

MAKING SENSE OF AIDS

**Culture, Sexuality, and Power
in Melanesia**



Edited by
Leslie Butt and Richard Eves



University of Hawai'i Press
Honolulu

Contents

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 Printed in the United States of America
 13 12 11 10 09 08 6 5 4 3 2 1

LIBRARY OF CONGRESS CATALOGING-IN-PUBLICATION DATA

Making sense of AIDS : culture, sexuality, and power in Melanesia /
 edited by Leslie Butt and Richard Eves.

p. ; cm.

Includes bibliographical references and index.

ISBN 978-0-8248-3193-6 (hardcover : alk. paper)—

ISBN 978-0-8248-3249-0 (pbk. : alk. paper)

1. AIDS (Disease)—Melanesia. 2. AIDS (Disease)—Social aspects—
 Melanesia. 3. AIDS (Disease)—Religious aspects. I. Butt, Leslie, 1960—
 II. Eves, Richard.

[DNLM: 1. HIV Infections—epidemiology—Melanesia.

2. HIV Infections—prevention & control—Melanesia. 3. Health Policy—
 Melanesia. 4. Public Opinion—Melanesia. 5. Religion and Medicine—
 Melanesia. 6. Sexual Behavior—Melanesia. WC 503.4 LA1 M235 2008]

RA643.86.M5M35 2008

362.196'9792—dc22

2007048540

University of Hawai'i Press books are printed on acid-free
 paper and meet the guidelines for permanence and
 durability of the Council on Library Resources.

Designed by the University of Hawai'i Press production department

Printed by The Maple-Vail Book Manufacturing Group

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Foreword

SHIRLEY LINDENBAUM

The human immunodeficiency virus (HIV) has taken us on a hunt along paths that lead in different directions. On the one hand, we document its transmission as it moves relentlessly around the world. On the other, we follow its manifestation in local eddies. This has resulted in strategies for research and intervention that differ vastly in scale. Broad-based strategies include a call for DNA fingerprinting to pinpoint and track the global movement of various HIV strains and clades (subgroups). DNA testing has shown already that the growing HIV epidemic in the former Soviet Union comes from a new strain spread by narcotics injection, an infection method that minimizes the mutation of the virus as it passes from one victim to another. In Asia, by way of contrast, several different clades are now circulating, and molecular evidence points to HIV moving along four major routes. The first is from the forests of eastern Myanmar into Yunnan, China. A second follows the same route and continues to Xinjiang. A third travels through Laos and northern Vietnam to Guangxi, China, and a fourth from western Myanmar to Manipur, India. Africa's epidemic is said to be more difficult to track genetically because it is much older and involves many diverse strains. Since its appearance in human beings several decades ago, the virus has mutated at a very high rate. Funding to support the targeted collection of blood samples, it is said, would help scientists understand the evolution of the virus (Garrett 2005).

Given the importance of the sexual transmission of the virus, another strategy that is both imaginative and wide in scope calls for studies of differing configurations of sexual networks. A mathematical model of networks—their periodicity, density, and randomness or clustering—is said to be as important as mapping individual sexual behaviors in understanding the dynamics of transmission, incidence, and prevalence. For anthropology this involves a shift from small-scale individual behaviors to large-scale social formations, and for epidemiology, a move from statistical aggregates of individual behavior to society-level structures. Using this approach to the epidemics in Uganda and South Africa, Thornton has identified large-scale systemic processes of the sexual networks in each region, placing his findings in the context of what could be called midlevel analyses of family social structures, domestic prop-

erty regimes, and political systems. Whereas Uganda's sexual networks appear to be highly clustered with limited numbers of links between clusters, South Africa's networks appear random, revealing multiply interlinked networks that span the entire country. The implications for successful intervention are said to be profound: the structure of Ugandan networks suggests that moderate changes in sexual behavior may have disproportionate effects on HIV prevalence, while the structure of South African networks suggests that even a large behavior change will have only small effects (Thornton n.d.).

Another large-scale proposal for turning the corner on AIDS (acquired immunodeficiency disease syndrome) comes from the World Health Organization, which supports the expansion of public health campaigns in poor countries to build health care systems that incorporate both HIV treatment and prevention, including voluntary counseling and testing. This more encompassing approach, it is said, would not only slow the spread of HIV but also help to reduce other debilitating diseases, such as malaria and tuberculosis (Kim 2005). Other grand visions suggest that "development" should be aimed at bringing the poor nations into the global economy so that they may eventually derive sufficient wealth to pay for the expenses involved in coping with HIV (Garrett 2005).

Broad-based schemes for research and intervention gain wide support in the absence of an effective HIV vaccine, about which there is much current debate. Some observers have expressed their frustration by suggesting that vaccine scientists may have met their match in this adaptable foe (Horton 2004), a view contested by those who note that the world waited for more than twenty years before a vaccine against polio was finally developed. Others see promise in a recent increase in funding for research, as well as a shift in targeted lines of inquiry and the collaborative effort of the newly constituted Global HIV Vaccine Enterprise (Seth Berkley, pers. comm., 2004).

A new sense of emergency underlies the call for such far-reaching projects, voiced recently by UNAIDS executive director Peter Piot, who declared that the AIDS epidemic continues to outstrip global and national efforts to contain it and that a rapid increase in the scale and scope of HIV prevention programs is urgently needed (UNAIDS and WHO 2005). This call to action arises as the global community also begins to acknowledge the profound economic and security dimensions of the pandemic as AIDS takes its toll among men and women aged twenty to fifty years, who are workers, parents, leaders, trained professionals, parliamentarians, and members of the army and the police. Their loss threatens economic development and national security and raises the specter of widespread social disruption as different waves of infection roll around the planet (Garrett 2005). This danger is now recognized

in Papua New Guinea, which may lose a generation of young intellectuals (Pamba 2005).

Proposals for expansive strategies also identify our gaps in knowledge, especially the lack of detailed empirical data that would provide policy-makers with the information they need in order to provide effective guidance and treatment (Garrett 2005; Thornton n.d.). A recent observer of the AIDS crisis in Africa was "impressed by the level of medical expertise and depressed by the lack of moral, sociological, psychological, and cultural expertise" (Brooks 2005). The moral, sociological, psychological, and cultural dimensions of the pandemic are directly addressed by the essays in this volume. Moreover, they come at a significant moment in the history of the pandemic in Melanesia, where AIDS has but recently arrived. In many Melanesian communities, documented cases of HIV are still few or absent. Nevertheless, the pandemic is already leaving its mark. Prevention campaigns and media coverage have led to intense discussions about the danger AIDS poses to certain individuals, families, and the body politic. The authors of the present book provide us with an extraordinarily rich assemblage of ethnographic information on the current status of the epidemics in the region, the beliefs people hold about the nature of the disease, what people are doing about it or believe they should do, and the degree to which current prevention efforts are embraced or resisted. We have here a compendium of local knowledge that makes the most persuasive case for utilizing research and intervention strategies of varying scope. HIV finds its way into very diverse communities, where new forms of sociality and sexual practice provide even more avenues of transmission.

The chapters raise two themes that merit particular attention, since they are not unique to this region, and they prod us to offer some pragmatic response. The pandemic in Melanesia is not a single phenomenon but a result of a series of superimposed epidemics in different subpopulations. How, then, should prevention and intervention strategies be fine-tuned? At the same time, the global reach of commerce, the media, and new technologies shapes new desires as well as the cultural meanings and experiences of sexuality. How can adequate knowledge and protection be provided for communities in which conservative Christian beliefs, often aligned with preexisting cultural codes, adopt sin-based models of AIDS and have a negative influence on the use of condoms?

The essays here address both themes. Given the cultural and linguistic diversity in Melanesia, the authors illustrate the mismatch between well-meaning prevention campaigns, which come from cultural institutions beyond Melanesia, and local understandings and responses. In rural West New Britain, for example, people understand educational posters, created for urban

residents, to be saying something about class disparities, rural-urban differences, the dangers of modernity, and the things money can buy. A Markham Valley media campaign was thought to be about the dangers of alcohol, not AIDS, and the lone anti-AIDS poster in Manokwari, a regional town in Irian Jaya Barat, had apparently failed to persuade even the health workers that HIV could be transmitted only by contact with infected blood and body fluids.

The topic of sexuality runs through all the chapters, and it is here that we begin to appreciate the diversity and force of the cultural meanings and experiences of sexuality. The importance of virginity in Auki, Malaita, for example, has led to a "sexual subculture" among young people, hidden from the watchful eyes of parents and the wider network of relatives and friends. In the Trobriands, on the other hand, people received with interest the information about sexuality, sexual behavior, and HIV provided in various AIDS awareness workshops. Unlike the negative assessments of sexuality in the official language of HIV prevention, Trobriand sexuality expresses the value of consensual, pleasurable acts that establish important exchange relations between different clans and lineages. The problem for Trobriand society lies not in hiding sexual behavior but in the ability to fashion forms of sociality that integrate new forms of knowledge with cultural forms that have long provided social cohesion and a strong sense of cultural identity. The authors all suggest appropriate ways to modify the standard templates for AIDS intervention by taking account of the diversity of cultural beliefs and practices, especially those concerning sexuality and gender relations.

