

“Like Normal”

The Ethics of Living with HIV

Recall Kelapi from chapter 1. In return for being allowed to live on his land, and a cash payment of K700, Kelapi's aunt and uncle, Huli migrants in Porgera, facilitated her rape and abduction by a neighboring landowner, who then took her as an additional wife.¹ After she tested HIV-positive and fled home to Tari, she was one of the first patients to seek help at the Catholic AIDS Care Centre:

I was the second person here when the AIDS Care Centre opened. A lot of people were too afraid to come, and at that time there were no ARVs, only (the antibiotic) Bactrim. . . . [So when you ran away and came back home, did you tell your family that you had this sickness?] Yes, I told them, but think, at this time everyone was terrified of AIDS. It was still new and there was no medicine, so everyone was afraid. My family wouldn't touch me, they didn't want to hand things to me, they didn't want me to eat with them. I was very thin, like a bony, bony chicken, but they didn't want to share food with me.

When ARVs became available at the Care Centre in 2007, Kelapi thrived, and eventually she was well enough to become a volunteer at a small elementary school.² She was one of the few HIV-positive women I interviewed who wanted to remarry and did so. She fell in love with a good friend of mine, a kind and thoughtful Huli man I'd known since my doctoral fieldwork, although she and I didn't realize this connection between us until after the interview.

I went to this little bush school to teach elementary (students) and I met him, and he didn't think I had AIDS. We worked together, and when he looked at me he thought I was a healthy, normal woman, and he wanted to marry me. And I was honest with him, “My body may look healthy, but I'm taking AIDS medicine. You shouldn't think about marrying me. I can't lie to you. I am not normal (she used the English word). You need to know this about me. And you should talk to your family—they will tell

you not to marry me.” . . . And he said he wasn’t worried about it. He said, “I’m an old man. If I end up dying of AIDS it’s okay. I want to marry you.”

In his analysis of what stigma is and how it operates, Erving Goffman (1963) laid out the complex set of unspoken rules the stigmatized are expected to learn and follow when interacting with “normals,” such as acting as if one is normal (that is, not drawing attention to one’s non-normalness) in order to protect “normals” from feeling uncomfortable, while simultaneously also subtly signaling that one is aware of one’s non-normal state. As if taking a page straight from Goffman, Kelapi, like many people in Tari, drew a distinction between HIV-positive people and “normal” people, using the English word “normal” to refer to people presumed to be HIV-negative. And, as will be seen, the other women I interviewed also enacted some of the interactional rules identified by Goffman, particularly protecting “normals” in various ways and taking care not to be seen as trying to pass as “normal.”

The English word “normal,” which I had never heard used before in Tari, had become a semiotically dense category: it referred to an HIV-negative sero-status, but it was also about having a “normal” body (that is, looking HIV-negative, based on stereotypes about HIV-positive people being thin and weak), having a hazard-free body (as opposed to the HIV-positive, who were sometimes spoken of as contaminating or polluting), and being morally reliable (as opposed to the HIV-positive, who were often considered morally suspect). Given the social safety of being “normal,” it was not surprising that the women I interviewed often expressed an acute longing to *kamap normal* (become normal)—that is, to be cured of HIV—or to be *olsem normal* (like normal). To “become normal” was not only to be free of the virus, but also free of the moral blemish and danger associated with HIV; to be “like normal” was simply to be treated like everyone else, without one’s HIV status overwhelming one’s other characteristics. However, with no cure in sight, “becoming normal” was unlikely, and being “like normal” presented many challenges.

As discussed in chapter 5, many of the women were uncertain about how they would fare on ARVs in the long term, or whether the medicines would continue to be available. Some were coming to terms with a weaker body, less able to contribute labor to their households. Some had been widowed by AIDS, and others ostracized by family, and in either case, they were usually worse off economically than before. All of these circumstances meant that they often felt that being “like normal” was out of reach and that they instead had to learn how best to live with their non-normal status (see also Mattes 2014). Some, like Kelapi (or Gloria, from chapter 5), thrived on ARVs and felt a renewed sense of strength, vigor, and purpose, but even these women had to confront questions about their ethical obligations to others given that they were HIV-positive. Kelapi, for example, was reluctant to expose her fiancé to the risk of becoming HIV-positive or to the disapproval of his family. Accommodating themselves to and managing others’ fears and suspicions also made the ability to live “like normal” nearly impossible for most women.

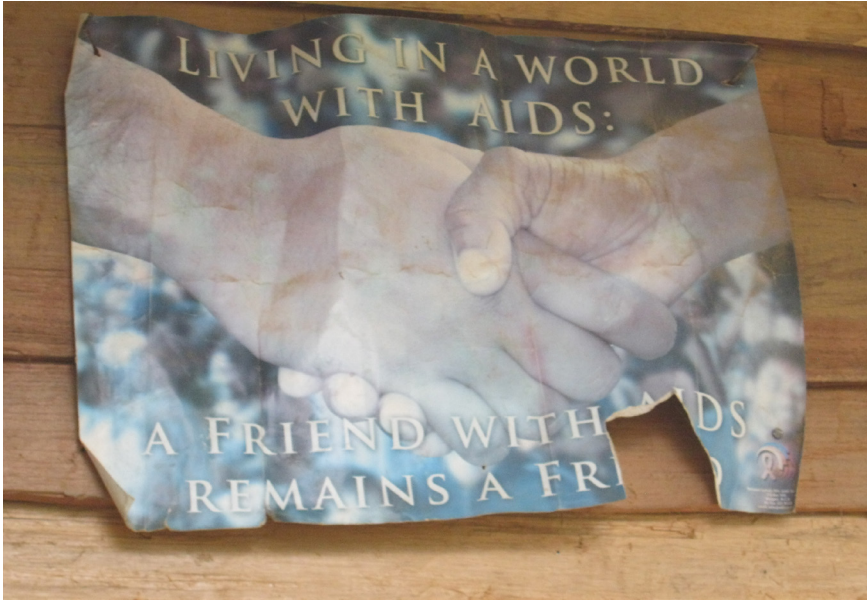


FIGURE 8. AIDS awareness poster on the outside of a house. Photo by author.

