around it. Taking this advice to heart leads women to focus a great deal of attention on their inner lives, sensations, and feelings. For some women, fencing in their feelings entails physically fencing themselves within their own households, since they fear that once outside of the family property they might run into people who would cause them to feel anger. I draw on feminist theory about emotion and affect to analyze the potential epistemological and political consequences of controlling emotions that have been labeled dangerous.

Chapter 6, in contrast, discusses the moral quandaries that women encounter because of HIV stigma and their often economically reduced and socially contracted circumstances. Dependent on nuclear family members to take them in, and often considered morally suspect, some women take special pains to anticipate others' fears and to reassure them that they are the "safe" kind of AIDS patient, not the kind that would intentionally or carelessly infect others. They make a point of demonstrating to others that, as some women said, "I fence myself in [*mi banisim mi yet*]." Here, as mentioned earlier, the fence is a moral symbol of discipline and obedience to social expectations regarding proper female behavior. In this chapter I draw on feminist moral philosophy, especially Lisa Tessman's critical virtue ethics, to argue that HIV-positive women cultivate what Tessman calls "burdened

virtues"—that is, virtues that enable a marginalized or oppressed person to manage their circumstances, but often at great cost to themselves.

The book as a whole provides a ten-year narrative about HIV in a place whose recent history has been turbulent and unpredictable, from the chaotic and desperate circumstances in which many women came to be infected to a period of relative plenitude characterized by good access to HIV testing, life-saving medicines, and medical care. It also highlights women's resilience, resolve, and humor in the face of vulnerability and violence.