The importance of recognizing cultural difference is already appreciated in some arenas of public health. It is now generally recognized that a one-size-fits-all approach to curb smoking, for example, should be replaced by initiatives tailored for specific regions and specific ethnic groups. The sexuality/condom problem seems more intractable, however, since it reaches back to the political struggle over the origin of life and of the human species that has especially animated American culture for more than a century. The contest makes its appearance in the theological agenda of the U.S. AIDS program, the President's Emergency Plan for AIDS Relief (PEPFAR), where it has had a negative impact on the delivery of health services in Africa, since much of the money for HIV prevention goes to evangelical Christian groups that disparage condoms (Epstein 2005). Charismatic and Pentecostal Christian missions, many of them from the United States, have a marked presence in Papua New Guinea, where they contribute to the view that AIDS is a sign of God's punishment for moral transgressions. The overlap between the religious and health care spheres in Papua New Guinea has also resulted in judgmental

attitudes toward condom use, even among health workers in STI (sexually transmitted infection) clinics, as well as disinformation campaigns about the deficiencies of condoms.

The worldwide debate over the ABCs of prevention advice (A for "abstinence," B for "be faithful," and C for "condoms," the three-pronged strategy promoted to reduce sexual transmission) has in many ways narrowed the discussion of sexuality. The discussions of sexuality in this volume, however, draw our attention to a wide range of sentiments not previously encountered in Oceanic ethnography. We are told of newfound sexual pleasures, emerging scripts of romance, love marriages, new technologies and linguistic euphemisms that stimulate arousal and desire, romantic underworlds of intimacy and fantasy, as well as guilt and shame. Moreover, attitudes toward sexual behaviors and experiences are lodged in a complex of newfound pleasures, sentiments, and desires. In recent years there has been an increase in research on the centrality of the emotions in cultural life, although there is little agreement on what they are. Some suggest that they are impulses occurring entirely in the brain, that they are intersubjective, or that they are located in the social space that individuals inhabit. Sometimes they are equated with desire, and sometimes desires are regarded as one emotion among others (Asad 2003).

Where do these emotions come from? In some cases the flow of people, ideas, and sexual aids from beyond the region are said to have changed local behaviors, allowing young people, in particular, to express sexual pleasures in new ways. Pornographic material, videos, and many sexual techniques are all new to the region. Some authors propose that the engine of change comes from state policies that have introduced sex workers and legalized prostitution, or from state-sponsored mining, logging, and military operations that have created the conditions for a flourishing transvestite sex industry. Some Papuan men are said to have been drawn toward middle-class lifestyles that encourage extramarital affairs with Indonesian sex workers, who are desired for their association with the "modern" world as well as their light skin color. In contrast to reports from Africa, poverty is said to account for transactional sex and short-lived marriages in only a few cases where the contraction of the cash economy seems most severe. In many cases young people describe the compelling allurements of lovemaking, perhaps best expressed by the young Manokwari woman who wished that "sex was not so enjoyable" and by Papuan transvestites describing the power of mutual attraction. Through the chapters here, we understand the emotions as being shaped by distant forces and stimuli and by more immediate political and economic conditions, but also as lodged in the body and mind. They are, in addition, constrained and

kept in place by older cultural codes that still monitor the mingling of men and women in public and private places. Desires may depend on biological structures, but they are also fashioned in cultural and historical ways.

These discerning analyses depend on the listening ear of the ethnographer tuned to semantics of local theories of causation concerning illness, the failures of development, and the attraction of Christianity. One of the great contributions of this volume to AIDS research is the demonstration that sexual behaviors, as well as attitudes toward sexuality and gender, are lodged in cosmological beliefs about correct behaviors toward kin, ancestors, enemies, and the environment. Human activities as well as bodily substances and objects of value build and reconstitute the known universe. The Duna vision of entropic decline thus requires corrective rituals using semen, blood, pig fat, and mineral oils to counter the immoral behaviors that have led to the depletion of fertility in people and in the ground. Huli visions of AIDS as God's punishment elicit a package of causation that includes a rise in crime, economic deterioration, the increase in transactional sex, political corruption, tribal conflict, and a general sense of moral decline. We can now begin to understand why condoms, the incorrect mingling of women and men in the marketplace, or women wearing trousers might seem to be a threat to an entire cultural edifice. Resistance to the use of condoms in Melanesia, and perhaps elsewhere, is not merely a local manifestation of the distance between rational, scientific explanation and religious conviction but a statement about the cultural principles underlying knowledge and conduct.

The authors' recipes for intervention, which take account of local understandings and contexts, in many ways mirror the complex knots of causation their ethnographic explorations have uncovered. They also avoid the Western assumptions and moralities about human sexuality often found in international approaches to HIV prevention. Research on AIDS has broadened the range of methods anthropologists bring to their studies, as well as the disciplines with which they interact. Several studies point to the value of combining midrange surveys of behavioral surveillance with ethnographic data collection in order to explore the reasons for the secrecies that affect young people's vulnerability to HIV infection. In some cases focus groups were found to be useful, as was the recruitment of youth researchers who could discuss with their peers the dynamics of negotiations in clandestine sex. Productive relationships among clinical, epidemiological, and anthropological investigations, also reported in this volume, have resulted in multisite, multimethod investigations. This mix of strategies and scales of research appears to overcome some of the challenges anthropologists conducting research on sexuality have faced during the past decade.

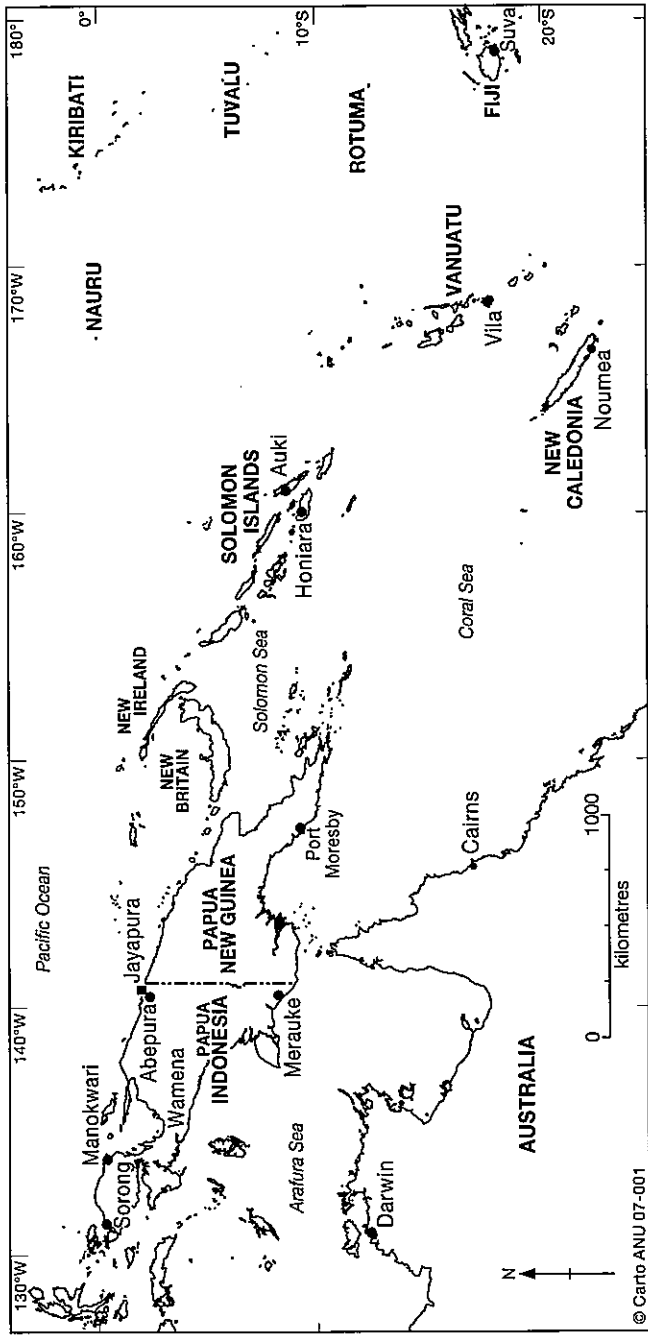
These fine-grained ethnographic studies tell us that in order to trace the long-distance and more intimate routes of viral transmission, we need to examine the nodes of connection between local cultures and the development projects and commercial markets that introduce goods, ideas, and new forms of personal expression. These imports do not enter unoccupied space but become integrated with older concepts that still endorse relationships with others and hold to notions of socially embedded personhood. Differences have thus arisen over new fashions and social arrangements, aggravating older tensions among the generations and between women and men. The perceived threat of AIDS also calls forth disparaging views about town life, people from distant regions, ethnic others, and sex workers, who are variously seen as vectors of disease, agents of immorality, and rivals for scarce resources. In addition, many young people are drawn to taste new pleasures and to sample new social relationships, suggesting that for many of them Western modernity has come to represent the exotic.