In chapter 5, I focused on how HIV-positive women care for themselves, often keeping an apprehensive eye on their own interior emotional states. In this chapter, I examine how they strive to act as moral persons, often by anticipating others' (often illusory) fears about AIDS and seeking to protect them. Because AIDS is stigmatized and associated with moral wrongdoing, the newly diagnosed face HIV, not only as a health problem, but also as a moral problem. To maintain others' forbearance and goodwill, they must demonstrate that they are "the good kind of HIV-positive person"—not the kind that might hide their status and infect others. And, given their dependence on others, and in some cases their isolation and reduced means, they must determine how to forge ethical lives in a society that values generosity, reciprocity, and exchange relations above all.

THE MORAL PROBLEM OF BEING HIV-POSITIVE

In the early 2000s, the stigma attached to AIDS was blatant, and the consequences were sometimes brutal. There were stories in Tari of infected people confined in pig houses, tied to trees and left out at night in the rain, or taken into the bush and abandoned, much as reported in the Eastern Highlands (Hammar 2010). How widespread such responses may have been is impossible to know, but the stories demonstrate the fear, revulsion, and moral opprobrium associated with AIDS at that time. Since 2007, the generally very good access to ARVs in the Tari area has dramatically lessened the fear and stigma associated with HIV and has changed how stigma is

expressed (cf. Castro and Farmer 2005). Almost all of the women I interviewed reported feeling healthy most of the time and were usually able to carry out some or most of the labor expected of women. No longer wasting away, and now able to do agricultural and household work, they were accepted by their families. And, because they looked “normal” they were treated “like normal” by their immediate family members, if not always by extended family or the wider community.

Widespread AIDS education, as well as the expectation that treatment supporters accompany patients to clinic appointments, have also played important roles in decreasing stigma. The women I interviewed were usually the most knowledgeable about HIV/AIDS in their households, but could not presume to act as the family educator. Consequently, they appreciated the “rule” that treatment supporters had to accompany a patient to her clinic appointments because it forced the accompanying family members to be educated about HIV when otherwise they might have retained incorrect knowledge that caused fear and justified exclusionary practices. Acquiring accurate information about transmission made family members far more willing to share housing, food, blankets, utensils, and clothing with patients. Thus, while policy makers may imagine that patients should have treatment supporters in order to ensure that they adhere to their medications, the female patients I interviewed saw their “treatment supporters” as a kind of captive clinic audience receiving accurate and destigmatizing health information.

This is not to say that equipping people with biomedically correct knowledge about HIV perfectly rectified mistreatment: one-third of the women I interviewed had been ostracized and treated cruelly, sometimes violently, by family members. For almost all of them, this was because their sexual reputations had been tarnished prior to their HIV diagnosis: they had “passengered around” before or during marriage, they had attended *dawe anda*, or they had run off to marry a husband their family disapproved of. In these cases, accurate information about AIDS did not dispel family feelings of disgust or disapproval, or their belief that an HIV-positive person was dirty and contaminating. For example, Shelly, discussed in chapter 5, had two older brothers who were convinced that she had infected herself and then her husband by “passengering around,” and she avoided going to a particular roadside market where she was likely to encounter one brother because he had once loudly announced, when she sat down next to him, “Look at this AIDS woman sitting next to me! She had better leave because I can smell the stench of her AIDS coming out of her vagina and getting on my skin.” She didn’t think her brother actually believed that HIV could be spread in this miasmatic way; rather, this was how he expressed his repugnance and his desire to humiliate her. His insult drew on long-standing Huli discourses about sexual pollution in which women’s bodily fluids and smells are said to “block men’s noses” or “get on their skin” and thereby damage their well-being and future fortunes (Glasse 1974, Frankel 1980, Clark 1993). While village court cases and demands for compensation for women’s “menstrual pollution” are much rarer now than in the past (Wardlow 2006a), the idioms and ideas that informed them—about the

connections between women's moral infractions, their bodily emanations, and others' illness—continue to have purchase, fueling misgivings about HIV-positive people, especially women.

Nevertheless, ARVs and AIDS education have significantly diminished AIDS dread by producing healthy, able bodies and by providing people with accurate information about transmission. But AIDS stigma derives not only from fears of death or physical contamination; it is also an act of judgment about a person's moral nature, intentions, and possible future acts, and ARVs have not diminished the suspicions that many people hold about the HIV-positive: that they brought infection upon themselves through moral transgression, that they must therefore deserve the punishment of HIV, and that their sexual misdeeds are indicative of broader moral flaws. For example, it is often said of women reputed to be passenger women that they also drink, smoke, gamble, refuse to do agricultural work, are more likely to lie and steal, were rebellious when young, had undisciplined upbringings, and come from bad families. Learning that someone is HIV-positive thus immediately raises doubts, suspicions, and sometimes *a priori* judgments, about her past behavior and moral makeup.

By the late 2000s, AIDS stigma was more subtly expressed. Public insults were far rarer than they had been, people said, but still occurred. For example, Jennifer, a young woman who had recently given birth to an HIV-negative baby, said that during her pregnancy women cruelly speculated aloud as to what she might give birth to (a frog? a snake? a rotting fetus?), and after the birth commented that it was unnatural and unfair that she had given birth to a healthy, "normal" child. She tried to control her reaction to these cruel comments because she did not want to give in to dangerous angry feelings. Her rejoinder (which other women I interviewed also articulated) was: "You can say what you want now, but AIDS can come just as easily to you. Tomorrow you could be next." Given the vicious and obscene insults that women typically exchange when angry, I was initially nonplussed by this seemingly tepid retort and by the pride my interlocutors clearly felt about it. I eventually came to understand that this was a quite calculated response: it did not reach the level of insult that could be characterized as "describing" a woman (that is, insulting her by talking about her body or her sexual reputation), which might invite retaliatory violence, but was instead intended to get under her skin and cause lingering worry by undermining her confidence in her husband's sexual fidelity. It was a way of evening the discursive playing field by emphasizing that all married women were vulnerable to a husband's philandering. Anyone might be next.