The essays in this volume make us appreciate the value of research methods that provide a shift in focus. From a global view, we see an emerging pandemic in which Melanesia appears to be but a regional version. Moving closer, we see that Melanesia consists of many little epidemics shaped by different cultural conceptions of danger, desire, morality, and visions of the future that the larger view left blurred. We also see that the global flow of information need not be unidirectional. Our ability to confront the pandemic in Melanesia depends on the mutual transfer of cultural knowledge.

Acknowledgments

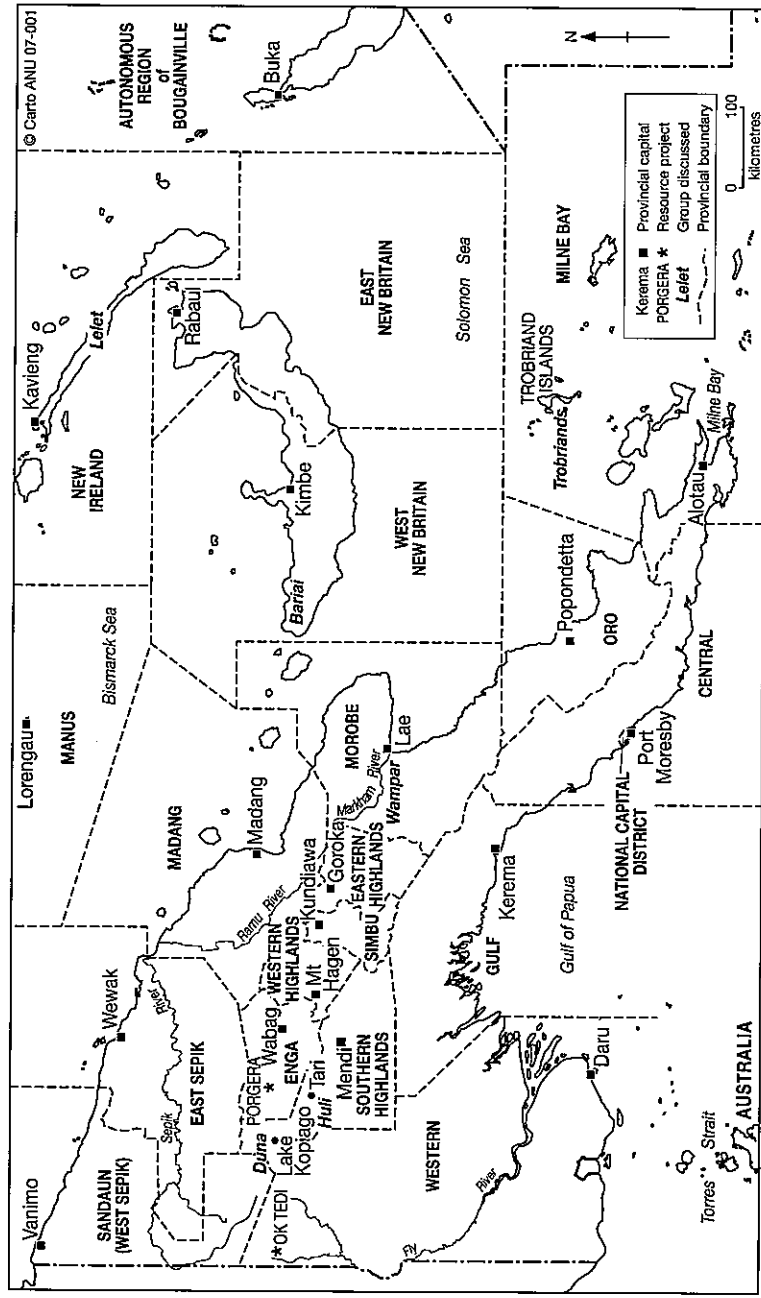
This book grew from the session we convened on “AIDS in Oceania” at the annual meeting of the Association for Social Anthropology in Oceania (ASAO) in Hilo, Hawai‘i, in February 2005. We are grateful to the Pacific Islands Scholars Fund at ASAO, Canada’s International Development Research Centre, and the Offices of the Dean of Humanities and the Dean of Social Sciences at the University of Victoria (UVic) for generously subsidizing the travel costs of some participants from the Pacific who would otherwise not have been able to attend. We acknowledge the further generous support of the United Nations Population Fund (UNFPA) in Port Moresby (organized by Duah Owusu-Sarfo), the Gender Relations Centre at the Australian National University (ANU), and the Office of International Affairs at UVic, which made a less expensive edition possible. We are grateful to the two reviewers of the manuscript, who gave us wise advice on enhancing the volume and enthusiastically supported its publication. We are most grateful to Roe Sybylla for her perceptive substantive editing, which has greatly improved the volume, and to Rosemary Wetherold for her meticulous copy-editing. Jenny Sheehan of the Cartography Unit at the Research School of Pacific and Asian Studies (ANU) prepared the maps. Micaela Campbell ably translated the chapter by Jack Morin. Richard thanks the Australian Research Council for fellowship and research funding, provided through the Oceanic Encounters Discovery Project, and Roe Sybylla for her intellectual and moral support over many years. The Centre for Asia-Pacific Initiatives at UVic provided a Faculty Fellowship for Leslie in 2004–2005, which provided the space and the time to conceptualize this volume. Leslie thanks Heidi Tyedmers for crucial assistance during the fellowship and Malcolm Blanchard and Ken Clarke for unconditional patience and support throughout.

Leslie Butt and Richard Eves



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MAP 1. Melanesia.



MAP 2. Papua New Guinea.

Introduction

RICHARD EVES AND LESLIE BUTT

So far unparalleled in magnitude, perseverance, and range, the AIDS pandemic may be the greatest public health disaster ever.¹ Though HIV has already made its way to all corners of the world, reaching places that in the past would have been spared because of their isolation, its full effects are yet to be felt. Until more successful means of dealing with it are found and implemented, it will continue to devastate future generations. Like the Black Death, AIDS has become inscribed in the popular imagination. As Herdt and Lindenbaum suggest, this disease has come to signify our era: we are living in the time of AIDS (1992). The pandemic is disrupting the ways that people live and organize their lives, “changing not only individual lives but also the trajectories of whole societies” (Barnett and Whiteside 2002, 13).

One corner of the world where HIV arrived comparatively late is Melanesia, but the virus has quickly gained a foothold almost everywhere in the region. Both countries of the island of New Guinea are now considered to have a generalized epidemic.² Predictions for Papua New Guinea appear catastrophic, with Shigeru Omi, World Health Organization regional director for the West Pacific, having warned that one million people could be infected within ten years (Millikin 2004).³ The picture for Papua is similarly bleak, with a World Health Organization report finding that 2 percent of the population is infected with HIV, twenty times the national average for Indonesia (Reuters, February 17, 2007). The apocalyptic tone of some predictions may provoke a cautious reaction, especially when the unreliable nature of the prevalence data is known, but the very real need for the pandemic in the region to be seriously and competently addressed cannot be overstated.

Melanesia is part of the wider region of the Pacific, or Oceania, an often neglected part of the world, but this neglect desperately needs to be con-

fronted as part of the worldwide response to AIDS. Although this volume has been able to attend only to Melanesia, we hope that some of the lessons it contains will be taken up as relevant to the wider Pacific and that it will encourage further research. Part of the reason for the neglect of the Pacific is that it is so often seen as vast, empty, and uninhabited. As one early commentator remarked, the Pacific is so vast that “the human mind can scarcely grasp it” (cited in Finney 2002, 38; see also Lockwood 2004, 10). For many, the Pacific appears as an “immense inconvenience” to those on the rim, a mere barrier to commerce, and indeed the study of HIV/AIDS in the wider region has concentrated on Asia and Southeast Asia (Finney 2002, 46). For example, at the Seventh International Congress on AIDS in Asia and the Pacific in 2005, only a handful of papers examined countries in the Pacific, while hundreds examined the epidemics in Asia. Also, the Joint United Nations Programme on HIV/AIDS (UNAIDS) brackets the two regions together under the label “Asia-Pacific,” an unfortunate move that relegates the Pacific to the position of lesser, neglected cousin.⁴

To call attention to the movement and the mingling of the inhabitants of this large area over many centuries, Hau’ofa speaks of the Pacific as a “sea of islands” rather than as “islands in the sea” (1993, 7, 8). This prioritizing of the spaces inhabited by people who travel emphasizes the interlinked nature of these island nations, whereas the alternative stresses the vast region of water in which the lands are simply isolated specks. And indeed, just as the peoples of the Pacific have long been moving and mingling, HIV is now following the same course.

Still, despite its many similarities and interconnections, the region of the Pacific is marked by considerable cultural and linguistic diversity, in fact more than any other region in the world, with well over a thousand languages and corresponding cultural groups. The region is generally divided into three broad cultural areas—Melanesia, Polynesia, and Micronesia—although these, too, contain great cultural and linguistic diversity.⁵ There is also considerable historical diversity in the region—different forms and experiences of missionization, conquest, colonialism, economic development, introduced disease, nation-states, globalization, and modernity. This is not to deny the commonalities of history and culture that exist, but rather to warn that, in seeking to address the specific epidemics in each country, generalizations are likely to be off target, whereas careful attention to the specifics of local societies and cultures is far more likely to produce workable solutions and achievable results.

Given that Melanesia is at the epicenter of the pandemic in the Pacific (see map 1), it is appropriate that this volume deals with this region. Our con-

tributors have drawn on a number of countries here, including the Solomon Islands, Vanuatu, New Caledonia, Papua New Guinea, and the province of Papua in Indonesia (previously known as Irian Jaya).⁶ Even this smaller part of the Pacific is not homogeneous. Of course many broad similarities exist—for example, in customary ways of life, the influence of Christianity, histories of colonialism, and resistance to current forms of neocolonialism. Melanesian approaches to the AIDS epidemic also have common features—*kastom*, or “tradition,” for example, has considerable authority in shaping responses. Newfound perceptions concerning the spread of HIV, such as the belief that condoms are only fifty-fifty reliable, are often widespread, as are some ideas about contagion and risk—for instance, that HIV can be contracted through kissing, through touching clothing, and through deliberate government scheming to infect populations. Common also is a lack of understanding of the distinction between HIV, the causal agent, and AIDS, the disease syndrome that may be its outcome.⁷ Poor-quality and inept official responses are also widely shared experiences.

However, as with the wider Pacific, the effort to control the epidemic would be seriously impaired if these commonalities led to the easy assumption that the whole of Melanesia can be treated as one. Even within Papua New Guinea (see map 2), each of the approximately 850 language groups, and even smaller groups within these, has its own set of cultural beliefs and practices, sometimes widely disparate. It is hardly surprising that there are significant differences around the issue of AIDS across the region, from localities where prevention measures have been accepted readily enough, to others that have their own unique interpretations. Because of these differences, and because the epidemics in Melanesia are occurring to varying degrees and in many different conditions, AIDS is made sense of in many different ways. Since the higher rates of infection in Melanesia are most likely a harbinger of what is to come in the rest of the Pacific, we hope that this record of Melanesian experiences can assist, though not delimit, planning and response in other parts of the region in the future.

In this volume, we seek to show how the particular course taken by an AIDS epidemic is shaped through relations of power, which act upon, and react with, the particular local forms of culture and sexuality. The systematized kind of power we are referring to has strategic effects; it establishes the modes and methods of conducting life and the knowledge and truths through which people make sense of their world and themselves. “Power” is the operative term in our subtitle because it is constitutive of the forms of culture and sexuality that exist in any particular society.

Beyond the Biomedical

As is often pointed out, epidemics are social processes in that their biological and sociocultural profiles are shaped by their particular political and cultural circumstances (Lindenbaum 1998, 36). Political economy, social relations, and culture all have a bearing on the spread of the infectious agents that move along the “fault lines” of society, the sites of particular vulnerability (Schoepf 2001, 336; Lindenbaum 1992, 323). Thus, HIV/AIDS is not simply a biomedical phenomenon—if only it were, for then it might be so much easier to deal with! We suggest that it is far better thought of as a complex biosocial occurrence (Ellison, Parker, and Campbell 2003, 2; see also Treichler 1999). Much as other incoming trends, beliefs, and practices are reshaped within different cultures, diseases are also changed when they appear in different cultures.

We are not speaking here of changes in the pathogens that cause disease, in this case the virus, but rather of how AIDS is understood, accounted for, acted upon, and experienced in localized contexts. For example, the language used, the meanings attached to AIDS, how it is positioned in relation to local conceptions of illness, death, and misfortune, and how it relates to local and imported conceptions of morality are all culturally various. Since culture is the “ordering principle . . . of organized human collectivities,” how an understanding of AIDS is incorporated into any society depends on the values and practices of that society and its cultural frameworks (Boggs 2004, 189; see also Abu-Lughod 1991; Brumann 1999; Sahlin 1999). How, and to what degree, a cultural framework establishes its own stamp on a new phenomenon such as AIDS varies, and the same applies to the incoming information, which imposes its stamp with varying degrees of success. In other words, this is a mediated process in which the languages of AIDS and culture interact in dialogical and mutually constitutive ways to produce something new and unique. For example, Christine Salomon and Christine Hamelin, in this volume, describe how AIDS has been appropriated into existing categories of sickness and contagion in New Caledonia, a dynamic process that has developed along with the rapidly changing political scene. Nicole Haley also reports how the Duna speakers of Lake Kapiago in Papua New Guinea have assimilated their experience of AIDS into their own cosmological conception of entropic decline.

Since the epidemic is in relatively early stages in Melanesia, most of our accounts here are of cultural understandings built on incoming information of various kinds, from official to rumor, rather than on direct experience (see

Farmer 1994, 801). When Maggie Cummings (this volume) carried out fieldwork in Vanuatu, in the absence of any diagnosed cases of HIV, AIDS was discussed in what she calls gossip mode—speculations about what kind of person might eventually be responsible for “setting off the ticking time bomb.” Similarly, Bettina Beer (this volume) found that her Wampar respondents had heard of the disease from assorted sources but had no direct knowledge of it.

That the accounts presented here are not derived from people who have direct experience of AIDS is not an intentional omission on the part of the editors. So far, few researchers have had the chance to focus on the unfolding epidemic in situations where they can document and analyze the transformations in cultural understandings that experience might bring. Neither has there been much scholarly collaboration between the kinds of academic researchers represented here and AIDS activists or people living with HIV. We see these as important areas for future research.

Culture and the Politics of the AIDS Industry

As we have already intimated, the concept of culture is not straightforward. Although our work here focuses largely on how culture is realized locally, the authors are also working with ideas about how they themselves conceive of it. This is often implicit in their texts rather than explicitly stated, but the theories of culture that emerge from these chapters are eminently more complex than those currently in use in the institutional campaign against AIDS, often referred to as the “AIDS industry.” This is Altman’s term for the institutions and discursive frameworks that set the agenda for defining, managing, and controlling AIDS; it includes “individual states; international agencies; transnational pharmaceutical companies; particular academic disciplines . . . and NGOs” (1998, 235). This is a specific instance of those dominating forms of modern knowledge and rationality that Foucault recognized and described as “globalising discourses with their hierarchy and all their privileges of a theoretical [vanguard]” (1980, 83). Though others have mobilized and challenged the institutionalization of approaches to AIDS, two groups nevertheless dominate the entire response—“those who control the science and medicine . . . and those in government who decide the allocations of resources to the HIV/AIDS programmes and organizations, both governmental and non-governmental” (Altman 1998, 235; see also R. G. Parker 2000).

Although globalization has brought an awareness of belonging to a larger collectivity and of being vulnerable to global risks such as HIV/AIDS, it has not made people the same the world over. Melanesian cultures are remark-

ably resilient under the winds of change—they bend, absorb, and expand, and do not disappear to become identical with the rest of the world. The AIDS industry, however, appears to operate under a misapprehension about this, since virtually uniform strategies for stemming the pandemic have been instituted everywhere. Despite declarations that primary health care should reflect and evolve from the “economic conditions and sociocultural and political characteristics of the country and its communities,” and that health promotion “strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems,” these good intentions have not really been embraced in relation to AIDS epidemics.⁸ Slogans such as “One World, One Hope,” used at the 1996 International AIDS Conference, for example, demonstrate that a unity that denies cultural diversity is, at best, assumed and, at worst, being imposed.

Although the late arrival of HIV in Melanesia meant that it was possible to learn from experience, the effort there is set up according to the criteria of the Global Program on AIDS within the framework of global mobilization involving science, governments, and agencies, which generally replicates the mistakes made elsewhere. This usually involves little more than an unquestioned importation of materials largely developed in and for other contexts. Despite an increasingly large literature that questions what Elizabeth Reid has felicitously called “briefcase concepts,” the importation continues of these ready-made and portable languages and tools that are carried anywhere an expert travels (pers. comm., 2006).

The strategies for stemming local epidemics, such as the ABC campaigns (A for “abstinence,” B for “be faithful,” and C for “condoms”) and the social marketing of condoms, are drawn from the authoritative, globalized discourses carried in the official briefcase.⁹ These strategies are meeting with small success in Melanesia, where prevention messages do not coincide with the cultural realities—a poster exhorting men to look after themselves is unlikely to be effective in a region where assertions of masculinity are so marked. In another example of mismatch, Beer cites how an early HIV prevention video showing married men drinking with prostitutes was interpreted as a warning against drinking alcohol. More worryingly, Naomi McPherson (this volume) tells how National AIDS Council posters and other prevention efforts were misconstrued in rural West New Britain. There people understood an educational drama to be explaining that HIV/AIDS exists in towns but not in villages and that women transmit the virus to men but not vice versa. In failing to relate to the local people accurately and sensitively, prevention campaigns can encourage the already appealing belief that HIV/AIDS is

a problem belonging to other people or to people who are already regarded negatively, in this case women in general.