Public insults were less common than before, women said, for two reasons. First, local leaders had made a point of educating their communities about the HAMP (HIV/AIDS Management and Prevention) Act, which forbids publicly shaming an HIV-positive person: "The term 'stigmatiser' is defined and includes 'to vilify or incite hatred, ridicule or contempt against a person or group on the grounds of an attribute,'" Genevieve Howse explains (2008: 4). Public verbal insults such as those

directed at Jennifer, Shelly, or Rosina (see chapter 5) were, in fact, violations of the HAMP Act. Second, people feared that they might become vulnerable to demands for homicide compensation if they insulted an HIV-positive person who subsequently died. People living with HIV/AIDS had been known to commit suicide, and others had died even while taking ARVs, deaths that were often attributed to lethal worry. In either case an insulter could be accused of being a *tene* (cause) of the person's death. Consequently, stigma was more often demonstrated through such behaviors as passing an HIV-positive person on the road and refusing to look at or speak to her (*ngui higibi* in Huli; *pulim nus* in Tok Pisin), refusing to buy a woman's produce at market, or discontinuing small, daily exchange relations, such as sharing cigarettes, betel nut, or soft drinks. Noticeably, these might all be characterized as inactions, rather than actions, making them less easily targeted by laws like the HAMP Act.

More egregious instances of inaction included refusing to help an HIV-positive person rebuild a house, prepare land for planting, or assist in paying children's school fees. The women I interviewed who had young children worried constantly that if they died, no one would assist in paying their school fees or that greedy kin might try to appropriate land to which their children had a rightful claim. They also worried that people would simply be cruel. As Shelly said,

I do this (adhere to her medication) for my children. If I die, it doesn't matter to me (*mi dai, nogat samting*). But my children—if I die people will say terrible things to them like, “This AIDS woman gave birth to you. You are not our child. Go cry on her grave.” And they won't take care of them. So that's how I strengthen my control over my thoughts. I think of my two children. Who will take care of them if I fall down dead?

Even women who were seen as victims of their husbands' wayward behavior suffered some degree of stigma in the form of skepticism about their moral intentions. Perhaps counterintuitively, such skepticism was in part a consequence of ARVs. Indeed, many HIV-negative people (or presumably HIV-negative people, since most had not been tested) expressed ambivalence about the medications provided to those living with HIV. ARVs were lauded because they had saved loved ones from death, allowed them to live productive lives, and had largely rendered nonexistent the abject and frightening body of the person dying from AIDS-related illnesses. However, ARVs were also widely spoken of with suspicion, and even condemnation, as enabling HIV-positive people to “pass as normal (*giaman olsem normal*).” To *giaman* is to lie or pretend. For example, when someone gives false testimony at a village court case, other people often stand up and loudly yell, *Em giaman!* (He's lying!). And when older women laugh about flirting with a man, they may say, *Mi giaman olsem mi kamap sixteen gen* (I acted like I was sixteen again). To *giaman olsem normal*, however, is not just to playfully pretend to be something; it is to duplicitously try to pass as something one isn't, possibly for malevolent reasons.

For many people—men in particular, it seemed to me—the arrival of ARVs in Tari blurred what they believed to have been a clear and visible distinction between the HIV-positive and the HIV-negative. Despite much AIDS education to the contrary, there was still a common misperception that you could, in fact, tell if someone was HIV-positive by looking at them. Many of the women I interviewed, for example, had been sexually propositioned by men who refused to believe they were HIV-positive because they looked healthy. They sometimes had to show these men their clinic books and medications to convince them. Consequently, many people—again, men in particular—asserted that ARVs had a questionable effect, which was that they prevented the easy identification of HIV-positive people by making them look *olsem normal*. In rural Malawi, Amy Kaler, Nicole Angotti, and Astha Ramaiya noted similar “anxieties about the possibility that women on treatment, who appear healthy, may actually be dangerous to men seeking a wife, a steady girlfriend or a casual partner, because treatment restores the body to a healthy appearance, thus concealing evidence of infection,” and ARVs were thus seen as “good for individuals” but a “danger to the community” (Kaler et al. 2016: 71, 74). In Tari, people sometimes said that ARVs made it possible for an HIV-positive person to *giaman olsem normal* and to *spreim sik AIDS* (spray AIDS) or *spredim sik AIDS* (spread AIDS). The English words “spray” and “spread”—perhaps introduced by health workers—had entered Huli vocabulary and were used interchangeably and conjoined, so that to “spray” or “spread” AIDS referred both to the spurting of dangerous sexual substances and the transmission of HIV.

Exacerbating this fear was that people living with HIV were sometimes spoken of as essentially, biologically different, and this was attributed to HIV being “a disease of the blood” (*sik bilong blat*), an idiom introduced by health workers, not anticipating how this might be taken up and interpreted. HIV changed the blood of those who were infected, some people said, so that the HIV-positive not only had dangerous bodies, but also harbored dangerous emotions and desires. Attributing intentionality and agency to the virus, some people said that because the virus wanted to spread itself to many bodies, it increased sexual desire in those it infected. Others said that having an incurable virus made people angry—angry enough to lash out and force others to join them by seducing or sexually assaulting them. After the arrival of good access to ARVs and widespread education, such ideas were losing purchase in the popular imagination. Nevertheless, it was a worrying paradox for some people that the same medicines that could “fence in” or “fight against” HIV might also make its spread more likely by camouflaging those who had it.

Giaman olsem normal and Being Morally Suspect

Because of doubts about the characters of people living with HIV and ambiguous perceptions of ARVs, the women I interviewed found themselves inhabiting a liminal moral status—they were not perceived as morally bad, but as morally suspect, not quite trustworthy. This status often necessitated that they behave in

ways that would continually reassure others about their benign intentions. They often felt they were walking a fine line between trying to *stap olsem normal* (live like normal) while making it clear that they were not trying to *giaman olsem normal* (pass as normal). Despite their stated desires *not* to stand out as exceptional or different, they had to perpetually interpellate themselves as HIV-positive, to reflect self-consciously on the implications of this essentialized difference, and to show others that they acknowledged it and acted accordingly. And since Huli women are typically dependent on others for housing, food, and protection, they often had to live in such a way that others believed they were worthy of care. Many spoke of trying to achieve a less suspect status by performing an exaggerated version of female morality.