Even though the new *Pacific Regional Strategy on HIV/AIDS 2004–2008* appeals for the recognition of diversity—for an approach that “feels and smells like the Pacific,” as Katherine Lepani (this volume) reminds us—far too little heed is paid to the cultures of the region in formulating responses. Indeed, some very sophisticated analyses of sexuality and gender in Melanesia have been published, but they are not being used by policy- and decision-makers to make sense of the epidemics there. As Pigg suggests, while there is often a recognition in the international templates of the AIDS industry of the need to adapt materials to local cultural circumstances, this injunction “conveys the neutrality—and hence natural universality—of the frameworks and the information they contain by relegating cultural difference to a problem of fine-tuning information delivery” (2005, 47). Local understandings, explanations, and meanings that deviate from Western or scientific forms of knowledge cannot find a place in health education and HIV prevention messages, because these are the “misconceptions” that the messages are meant to correct (Pigg 2005, 47). Generally, culture is seen as a category that explains why the epidemic is difficult to halt. It has become an important explanatory term in specialist and popular literature on AIDS, being seen as an impediment that needs to be broken, rather than something to be positively harnessed (see Taylor 2007).

Forgetting that “knowledge is fundamentally a social product that often incorporates ideological elements,” and though believing that open-mindedness is desirable, many AIDS workers unthinkingly retain their own norms (Bibeau and Pederson 2002, 164). Culture, in that case, is what inspires deviation from unquestioned standards of behavior. This applies particularly to the norm of monogamy, which, it so happens, is also understood to be the best protection against HIV infection. Such a neat correlation calls for some soul searching. Long-standing customs such as polygyny or premarital sexual relations are also frowned on and labeled less safe, whereas a fully impartial approach might simply promote the practice of safe sex. The production of disapproved categories of sexual behavior that ignore local knowledge of reproduction, local valuing of procreation and lineage, and local power structures is uncomfortably close to scientific racism (Bibeau and Pederson 2002, 156; Butt 2005a, 421).

As O’Manique remarks, “Certain approaches predominate not because they necessarily offer the most comprehensive framework for understanding AIDS, but because of the power and legitimacy of the institutions from which they emerge, and society’s faith in their analyses” (2004, 4). The understand-

ings produced, and their translation into practice, are not value-free; while some questions do get raised, they are not effectively answered, and others are not asked at all, such as a “consideration of how broader economic and social forces contribute to both the shape of emerging epidemics and the policy response” (O’Manique 2004, 17; see also Paluzzi and Farmer 2005). Many of these shortcomings continue despite an extensive critical literature questioning the helpfulness of models that ignore context, whether social, economic, or cultural (Barnett and Whiteside 2002, 73).

Commonly, the AIDS industry uses conceptions of human behavior that are thoroughly Western and fit remarkably well with the political philosophy of neoliberalism, which is recasting economic, social, and political life across the globe. This philosophy sees the world through the lens of the market and, correspondingly, considers every human being as properly an entrepreneur managing his or her own life. Neoliberalism “posits that the rational, isolated individual is the fundamental unit of society, and the market, the natural and just distributor of societies’ needs” (O’Manique 2004, 7). This narrow philosophy is unable to deal concretely with lived social realities, failing to recognize that people are enmeshed in webs of social relations that unavoidably set limits on options.

The theoretical models in the AIDS industry briefcase include the health belief model, the theory of reasoned action, and social learning theory, which predict that changes in behavior will follow changes in knowledge, belief, and attitudes. Behavior is understood through a rationalistic lens as readily enough changed in the light of well-presented information. Such theories have been widely criticized for assuming that individuals routinely assess risks from a narrow rationalistic point of view and participate in social interactions free of duress or the influence of structural factors (R. G. Parker, Barbosa, and Aggleton 2000; Herdt and Lindenbaum 1992; Pigg and Adams 2005).¹⁰ It is further assumed that wise advice enables people to change, and failure to do so “is seen as a function of failure of understanding or failure of will or of both” (Frankenberg 1994, 1326).

Accordingly, HIV prevention campaigns have focused largely on changing individual behavior. In the Pacific, this has meant changing sexual behavior, since that is considered the essential problem there. Studies using these theories attempt “to construct a science of sexual behavior valid independent of vagaries of time and place” (Parker, Barbosa, and Aggleton 2000, 3). As Holly Buchanan-Aruwafu and Rose Maebiru show (this volume), studies based on such abstract and individualist frameworks do not pay serious regard to what sex means to the parties involved, the contexts in which it takes place, the structure of sexual encounters, or the sexual cultures present in particular

societies (see Parker, Barbosa, and Aggleton 2000, 6). When these factors are given attention, behavior-based categories such as MSM (men who have sex with men) and CSW (commercial sex worker) no longer appear universal or even applicable to specific situations (see Dowsett 2003).

Much money has been poured into behavior change programs that have raised awareness about HIV/AIDS without much impact on behavior. Numerous studies have pointed out that people often have unprotected sex with many partners despite knowing how to protect themselves (Campbell 2003; Campbell and Cornish 2003). Further, innumerable studies have stressed that conscious, individual control over sexual behavior is constrained by a host of factors over which individuals have little, if any, control (Ellison, Parker, and Campbell 2003, 5). Rarely is it understood that risk itself may be a rational choice in some circumstances. Several chapters in this volume show how women often have little choice in negotiating condom use and are often subject to sexual violence and coercion. As Sarah Hewat (this volume) points out, in assessing whether to engage in safe sex, people’s thinking is informed not only by the possibility of infection but also by their diverse values, concerns, and experiences. Even though major agencies sometimes recognize that the circumstances need changing—most evident in the rhetorical statement that HIV/AIDS is a development issue—the same agencies continue to insist on economic policies, such as structural adjustment programs, that seriously undermine initiatives to improve the livelihoods of people in the developing world (see Lewis 2006; Poku and Whiteside 2002; Pfeiffer 2004; Paluzzi and Farmer 2005). Many authors in this volume point to the seriously deteriorating health and social services that are impeding efforts to stem the spread of HIV in parts of Melanesia.

The recognition of context is greeted not only with lip service but with an ever more fixed focus on “risk” behaviors—on risk groups, risk areas, and targeted risk behaviors, which have been widely criticized in the social science literature (Dworkin 2005; Haram 2005; Kane 1993, 1998; R. G. Parker 1995, 2001; Schoepf 2001). Epidemiological understandings of risk, and of categories such as “risk group,” “high risk,” and “low risk,” involve gross oversimplification and are biased toward targeting marginalized groups (Ellison, Parker, and Campbell 2003, 14). Further, categorization tends to erase the differences among people who are assigned to “risk groups” (Schoepf 2001, 338). As Hewat says, “Imagining risk as a characteristic of group membership conceptually eliminates the varied dimensions of identity as well as the multiple concerns in people’s lives.” Perhaps even more worrying, the language of risk groups “nourishes the illusion that AIDS is a disease of the marginal or foreign, from which the majority of the population is ‘safe’” (Beer, this vol-

ume). Reinforcing this othering, such categories often bear subtexts of moral and social deviancy.

Culture and “Tradition” Encounter AIDS

One objection to a focus on culture in research is that it readily becomes synonymous with race. Also, particularly when used as a noun, it seems to imply that culture is unchanging, “some kind of object, thing, or substance, whether physical or metaphysical,” with a rigidity it was originally formulated to avoid (Appadurai 1996, 12). In the Pacific, many people have reified notions of culture, heavily inflected with ideas of racial and ethnic difference. As Brumann has remarked, “Whether anthropologists like it or not, it appears that people—and not only those with power—*want* culture, and they often want it in precisely the bounded, reified, essentialized, and timeless fashion that most of us now reject” (1999, S11).

Idioms to express the idea of traditional culture have emerged and become popular in the Pacific—for example, the Fijian *vaka vanua* (the way of the land), the Samoan *fa’a Samoa*, and the Melanesian *kastam* or *kastom*. An extensive literature also exists, exploring how and why these terms are being used, in particular how tradition is being creatively constructed today (see Jolly and Thomas 1992; White and Lindstrom 1993).¹¹ While some of these assertions of cultural identity are constructed in opposition to colonialism, they also lend themselves to deployment against other groups within the nation-state and can produce or heighten tensions.

Tensions between different cultural and language groups have become critical issues in the Pacific, having brought violence, discrimination, and even the overthrow of elected governments, as in Fiji and the Solomon Islands. Some of these tensions arose during the colonial period, and some have been aggravated by the destabilization produced by globalization (Lockwood 2004, 29; Castro and Farmer 2005, 54–55). However, some communities tended to assert forms of cultural distinctiveness prior to colonialism, identifying neighbors and other cultural groups negatively as cannibals, witches, or just plain stupid (Nash and Ogan 1990; Hau’ofa 1993, 3; Linnekin and Poyer 1990). Today assertions of cultural distinctiveness are increasingly being made in the face of threats like HIV/AIDS, which is often deemed to have come from particular other groups or places. This is especially evident in Beer’s chapter, which describes how the Wampar, in an effort to maintain their Wampar-ness in the face of increasing migration, single out incoming migrants as outsiders and the source of HIV. Leslie Butt (this volume) also reports this for Papua, where migrant sex workers from other parts of Indonesia are blamed and

persecuted for introducing HIV to specific indigenous groups. Elsewhere in Melanesia, white people are often seen as the source of infection; in New Caledonia, as Salomon and Hamelin explain, AIDS was originally seen as something that afflicted European others—in this case the French colonizers. In Vanuatu also, says Cummings, HIV/AIDS is seen as foreign, one aspect of the broader changes of modernity that threaten to erode and even destroy *kastom*. In the Solomon Islands, there is a phrase in the Kwara’ae language that is used quickly and quietly in warning if one local person sees another with a European: “*AIDS te taknin*” (Watch out, whites have AIDS) (Clive Moore, pers. comm., 2006). Historically, epidemics have been accompanied by waves of prejudice and persecution, and the ethnographic examples in this volume show this is true of Melanesia today (see Frankenberg 1994, 1326; Brandt 1985, 1988). Haley, for example, describes how increasing anxiety in the context of AIDS and unexplained deaths is leading to witchcraft accusations and torture, with horrific consequences. Though she tellingly demonstrates that the link between the epidemic and suspicions of witchcraft is neither simple nor straightforward, it remains true that women bear the greatest burden of blame.

The fears aroused by the epidemic can intensify the politics of identity and its deployment for political purposes. Haley, for example, shows how the assertion, by an aspiring politician in a letter to a national newspaper, that AIDS sufferers should be stigmatized and crushed to death is not simply bigotry. Rather, it is a carefully crafted appeal to his electorate’s unique understanding of the world, a good example of culture being harnessed for political reasons. Butt’s chapter also shows how discourses about AIDS are brought to bear on the struggle for independence from Indonesia and used in the political maneuvering of emerging elites. Similarly, rumors and stories about AIDS may be harnessed both nationally and locally to promote particular moral or political agendas—for example, rumors of sexually aggressive women who have sex with men and then leave notes welcoming them to the “AIDS club” (see Niehaus and Jonsson 2005; Goldstein 2004). More broadly, whether aimed at migrants, women, the people in the next village or province, or those who do not conform, AIDS rumors are one of the ways in which negative “others” are constructed, often with very unpleasant consequences.

Global Flows and Cultural Change

Most Melanesians continue to live in relatively isolated places where they have long-standing historical connections.¹² As we have already intimated, these are not unchanging worlds, for all cultures are “contested, temporal,

and emergent” and they are situated, and always have been, in an interconnected world in which people, objects, and ideas are shifting and refusing to stay in place (Clifford 1986, 19; see also Gupta and Ferguson 1997, 4; Hannerz 1996, 18).

However, in today's world, global flows of capital, commodities, technology, people, ideas, and diseases are circulating on an unprecedented scale (Hannerz 1996). Global flows in the past have usually carried negative consequences, including the spread of disease, and today's globalization is little different, producing conditions of disruption and poverty that encourage the spread of HIV. AIDS is bringing global inequalities into sharp focus, for while many epidemics of communicable disease cut democratically across divisions in society, as Lindenbaum (1992, 323) has suggested, the pandemic is being experienced at its worst in the poorest parts of the world, such as sub-Saharan Africa and South and Southeast Asia (Barnett and Whiteside 2002, 24; Johnson 2005). Likewise in the Pacific, the effects of HIV are being felt most heavily in the poorest countries, mainly in Melanesia, where there is widespread poverty, poor health, unemployment, and rural-urban migration. In Papua, the fastest increase in infection is in the town of Timika, home to the large Freeport-McMoRan mine. Papua New Guinea, where the epidemic is probably greatest, also has large resource projects and is characterized by increasing poverty.

Women often bear the brunt of these developments, and indeed there is an increasing feminization of the epidemic in the region. Salomon and Hamelin argue that, in New Caledonia, Kanak women's chances of contracting HIV are linked to culturally inscribed gender inequalities, poverty, and educational levels. These factors, along with sexual violence, create a climate of vulnerability that encourages or enforces risk-taking behavior. As Beer also explains, landless migrants have no choice but to engage in the exchange of sex for money or goods in order to survive, and so are potentially exposed to infection. Migration of workers to large resource extraction projects also dislocates social and marital relationships. Haley argues that the failure of health and other services in Papua New Guinea not only leads to transactional sex and a proliferation of polygynous and often transient unions of women with men employed in the mining sector, but also affects the way that the epidemic is received and understood. Similarly, Holly Wardlow (this volume) finds that the Huli in the Southern Highlands, like the Duna discussed by Haley, feel abandoned by the government as services continue to decline. There, as in many other places, the economic downturn has increased the pool of women willing to exchange sex for money or other favors.

Religion and the Epidemic

Christianity is the most pervasive and influential of the religions in the Pacific, a vital part of the framework through which most people make sense of the world.¹³ It is impossible to think about Christianity in Melanesia without the question of power springing to mind, for this religion has remarkable influence there. In Papua New Guinea, for example, almost 97 percent of the population define themselves as Christian, and the majority of these take their beliefs seriously (though this does not mean that they are always in conformity with them). It is through this widespread and often unquestioning acceptance of its authority that Christianity comes to play a major role in defining the parameters of the response to the AIDS epidemic. Of course, religions wield huge power the world over, but the key question is, exactly how is this realized in locally specific contexts? Power, after all, is a name we give to a “complex strategic situation in a particular society” (Foucault 1981, 93).

Unfortunately, we are unable to answer this question in any depth here, for scholars have not generally taken Christianity seriously in Melanesia. Despite a general recognition of its importance to the people, its role in governmentality has not been studied, the reciprocal effects between Christian beliefs and the AIDS epidemic have scarcely been looked at, and no scholarly study of any of the churches' reactions to AIDS has been made. Another sign of this inattention is an overinclination to use the generic label “Christian” rather than recognizing the significant differences in values and practices between denominations. Several of our contributors have begun to address some of these shortcomings to show how some faith-based organizations understand HIV/AIDS and are responding to the epidemic.

The churches have responded to AIDS in widely different ways in Melanesia. On the positive side, some mainstream churches took the lead early, tackling the issue while it was still largely ignored by governments. These more enlightened churches have been especially active in Papua New Guinea, where they have allied with funding agencies and have used assistance from the parent churches from which they grew. In Melanesia and the wider region, religion-based nongovernmental organizations (NGOs) and church development organizations, such as Save the Children and World Vision, are making valuable contributions to HIV prevention and care. A number of churches have challenged the punitive approaches taken by some Christians (Bouten 1996, 220; World Council of Churches 2004). For example, at the Pan Pacific Regional HIV/AIDS Conference in 2005, Bishop Qiliho of the Anglican Church in Fiji argued strongly that being HIV-positive was not a sin and that

Christians should stand up for “the marginalised and excluded and care for them, fight for them for justice” (*New Zealand Herald*, October 27, 2005; see Qiliho 2005).¹⁴ In Papua New Guinea, religious organizations are taking a lead in caring for people living with HIV, often with funding from the Australian Agency for International Development (AusAID) or other development organizations.

However, these progressive approaches toward HIV/AIDS by some religious groups are being heavily challenged by the adherents of the innumerable new fundamentalist Christian groups and churches, especially those of a charismatic and Pentecostal persuasion, which have appeared in Melanesia and the wider Pacific in recent years (Robbins, Stewart, and Strathern 2001; Ernst 1994). Many of the long-established churches are losing members to these more intense new groups, and some of these churches have adopted similar beliefs. With their emphatically dualistic schema of right and wrong, good and evil, sinner and righteous, these fundamentalist forms of Christianity are having a profound effect on approaches to the epidemic in many parts of the Pacific. Their focus on personal salvation means they have little interest in charitable works, in contrast to the more established churches, which maintain their long history of involvement in education and health care in the Pacific (Hauck, Mandie-Filer, and Bolger 2005). Some fundamentalist groups are making the extreme claim that the way to cure AIDS is simply to appeal to God. While the accounts in this volume (Eves and McPherson) draw on examples from Papua New Guinea, such claims have been made elsewhere; in Fiji, for example, religious groups claiming that they can cure AIDS have persuaded some people to abandon antiretroviral treatment (Rob Condon, pers. comm., 2005).

Worryingly, the fundamentalist moral agenda and worldview are increasingly dominant.¹⁵ Several of our authors show how widely AIDS is understood to be the “wages of sin” in Papua New Guinea. For the New Ireland Pentecostals discussed by Richard Eves, AIDS is a big stick God uses to chastise sinners, and a warning sign that people must mend their immoral ways before it is too late. Wardlow’s Huli also see AIDS as a “stern wake-up call from God: become good Christians or face the consequences.” This retributive view is widespread in the region, although some countries are surprisingly free of it. In the Solomon Islands, though it has been raised in the past by the South Seas Evangelical Church, it is not often evident in public discourse today. One possible reason for this, suggests Buchanan-Aruwafu, is the small number of HIV-positive cases there, which means that AIDS is still identified with foreigners (pers. comm., 2006; see also SIG MHMS and Oxfam 2004, 125–127).