Hygienic Morality. A common practice of the women I interviewed was what I call hygienic morality—that is, they created and policed boundaries between themselves and other household members in order to guarantee that they would not infect them. Many of them said that household members were happy to “finish my Coca Cola” or “share my blanket,” but they also spoke of not permitting family members to do so. If they had their own rooms or mattresses, they would not allow children or their sisters to sleep with them, despite the normalcy of this sleeping arrangement and their own desires for this companionship. Similarly, they insisted on having their own set of utensils, cup, and plate, which they alone ate from and washed. Such boundary-drawing behavior is reminiscent of Huli women’s bodily comportment during menstruation, when women protect those around them by not handling food, not stepping over household objects, and even minimizing speech, so that their exhalations won’t affect others. Although none of the women I interviewed explicitly articulated parallels between menstrual pollution and HIV, it seemed that they drew on moral practices from the former domain to inform the management of their bodies with respect to the latter.

Since both they and their household members knew that HIV could not be transmitted through these modes of sharing, these acts of boundary-drawing were intended by the women, and taken by their families, as demonstrations of their commitment to protecting and caring for others. Indeed, an HIV-positive woman and her family often engaged in an ethical *pas de deux* in which the woman would demonstrate her love and care for them by establishing spatial boundaries around herself and objects she touched, and they would demonstrate their love and care for her by violating these boundaries—drinking from her cup, borrowing her clothes, and so on. They knew that these boundaries were biomedically unnecessary, and that she was demonstrating her intent to protect them, and she knew that their boundary-crossing was intended to show her that they were not afraid and trusted her. In a sense, information about how HIV could not be transmitted (by sharing cups, spoons, clothes) was mobilized by family members in a subtle dance of love and care.

HIV-positive women's care-taking and hygienic morality carried over into public settings, such as the roadside markets where women often sell produce or cooked food. For example, this was how Gloria (who, as we saw in chapter 5, asserted that she now lived better than she had when her husband was alive) described how she prepared herself when going to the market:

I wash myself thoroughly before I sell things in the market. I tie my hair up and cover it. Only then do I carry my produce to market, and then people aren't afraid of me. I think to myself that I must stay healthy and I must look healthy. I must look like all of them. So I wash well, and I arrange my hair. I clip my nails. And I wear gloves. I make sure my clothes look nice and clean and don't have tears or stains. And I make sure that if I'm selling cooked food that it is covered well with a cloth. And I always bring a fork or some tongs, and I use them to serve people. I never touch the food with my hands when I'm at the market. I make sure the food is in a good clean bowl. [It sounds like you have thought of everything and that you arrive at the market really prepared.] Yes, I think of everything. I think that if I go to market I cannot look as if I am sick. I must look completely normal. That way people will think, "Yes, we know she's sick. But she looks healthy and clean, so we can buy from her."

There is a tension here between Gloria's desire to be perceived as "normal" and the elaborate and atypical practices she undertakes in order to achieve this. In other words, in order to be accepted as normal, Gloria, and many of the other women I interviewed, adopted exceptional—that is, "abnormal"—practices. For example, Gloria demonstrates exaggerated care about hygiene. Although women generally make sure that their produce is well washed for market display, they do not cover their hair, clip their nails, wear gloves, or use tongs to handle food. Gloria does these things, not only to assure people that her food is safe, but also to advertise to them that she is the kind of HIV-positive woman who has reflected on her sero-status and is taking care to minimize any hazard they think she might pose. In other words, she is both protecting others and making her intent to protect them visible. And, though she used the word "normal" to describe the impression she was trying to achieve, in fact Gloria is not striving to "pass" as "normal"; rather, by setting herself apart from other women at the market with her rigorously hygienic behavior, she is semiotically mobilizing information about how HIV is *not* transmitted to establish her ethical intentions.

Absolute Candor. One might wonder how the people at the market knew that Gloria was HIV-positive. This is likely because of another ethical practice that many of the women I interviewed stressed: absolute candor about their HIV-positive status. AIDS policy makers have encouraged open disclosure about HIV, the logic being that secrecy only reinforces exceptionalism, stigma, and shame, while candor contributes to normalization and stigma reduction. Nevertheless, the existing public health and anthropological research suggests that

people living with HIV exercise cautious deliberation about whom to tell and whom not to tell, and typically disclose their HIV status to few people in order to avoid stigma, or simply to preserve their existing identities and social belonging (Bond 2010, Hardon and Posel 2012, Mattes 2012). In contrast, almost all the women I interviewed said that they had disclosed their sero-status to neighbors and clan members, as well as to close and extended family members, and had even announced it at local markets and other large community venues, such as before weekly village court cases or before church services began. I was repeatedly told, “Everyone knows, everyone in my community knows.”

The most common reason women gave for this practice of wide disclosure was that they recognized that for some community members (though certainly not all), not informing others of one’s HIV-positive status was equivalent to hiding it. Remaining silent about one’s sero-status left open the possibility that one was trying to *giaman olsem normal*, which cast one’s moral intentions into doubt. Ethical behavior thus entailed, not only not infecting others, but also assertively and widely disclosing one’s status in order to prevent others’ suspicions about one’s possible malevolent intentions. As a number of women stated plainly, “Only people who want to spread/spray it around don’t reveal their status to everyone.” In openly confessing or avowing their HIV-positive status, women were likely informed by a Christian tradition. Most of them belonged to a Christian denomination and had grown up going to church, and as HIV patients, they had received counselling about the importance of disclosing their HIV status to others (Nguyen 2013), though I never witnessed any health workers urging patients to make public declarations. Again, the desire to live one’s life “like normal” came into conflict with the possibility of being perceived as trying to “pass” as normal, and in the end many women chose active and widespread disclosure as both the most ethical and self-protective path.