While many of the mainstream churches have “softened their approach” to allow prevention methods previously condemned, this is not necessarily the case with their followers (Kidu 2005; see also Iniakwala 2005). Wardlow argues that disagreements over the strategies and policies of HIV prevention have galvanized a postcolonial Christian nationalist discourse. Some Christians have taken a lead in defending their country’s moral values, condemning both sexual activity outside of marriage and the prophylactic use of condoms. The pious sentiments of government health workers influence not only the health messages conveyed but also access to health resources. In some places, health workers have refused to distribute condoms to young unmarried men, and officials working for National AIDS Councils have objected to publicizing safe sex messages.

Sexuality and Desire

Because it is so central an issue to making sense of AIDS in Melanesia, the theme of sexuality weaves throughout this volume. A thorough understanding of the ways that sexuality is regarded and organized is essential to the development of appropriate and effective responses to HIV. Even today, many people assume that the categories of sex, gender, and sexuality are universal, transcending time and place, despite an enormous amount of evidence to the contrary, much of it collected by anthropologists in many different parts of the world.¹⁶ Social theorists generally agree that sex is far more than an innate biological urge to reproduce and that sexuality varies historically and culturally. As Foucault has persuasively argued, sexuality gains its meaning within the forms of knowledge that arise within historically changing regimes of power (1981; see also Stoler 1997). Western people today, he contends, interpret themselves largely through the lens of sexuality, which has become the site where self and identity are created and accessed. “Hence,” he says, “the importance we ascribe to it, the reverential fear with which we surround it, and the care we take to know it” (1981, 156). Sexuality became autonomous and reified in this way during the restructuring of production under capitalism when sexual practices came to be subjected to medical scrutiny, systematic evaluation, and pathologization (Pigg and Adams 2005, 2–3).

That people today interpret themselves to a large degree through the lens of sexuality has been cogently argued and substantiated in regard to Western societies, but what can be said about the utility of this insight for non-Euro-American contexts, such as Melanesia? Epistemological and ethical difficulties exist in translating categories, terms, and languages used in one historical and cultural context to another, and these bring considerable danger of

exoticism and overemphasis of difference (see Pigg and Adams 2005, 9; Jolly and Manderson 1997, 1). However, even as we acknowledge the dangers of misrepresentation and misinterpretation, we must also confront the dire need to gain the best possible understanding of those we seek to help—through attempting to produce sensitive and accurate interpretations of the meaning and significance of sexuality in their cultures—and to note the effects of the globalizing discourses produced by the AIDS industry.

Situating discussion of others' sexuality within their own context, which includes their history of sexual and erotic engagement with other peoples, helps overcome the tendency to emphasize difference (Jolly and Manderson 1997, 1; see also Wallace 2003; Wardlow 2006b). This seems entirely appropriate, since the countries of the Pacific are increasingly under the influence of what Altman (2001) calls "global sex"—that is, the new ways of arousing desire and seeking pleasure that have accompanied globalization. Accordingly, the papers in this volume do not propose pure indigenous sexualities uncontaminated by outside influences. Rather, they show how local beliefs and practices are being reconfigured, not only through influences such as global sex and Christianity but also by the very existence in their midst of HIV/AIDS.

Globalization has everywhere brought a redefinition of the nature of the intimate. An unprecedented commodification of sexuality and commercialization of sex has occurred, a movement of images, bodies, and ideas that defies the limits of nation-state boundaries. New desires and new opportunities for their realization are opening up, and new forms of sexual identity are being imagined and realized. People are coming together through their common desires and practices and are identifying on this basis. Such new behaviors are mostly concealed in Melanesia, but they are a growing trend nevertheless. Hewat describes, for example, how the young women of Manokwari in Papua are increasingly internalizing the myths of romantic love articulated in popular culture, such as Jakartan-made films, soap operas, love songs, advertisements, music clips, and karaoke, while pornography is also widely used and mobile phones and text messaging enable new forms of sociality and sexual interaction to emerge with unprecedented speed. Buchanan-Aruwafu and Maebiru also report that globalization is introducing new ways for some young Solomon Islanders to express their sexuality and eroticism, despite rigid and proscriptive social conventions. Similarly in Papua New Guinea, new erotic practices, such as penile inserts, circumcision, and subincision, have emerged. Much of this innovation is propelled through links forged in the quintessentially masculine spaces of mining and logging camps and prisons, but even at

the local village level, herbs and concoctions are being devised and used for the same ends.

Thus it seems that HIV/AIDS has not, as one might expect, disinclined people from practicing sex—quite the contrary! Just when the advent of HIV/AIDS brought sex to be construed as dangerous and risky, connected with death and disease, there has been a huge proliferation in the ways sex is talked about and practiced.

Normalizing Sexuality, Normalizing through Sexuality

With the advent of HIV/AIDS, it was assumed that "facts" were needed to persuade people to protect themselves from infection. It therefore became necessary to speak publicly, unashamedly, and openly about sex, with the result that sex can now more straightforwardly be thought about, talked about, and acted upon. However, as talk about sex has become more open, and as sexual practices have proliferated in turn, the attitudes of religious conservatives and traditionalists have hardened, and their opposition to the language and content of messages about HIV/AIDS has been vociferous.

This "new puritanism," as Altman (1986) describes such responses to HIV/AIDS awareness messages, follows in the wake of a long history of proscriptive moralism in the Pacific. Christianity has indeed been influential in this outcome, but so have the indigenous moral frameworks, which generally have very strict rules of sexual conduct and gender relations. As several of our authors point out, sex outside marriage was often condemned and severely punished in the past and discussion of sexual matters was extremely circumscribed, especially in public, and this continues today. Missionaries have often reinforced these moral frameworks, giving them a new kind of authority in the context of modernity. Especially in Papua New Guinea, the conservative backlash against overt discussions of sexuality in HIV prevention messages has these mixed origins; it may sound distinctly Christian but often is actually a realization of tradition.

Haley argues, for example, that the Christian-sounding moral reform agenda of the Duna has its roots in local conceptions. Indeed, she reports that the Duna are turning away from Christianity toward a positive reevaluation of tradition, including the reinstatement of a men's cult that promotes restrained sexuality. Such cultural moralities are not always easily deciphered; in some places, strict rules of sexual conduct continue to coexist with public manifestations of overt, and occasionally aggressive, sexuality, which takes the form of sexual joking and play, singing, and rituals of inversion. Whether old or new,

such interdictions can be seen as a means of regulating desire, of ensuring that it is directed only in socially sanctioned ways. This abiding concern to regulate desire and sexuality, with its implication of shame and stigma, raises the issue of sexual inequality.

Sexual inequality is a partly a question of agency—the control, or lack of it, of sexual subjects in their sexual worlds—but it is equally a question of regard for the other. We would define the sexual inequality that exists in much of Melanesia as essentially a lack of reciprocity in regard for the other. Objections of universalization are often raised when the subject of equality is broached in regard to non-Euro-American contexts. That extensive sexual inequality exists in Melanesia and that this contributes greatly to the spread of HIV are undoubted, as many of the chapters in this volume make very clear. Equality does not imply sameness. Rather it is the precise form that inequality takes and the precise form of power relations that create and support it that vary between cultures. This is the very point we make—that the locally particular forms of institutionalized power, and the different knowledges, truths, and practices it produces, must be understood and taken into account. Further, it is the women of many Melanesian countries who express a desire for more equitable treatment.

Teunis and Herdt give a definition of sexual inequality that applies quite well to the kinds of problems being noted in Melanesia: “the forms of indignity, social disadvantage, stigma, discrimination, and violence perpetuated by or based on sexual conduct, sexual identity, or perceived sexual orientation or membership in a sexual category or sexual culture” (2007, 1). In similarly concrete terms, Parker refers to the “forms of ‘structural violence’ that shape and structure the possibilities of sexual expression: class, poverty, and economic exclusion, gender oppression, racism and ethnic discrimination” (R. G. Parker 2007, x; see also R. G. Parker 2002; Carrillo 2007; Farmer 1992, 2004; Parker, Easton, and Klein 2000).

As happens elsewhere, conservatives in Melanesia constantly provide justification for violence and discrimination by representing nonnormative sexuality as a threat to public morality (Teunis and Herdt 2007, 8). Applied to groups classified as marginal, constructions of an improper sexuality are a successful way of reinforcing classifications of order and disorder, or insider and outsider. Thus, for example, same-sex relations are condemned by the state, traditional culture, and churches (sometimes through reference to Sodom and Gomorrah), and sodomy is still a criminal offense in many countries in the region. The Methodist Church in Fiji has been particularly outspoken, calling for homosexuals to be stoned to death and organizing antihomosexual marches (*Pacific Magazine*, October 27, 2005). Even when their churches are

progressive on such issues, some adherents persist in asserting their own conservative views. Some even deny the existence of homosexuals in their society, as Salomon and Hamelin report for the Kanak. In such circumstances, infected men are unlikely to disclose that they have been exposed to HIV through same-sex relations. Denial, with all of its ill consequences for the HIV-positive and for others, is far more likely.

The marginal status and danger experienced by Papuan transvestites, described by Jack Morin in this volume, show how the categorization of non-normative sex relations as shameful legitimates violence and abuse in everyday relations. Such results of sexual inequality also occur in Papua New Guinea, where sex workers have been forced by the police to march through the streets of the national capital, Port Moresby, before being subject to incarceration, violence, and rape (HRW 2005, 118–121). In the same city, women and men have been harassed by police for carrying condoms and have even been forced to chew and swallow them (HRW 2005, 78–79).