Women’s commitment to candor extended to men who propositioned them, though they typically had mixed motives, both wanting to protect the men from HIV and wanting to protect themselves from unwanted advances. Men might be looking for a one-off sexual encounter, a girlfriend, or a wife, but whatever their intentions, almost all the women I interviewed said that they were regularly sexually propositioned. All but a couple of the women asserted that they uniformly rejected these proposals and, moreover, informed the propositioners of their HIV-positive status. For example, Betty—a middle-aged woman who had fled to a *dawe anda* after two very violent marriages, and who continued to attend *dawe anda* post-diagnosis, despite the damage this did to her reputation—had this to say about her HIV candor:

[So did you tell your family when you found out your diagnosis?] Yes, I told them. I told everyone. I told it everywhere. [Everywhere?] Yes, everywhere—if someone asks me, I tell him/her yes. [Do you mean like if men ask you?] Yes, yes! Men often ask

me to have sex with them, and I say, “No, I have HIV.” [And how do they respond?] Many of them accuse me of lying and making excuses. [So what do you do?] I always carry around my medicine and my clinic book, and I show them. I say, “Look, here in my clinic book it says I have AIDS. Look, here is my AIDS medicine.” Lots of men have propositioned me, and they say, “But you don’t look like an AIDS woman. You look healthy—let’s go have sex at a guesthouse.” And I say, “No, sorry, good man. I am an AIDS woman. I am a dead woman. Look at my clinic book. Look at my medicine.”

Women typically used the phrases “I am an AIDS woman” (*mi AIDS meri*) or “My blood is ruined” (*blad bilong mi bagarap finis*), or even “I am already dead” (*mi dai finis*), to deter their propositioners. While this language arguably reinforced AIDS stigma—and perhaps reflects a degree of internalized abjection—it was also effective in driving away unwanted advances. When such self-descriptors failed, women resorted to the kinds of demonstrations described by Betty or even, in a couple of cases, to announcing loudly for anyone nearby to hear, “I have AIDS, and this man is propositioning me!”

MORAL LUCK, BURDENED VIRTUES, AND BEING AN HIV-POSITIVE WOMAN

The moral logic employed in many of the women’s narratives tended towards what might be called a deontological ethical orientation; in other words, women indicated that their morality was guided by and would be judged according to whether they abided by particular rules, duties, and obligations. In the field of moral philosophy, ethical theories are often divided into three rough schools of thought: deontological ethics, which emphasizes norms and rules; virtue ethics, which focuses on the cultivation of virtues, character, and moral reasoning; and consequentialist ethics, which privileges the harmful or beneficial consequences of an act in determining its moral value. Much recent anthropological work has adopted a virtue ethics approach (Laidlaw 2002; Zigon 2009; Lambek 2010a, 2010b; Mattingly 2014; Das 2015). In contrast, the women I interviewed emphasized a range of duties and obligations: to protect others from the (often illusory) threat of their bodies, to protect family from compensation demands that might ensue from their HIV-positive status, and to avoid any appearance of duplicity about their sero-status. Categorizing my interlocutors’ practices into one school of moral thought or another is, admittedly, a tricky undertaking since, for example, cultivating obedience to particular rules would likely be considered a virtue for Huli women. And, as Didier Fassin notes, “in ‘real world’ situations that anthropologists examine, when they attempt to comprehend the moral arguments expressed by individuals to justify their actions or the ethical practices performed by them in the course of their everyday life, it is seldom possible to sort out the deontological, virtuous, and consequentialist threads” (Fassin 2015: 8). Nevertheless, it is worth considering why the women I interviewed put such emphasis on rules and obligations.

First, it should be noted that Huli moral philosophy might be said to have a deontological cast—that is, people often emphasize the importance of moral injunctions, taboos, and duties, and this is especially true for women. Women have long been figured as needing to be “fenced in” by specific rules and by the disciplinary practices of others (especially brothers and husbands) in order to behave morally. Without forceful—which is to say, physically punitive—socialization about gendered rules of conduct, women are thought likely to become “wayward” (Wardlow 2006a). That said, I believe that many Huli would assert that no one, male or female, can cultivate a virtuous character without first prioritizing moral rules. Everyone needs to be “fenced in,” and rules, taboos, duties, and obligations are the fences.³ Indeed, one of the problems with the modern era, people say, is that “we are no longer fenced in.”

As important as the deontological tendencies in Huli moral thought is the positionality of the women I interviewed. That they were gendered female and viewed as not “normal” strongly shaped their moral reasoning and acts. The work of feminist moral philosophers helps to elucidate how being female, socioeconomically dependent, and morally suspect pushed them to think about their actions in terms of moral duties. While the field of moral philosophy has traditionally posited an ahistorical, context-free, autonomous ethical subject who can freely choose his or her course of action, feminist philosophers have made a point of considering the effect that a subject’s socially structured position might have on his or her ethical capacity, reasoning, and conduct. For example, Claudia Card, in her book *The Unnatural Lottery* (1996), took the philosophical concept of “moral luck” (Williams 1981, Nagel 1993)—a situation where circumstances beyond one’s control affect one’s moral actions—and argued for the necessity of considering “circumstances that are *systematically* arranged and that tend to affect people as members of social groups” (Tessman 2000: 377, emphasis in original). In other words, she urged moral philosophers to conceptualize “luck” not as haphazard circumstances, but rather as robust, structuring inequalities, such as class, race, and gender. She referred to these as “the unnatural lottery” because, as she explained, the “lottery” of one’s life chances could not be considered random or “natural” when they were partially determined by skin color, sexed body, and so on.

The moral problems Card examines using the concept of moral luck consequently diverge significantly, for example, from the question of whether two equally attentive and skilled drivers should be morally assessed in the same way when one of them suffers the unfortunate circumstance of having a dog run across the road, causing her to swerve and fatally hit people (this is a classic example often used to explain the concept of moral luck). Rather, Card asks how gender inequality, gendered violence, and what is now sometimes called “rape culture” affect women’s ability to live fully flourishing ethical lives. She also develops the concept of “moral damage”—that is, the ways in which abusive contexts can have limiting or distorting effects on a subject’s moral reasoning and judgment.

Lisa Tessman, building on Card's work, focuses on how experiencing systemic marginalization or oppression, such as racism, shapes the moral self: "The first and most obvious way is that it creates circumstances external to the oppressed agent . . . that limit options so that every way one turns one runs into barriers that make it difficult or impossible to gain or be granted freedom, material resources, political power, and respect or social recognition of personhood—all of which are needed to live well" (Tessman 2000: 375). When she says that these things are needed "to live well," she is referring to Aristotle's concept of *eudaimonia*, a key concept in virtue ethics, which has been variably translated as human flourishing, self-cultivation, self-actualization, or the pursuit of excellence. In order to differentiate her work from that of classical, Aristotelian or neo-Aristotelian virtue ethics, and to signal her attention to structures of inequality, Tessman characterizes her own work as *critical* virtue ethics (Tessman 2001). A critical virtue ethics, she says, examines the specific ways that exclusion, violence, discrimination, and precarity not only limit a subject's *socioeconomic* opportunities, or damage her *psychological* well-being, but also cause harm to her as a *moral* actor, constraining her chances of achieving *eudaimonia*. Her aim, Tessman says, is "to name moral limitations and burdens as belonging on a list of harms that oppression causes, and to express both anger and grief over these harms" (Tessman 2005: 5).

By moral harm or damage Tessman does not mean that an actor will engage in unethical acts that she wouldn't have otherwise; rather, there is a certain sort of a self that one ought to be, but the uncondusive conditions of oppression bar one from cultivating this self. In an Aristotelian schema, such moral damage in turn disqualifies one from flourishing, for virtue is necessary for flourishing (Tessman 2005:4).

In other words, because a subject has not come into herself in a context of security or inclusion, she cannot fully act as the moral self that she might have become if she had lived with greater social justice and equality. She has not had the opportunity to cultivate the virtues, moral reasoning, and judgment that she might have. Crucially, it is also possible, even likely, that she has developed other virtues that have helped her endure her situation of oppression or discrimination. Tessman calls these "burdened virtues," which she defines as "a set of virtues that, while practically necessitated for surviving oppression or morally necessitated for opposing it, carry with them a cost to their bearer" (Tessman 2005: 4).

One of Tessman's examples of a burdened virtue is anger about oppression, and she discusses the many ways in which anger can be a virtue, drawing on work by Audre Lorde, Elizabeth Spelman, and others (Tessman 2005: 117–23; see also chapter 5). "Focused with precision [anger] can become a powerful source of energy serving progress and change," Lorde observes (1984: 127), and Spelman argues that anger at an oppressor is an assertion of equality, because it constitutes a judgment of the oppressor's actions, and thus implicitly conveys that one has assumed the right to judge. "I am acting as if I have as much right to judge

him as he assumes he has to judge me” (Spelman 1989: 266). That said, Tessman notes that anger is often a “burden”: its expression can trigger retaliation from the oppressor; it can become painfully consuming as one comes to understand the intractable nature of oppression; or it can be misdirected “at others subject to the same mistreatments as oneself” (Tessman 2005: 122; cf. Lorde 1984). In short, burdened virtues come at a steep cost to the self and do not necessarily, or even often, contribute to *eudaimonia*, the subject’s human flourishing. Rather, they emerge, become necessary, and are cultivated precisely because of the need to survive and sometimes to resist structures of stigma and oppression.

Hygienic morality, absolute candor, and other steps HIV-positive Huli women take to make others feel safe might also be considered burdened virtues. They often described their unusual practices as “rules I made for myself”; as discussed above, their discursive framing suggested a deontological slant in their approach to ethical behavior—an emphasis on rules, obligations, and imperatives. However, drawing on Tessman’s work, I think one can see their practices as virtues that come at a cost to them, and that they cultivate in order to endure their reduced, dependent, and stigmatized circumstances. Taking precautions against being perceived as *giaman olsem normal*, for example, was a virtue that enabled women to be accepted by family and community; it demonstrated to others that one was a “good” HIV-positive person who was committed to protecting others. But this virtue was heavily “burdened”: a woman had to be willing to repeatedly rehearse her difference from others through practices such as radical HIV disclosure. In essence, she had to sacrifice being “like normal,” which is what most of the women longed for, to persuade others she wasn’t trying to pass as normal. Similarly, biting one’s tongue and walking away from people who were publicly insulting one prevented an altercation that might result in one’s kin having to pay compensation, but it was humiliating and often came at a great cost to a woman’s sense of dignity.

When considering why HIV-positive women have developed these burdened virtues, two factors emerge: (1) the atomism and lack of social support they experience, and (2) the pervasive violence in Tari. As observed in chapter 5, it is notable that there are no AIDS support groups in Tari, and there have been next to no efforts to bring people living with HIV together, to enable their greater self-reliance, or to assist them in reflecting critically on their shared experiences. One question I asked everyone I interviewed was whether they knew other HIV-positive people or had HIV-positive friends, and many said that although they had met others at the clinic, they only ever saw them when they came to pick up their medication every three months. A few women expressed a desire to live with women they had met at the clinic, but none could imagine a way for this to be possible, given that they didn’t own their own houses or land. In other words, women’s material dependencies not only make them more vulnerable to HIV, but also make it more difficult for them to form networks of care once they are HIV-positive.

Some of the anthropological literature about HIV support groups has stressed how they operate as nodes in the global AIDS governmental assemblage, enforcing “the rules” of ART adherence, making access to ARVs contingent on group membership, strongly shaping the confessional narratives members tell about their intimate lives, policing each other’s conduct, and, in tandem with HIV counselling, producing obedient responsibilized patient-subjects (Colvin et al. 2010, Mattes 2011, Mfecane 2011, Prince 2012). This literature is often skeptical of support groups, despite their intended function of enabling mutual assistance and community. That said, support groups have also been analyzed as sites for combatting public and internalized stigma (Beckman and Bujra 2010, Liamputtong et al. 2009, Paudel and Baral 2015), creating greater self-sufficiency (White and Morton 2005), and forging critical consciousness-raising and solidarity (Lyttleton 2004, Robins 2006). The absence of such groups in Tari meant not only that my interlocutors typically had no friends who shared their situation, but also that they felt no sense of solidarity around the issues of HIV stigma or precarity. Rather, they usually felt very alone in their experiences of living with HIV. And, alone in their situations, and often dependent on kin, they felt compelled to prove that they were doing all they could to behave as moral HIV-positive persons who were worthy of care.

Violence also shaped women’s moral reasoning and acts. Most of the women knew about cases of violence towards people living with AIDS during the pre-ARVs era, and were aware that some kin and neighbors continued to harbor fear and suspicion of HIV-positive people. Women’s own personal experiences of violence must also be taken into account when analyzing how they understood themselves as ethical subjects. Whether raped by their husband, like Kelapi, or raped during an armed holdup of a PMV, like Sarah (see chapter 2), many of the women had been victims of sexual violence. Most had also experienced violence in their marriages, and many had experienced injury at the hands of brothers and other family members. Physical violence—whether inflicted by kin, criminals, or clan enemies—was never far away for anyone in Tari, but women were particularly vulnerable, and, because of the fear and suspicion associated with HIV, a positive diagnosis only exacerbated this vulnerability. Women living with family worried about the consequences of making household members angry (being evicted), and women living alone worried about home invasion. And, all of them were well aware that, as discussed in chapter 2, interpersonal violence could quickly escalate into “trouble”—that is, political violence—as threatened to happen in Rosina’s case (see chapter 5), when insults traded over a basketball game became a physical fight between people from different families and clans.

Dependence on family and a context of pervasive interpersonal, political, and gendered violence intersected to shape women’s moral behavior. For many, their uncertain and tenuous positions in their households forced them to think about how best to maintain others’ indulgence and care. For example, some made a point of providing as much domestic and agricultural labor as their health allowed.

Most important, their dependence and fear of violence created two overarching moral imperatives for them: (1) do not *giaman olsem normal*, and (2) do not bring “trouble” to one’s family. By following these imperatives, they hoped to avoid the possibility of punitive violence (from family) or retaliatory violence (from non-family) should they be accused of infecting others. Whether we want to call women’s allegiance to self-imposed rules a tendency to deontology or a burdened virtue, this allegiance emerged from their specific positionality of being female and HIV-positive in a context where physical violence was pervasive and there were few supports for people living with HIV/AIDS apart from family.

THE HIGHEST VIRTUE: GIVING

A number of ethnographers have analyzed the challenges of trying to live a “normal” life when living with HIV. Dominik Mattes, for example, casts a skeptical eye on global health discourses that assert that ARVs enable patients to resume a normal life, noting that in Tanzania, “‘normalcy’ entailed more than mere bodily reconstitution. It implied . . . rehabilitated social and economic relations, resumed sexual activity, and a reconstituted sense of self” (Mattes 2014: 271), all of which were almost impossible to achieve in a context of precarity and continuing HIV stigma. Mattes observes that the hallmark of “normal” life, marrying and having children, was the biggest challenge because it “confronted patients with the basically unresolvable moral dilemma that this was only possible at the cost of accepting the risk of infecting one’s partner” (283). While marriage and childbearing are also markers of normalcy among the Huli, equally important is being enmeshed in relations of giving and reciprocity. In the language of virtue ethics, generosity, the skillful expansion of one’s social networks, and acumen in contributing materially to others’ endeavors are all virtues to be cultivated through practice, self-sacrifice, reflection, and the discerning observation of how others conduct their own exchange relationships. Indeed, these could be said to be the most important virtues for *eudaimonia*—human flourishing.

Relations of reciprocity and exchange have been emphasized in the ethnographic literature about Papua New Guinea so often that its inhabitants have come to serve as exemplars of these cultural traits, “an anthology of images in and through which anthropologists have frozen the contribution of specific cultures to our understanding of the human condition,” constituting a “language of incarceration” (Appadurai 1988: 36–37). Most anthropology students are familiar, for example, with the competitive, ceremonial exchange of pigs and other wealth items in the Highlands of Papua New Guinea (Strathern 1971) or the kula ring of the Trobriand islands, in which men canoe from one island to another to exchange prized items (Malinowski 1922). Probably almost as familiar are practices of bridewealth or homicide compensation—the giving of pigs, money, shells, and other valuables to a group that has lost one of its members, whether through marriage or death.

What has been less emphasized in the ethnographic literature (but see Lederman 1986) are the little gifts—sweet potatoes, betel nut, cigarettes, fresh greens, an item of secondhand clothing, a small piece of roast pork, boiled chicken feet, flavor sachets from an instant noodle soup packet, a couple of kina, “flex cards” (mobile phone credit vouchers)—that make up everyone’s days, especially women’s. Before leaving home, most women I know try to put a few such items in their string bags, knowing that they are likely to run into friends or kin to whom they should give something, no matter how small. And this ethos of daily giving is actively socialized: the first words taught to children are *ngi* (give me) and *ma* (here, take it), which are practiced over and over with various small objects until a toddler readily gives up what she has when asked, and takes what is given to her. Children who display selfishness or lack of gratitude are told sternly that if they aren’t generous or fail to show appreciation for others’ generosity, they will “have only their own shit to eat,” a graphic reminder that hermetic individualism is pragmatically unwise and morally repugnant (Wardlow 2006). And, through witnessing their family members contribute to others’ bridewealth and homicide payments, school fees, and plane tickets, children learn that it is through this regular give-and-take that one not only forges necessary networks of assistance but also cultivates a life that is affectively rich and morally meaningful. Underlying the large, competitive, ritual exchanges analyzed in much of the ethnographic literature, in other words, is a powerful, simple message learned when young—that one must give.

These daily small acts of giving can be seen as a mode of “ordinary ethics.” Michael Lambek uses the term “ordinary ethics” (2010a and b) to signal that ethical sensibilities are intrinsic to everyday speech and action. Rather than understanding ethical decisions or acts as particular moments that punctuate the flow of normal life, Lambek sees ethical considerations as saturating this flow. Since social interaction entails the continuous, often subconscious, evaluation of others, as well as continual self-evaluation and self-adjustment to the (perceived) judgment of our actions by others, most of our social interactions, he suggests, entail ethical considerations. Moreover, “ordinary,” for Lambek, “implies an ethics that is relatively tacit, grounded in agreement rather than rule, in practice rather than knowledge or belief, and happening without calling undue attention to itself” (Lambek 2010a: 2). All this well describes Huli women’s daily practices of gift-giving.

For Veena Das, ordinary ethics are “small acts of everyday repair” or “textures of attentiveness in sustaining everyday life” (2015: 79); they are inconspicuous gestures that spare another’s dignity or create a connection across difference. Das adds that in her notion of the everydayness of ordinary ethics, “the everyday is not simply the world of routines or habits but is shadowed by doubts that can become world annihilating” (2015: 86). Much as Das says, the pervasive nature of violence in Tari—and most people’s daily unease that something brutal and frightening (a murder in the marketplace, a home invasion at night) could happen at any time—means that their lives are indeed “shadowed by doubts that can become world

annihilating.” The little gifts that serve as “small acts of everyday repair” may, of course, involve strategy and calculus, but they more often entail remembering who has been kind in the past or suffered recently from illness, upset, or loss.

The women I interviewed were often preoccupied with the ordinary ethics of how to manage their relations of reciprocity. Whether to share or keep what one had; to expand one’s networks or contract them; to invite people inside their homes or not; to cadge food and cigarettes from others, knowing one couldn’t reciprocate, or to go hungry and smoke-free—all these were dilemmas they mulled over. Their strategies for self-care often entered into these deliberations. Peony, for example, said that when her daughter had married, she had given away all of her *imane aka*, a specific item of bridewealth, usually a large sum of money, given to the bride’s mother, which she is not expected share. When I pointed out that her behavior was unusual, she said,

Yes, you are right. But my reasoning was that I am a sick woman, so I shouldn’t keep this money for myself. I should share it with my kin. Then later, if I need help because I’m sick, they will help me. It could be that later I won’t have the strength and I will need help. So it’s good if I am generous with my kin now.

In contrast, Zoli, whose daughter was also HIV-positive (see chapter 5), said that when her kin asked her to contribute to bridewealth or compensation payments she would reply,

“Oh, sorry! I can’t. I’ve got this sickness. I’m a sick woman!” I don’t help other people with this kind of thing. I just take care of myself and my daughter. How can I help them?! I just say to them, “Will I continue to live or will I die? I don’t know. So don’t ask me to help with troubles or with marriages.” That’s what I tell people.

Peony’s generosity was only partially successful, though other factors played a complicating role. When I interviewed her in 2012, she said that when she and her husband were diagnosed, they had agreed that they would renew their faith in God together, attend church regularly, and strive to be good Christians. When I interviewed her again in 2013, she was living alone and said she felt hungry much of the time: “Hunger kills me. In the evening I walk around to see who has smoke coming from their house, and then I go to their door and say, ‘I’ve come because I’m hungry.’ And they give me some sweet potato and greens.” Since our previous interview, she had burned down her husband’s house after he abandoned her to marry another woman from the AIDS clinic. Consequently, she’d had to flee his clan land, had no access to the sweet potato fields she had planted, and couldn’t easily benefit from exchange relations she had established and worked hard to maintain there.

The strategies adopted by Peony and Zoli suggest that women’s decisions about whether to give generously to others are primarily pragmatic and aimed at preserving their own lives, but women also spoke of feeling ashamed about husbanding

their meager resources rather than sharing them. Lucy, for example, told me she did not invite people into her house because she knew exactly how long her supply of tea and sugar would last if she rationed it for herself, and she had decided that being able to have this small pleasure outweighed the shame she felt about being ungenerous. Most important, many women were ashamed about being so often in the position of having to ask for care, rather than being able to give it, and about feeling unable to act as generously as they had been before becoming sick. For some this was because they tired more easily and so couldn't work as hard at agricultural labor. Others, evicted by their kin, no longer had the gardens that make possible women's generosity to each other: they didn't have produce to sell, and thus weren't able to buy the betel nut, packets of cheese twists, and other small items that sustain women's intimate ties with others. If daily generosity and the development of vibrant relations of exchange are key elements of *eudaimonia* in this context, then the inability to participate in these relations can be seen as a form of "moral damage" (Tessman 2005) caused by the material and social losses of being HIV-positive.

CONCLUSION

AIDS stigma is expressed in multiple ways in Tari—sometimes through insults, but more often through acts of neglect and refusal. It is also reinforced through the new language of "normal" in which women walk a fine line between *stap olsem normal* (living like normal) and being careful not to *giaman olsem normal* (try to pass as normal). Access to ARVs, widespread AIDS education, and the effective communication of laws like the HAMP Act have reduced fear of HIV-positive people and curtailed the violent forms of stigma that occurred in the past. Nevertheless, a tenacious dimension of AIDS stigma is a kind of moral uncertainty about the HIV-positive: can they be relied on to keep their HIV to themselves, as it were, and not infect others? This moral doubt is to some extent exacerbated by ARVs, in that they are understood as masking what would otherwise be obvious illness; they save and strengthen the body, and thereby hide the virus it harbors. This moral doubt is greatly intensified for women whose reputations were damaged pre-diagnosis by transgressive sexual practices, such as "passenger around." Moral doubt is a perception—or simply a feeling of apprehension or unease—on the part of those who presume themselves to be HIV-negative. Nevertheless, the stigma is projected onto the HIV-positive as a group and becomes their responsibility to manage, in the manner suggested by Erving Goffman (1963).

Acting to assuage others' concerns about their intentions becomes part of the moral habitus for some HIV-positive women. They disclose their status widely in order to assure people that they aren't hiding it, and then make a point of demonstrating to people that they aren't "that kind" of HIV-positive person—the kind that might spray/spread it—by presenting themselves as both the same as other

women (e.g., they sell produce at the market), but also different (e.g., they make a point of creating a hygienic buffer between themselves and their customers). This strategy works well for women like Gloria, who said she lives better now than pre-diagnosis, or Kelapi, who found work as a teacher and forged a new, loving marriage. For others, however, like Shelly, who often slept under a tarp in people's fields, these steps are not enough to overcome the sexually spoiled identities they had pre-diagnosis. AIDS stigma "feeds upon, strengthens and reproduces existing inequalities" (Parker and Aggleton 2003: 13), in this case the inequality between women categorized as good and those considered wayward (Wardlow 2006a). Gloria, for example, was perceived as a victim of her husband's transgressions and was warmly embraced by her family. In Shelly's case, a positive diagnosis only served to confirm her brothers' conviction that she was immoral. HIV was seen as just deserts for what they assumed was her previous sexually transgressive behavior.

AIDS stigma can be understood as a form of "moral damage" in that it can grievously diminish and constrain women's ability to cultivate the virtues—such as those developed through rich relations of generosity and exchange—that constitute an important element of human flourishing in this context. The practices women develop to manage other people's concerns about them can be understood as "burdened virtues"—capacities and skills that are perceived as good by others, and that enable them to manage their social relations successfully, but that come at a cost. These costs may include the disclosure of one's HIV status, when one might rather tell only family members, and the regular demonstration to others that one is not the kind of HIV-positive person who should be feared.