Lewis stresses the significance of the problem of sexual inequality when he says, “Eradicating stigma will be the last holdout in the epic battle against AIDS” (2006, 69). This would certainly apply to Melanesia, where a pervasive retributive logic lays blame on the infected, since they are said to have sinned, defied traditional customs, or both. The ABC campaign, which dominates the HIV prevention response in Melanesia with its emphasis on abstinence and being faithful, only reinforces this blaming of the infected. The continuing traditional association between sexuality and shame in much of Melanesia not only makes it difficult to talk openly about sex but also means that people are less likely to take control of their sexual health. Those who endure the effects of sexual inequality—coercion, stigma, violence, and discrimination—are the most susceptible to poor reproductive and sexual health. Women subject to violence from their husbands cannot negotiate condom use and so are subject to serial pregnancy and exposure to HIV. As Wardlow and Lawrence Hammar explain, women whose livelihoods depend on the exchange of sex for money are reluctant to seek treatment for sexually transmitted infections, due to the stigma and shame associated with attending clinics, where health workers often disdainfully present themselves as the guardians of the nation’s morals. Morin’s study of transvestites in Papua shows that a culture of strong heteronormative gender conventions pushes much male homosexual activity into insecure isolated locations, endangering the participants and undermining their health. By contrast, sexual health “requires a positive and respectful approach to sexuality and sexual relations, as well as the possibility of having pleasure and safe sexual experiences, free of coercion, discrimination, and violence” (Teunis and Herdt 2007, 10, 23; Carrillo 2007).

There is in Melanesia a general pattern of what Cummings describes as “gendered culpability,” which sees women blamed and punished for many things. We would argue that many of the instances of this in Melanesia are forms of sexual inequality—that gender and sexuality cannot be so easily separated, that they form a continuum. We have defined sexual inequality as a question of agency—the control, or lack of it, of sexual subjects in their sexual worlds—and this definition, we suggest, fits many of the examples of discrimination against women to be found in Melanesia.

Throughout the region, women who do not conform to traditional or religious standards on matters such as dress, propriety, and deportment are castigated as wayward and spoken of in contemptuous terms. In Papua, such women may be referred to as *wanita tuna susila* or simply, WTS (Indonesian: women without morals), while in other parts of Melanesia designations such as *pamuk meri* (Tok Pisin: promiscuous women), *pasindia meri* (Tok Pisin: literally passenger women), *woman blong rod* (Bislama: slut or whore, literally woman of the road), and *rabis woman* (Bislama: literally rubbish woman) are used. Such terms are applied particularly to young urban women who have adopted modern Western fashions of dress, makeup, and hairstyle. A large number of myths in Melanesia are concerned with the dangerous nature of uncontrolled female sexuality, and it is this notion that often underlies such castigation (see Kirsch 2002, 64). Sometimes this “uncontrolled sexuality” is as simple as having a relationship with someone construed as other, such as the young woman banished from her village for having been sexually involved with Europeans, as reported by Salomon and Hamelin. At other times it is as simple as wearing trousers, for which, as Cummings reports, women can incur the wrath of the church leaders for misusing their bodies, which are “God’s property.”

Governing Sex, Governing AIDS

HIV/AIDS interventions often name and talk about sex and sexual practices with great authority and in ways that are unaccustomed to the people being addressed. As a consequence, they come to redefine what constitutes sexuality, re-forming it within new relations of power and knowledge. An example is the medical approach to HIV/AIDS, which, in reducing the complexity of sexuality to sex, removes sex from its much wider frame of ideas and practices pertaining to bodies, desires, and pleasure, as well as from the context in which people live. Then, as Pigg and Adams comment, “this discourse on sex creates a set of imaginings about what people do sexually, which in turn implies a vision of how they should respond to health programs” (2005, 16;

see also R. Bolton 1992a). This has been the approach taken in Melanesia, where the response has focused almost entirely on sex and where lack of success is explained as due to the irrational and unenlightened nature of cultural beliefs. We do not deny, of course, that HIV is transmitted through sex, but the question we ask is: What else is happening here? It is supremely naïve to assume that interventions have consequences only for health (Pigg and Adams 2005, 16).

The naming of those considered to be at risk of infection as targets for interventions not only cultivates a sense of identity among people on the basis of sexual preference and lifestyle but also delineates boundaries of sexual inequality and discrimination. In fact, such interventions affect a great deal more than sexual behavior, for they have a powerful effect over the whole population. By this we mean that scrutiny and the creation of normative and nonnormative categories of behavior have disciplinary outcomes, for categorized and scrutinized populations are more manageable. In other words, through their concern to prescribe how people should live their lives, HIV prevention messages act as a mode of governmentality.¹⁷ The common configuration of “the problem,” which encircles people “according to known, stable categories of risk groups, risk behaviors, or lacks and constraints, binds the HIV intervention to a rule of governance” (Porter 1997, 230).

One consequence of sex being central to modern technologies of power is that Western observers have taken an overwhelmingly negative view of sex in the Pacific, for it has appeared inexplicable and uncontrollable. The prominent discourses on depopulation in the late nineteenth and early twentieth centuries often singled out sexually transmitted infections as the cause of the problem. Government and missionary programs to arrest population decline almost invariably focused on what was considered the unbridled and licentious passions of indigenous populations. Similarly today, the regulation of sexual behavior in the effort to stem the tide of HIV forms part of broader processes of regulating populations.

The experience of the Pacific is not unique. Much past research on sex and sexuality emphasized danger over pleasure and served to support repressive antisexual movements. As R. Bolton writes,

by focusing on risks, too many of the positive dimensions of sexuality have been ignored along with the richness and complexity of behavior in this domain. . . . AIDS has reduced the scope of sexual freedom . . . but the goal of sex research should be not to assist in imposing a sexophobic ideology on people who are at risk but to help to restructure and re-create a sexuality that is life-sustaining and beneficial (1992b, 153–154).

This is what Hammar means when he says that public health campaigns in Papua New Guinea still work against, not with, the logic of sexual praxis. For him, what is needed is sex of a different, affirmative kind, since, as he reminds us, interventions from a sex-negative position have not worked. The chapter by Lepani captures a more positive view of the epidemic in the Trobriand Islands through its focus on culturally valued aspects of sexuality. There, since sexuality is a positive expression of the power of consensual and pleasurable practice to build and reinforce the exchange relations that are at the center of social reproduction, the use of condoms is not perceived as a great problem. The chapters by Hewat and by Buchanan-Aruwafu and Maebiru also show, through their detailed accounts of youthful sexuality, how sex is such a vibrant part of life in Melanesia that it is not going to be so readily displaced by what Hammar refers to as the "politics of chastity." These case studies are wonderful reminders that we should work with, not against, culture and local conceptions of sexual pleasure in our efforts to stem the epidemic.

Conclusion

It has been argued that in the 1980s, when the initial impact of AIDS began to be felt worldwide, anthropologists were slow to respond and, in so doing, allowed an essentially biomedical and highly individualistic model of AIDS research and intervention to dominate (R. G. Parker 2001, 172; see also Lindenbaum 2001, 378; Heald 2003; Waterston 1997). This is certainly true for the Pacific, where anthropologists have, on the whole, been reactive rather than active as events almost pass them by, despite the Pacific's being an area of intense anthropological scrutiny. Even though anthropologists were in a position to know that there were good grounds for expecting an AIDS epidemic, they did not sound a warning. So, rather than learning from elsewhere, they have largely made the same mistakes. Certainly, good work has been done, but no critical mass of scholarly interest has been generated.¹⁸

This situation probably has something to do with the nature of the anthropological project in the Pacific, which has often sought, perhaps nostalgically, a "tradition" untouched by the contemporary world and its problems. Although the presence of AIDS has been felt in the Pacific since 1982, it is only now, when the epidemics there are starting to spiral out of control, that the issue is being taken seriously and research has begun to increase. By far the most research has been done in Melanesia, a circumstance that is largely reflected in the focus of this volume, but still there is not nearly enough.¹⁹

Although many of the authors represented here are concerned with what Treichler (1999, 11) refers to as an "epidemic of signification"—the ways

HIV/AIDS is represented in speech, texts, discourses, images, and performances—their accounts are not abstract but are embedded in the reality of the daily lives and social practices that shape the ways the epidemic is being experienced and understood. The various chapters of this volume testify that there is no single way of making sense of AIDS in Melanesia, and there is no single epidemic. Rather, there are diverse and multiple narratives—cultural, political, economic, epidemiological, historical—that circulate, compete, intersect, and overlap (Setel 1999, 25).

The relentless spread of HIV against all efforts to stem it shows, we believe, that there is a great need for the kinds of research presented here and the kinds of approaches we advocate. This volume is thus both an assessment of what has been done to date and a call for social scientists to participate meaningfully in the response against AIDS, not only in Melanesia but also in the wider Pacific. We hope that this volume will inspire others to see the need to undertake research, to fill in the missing gaps, and to examine the new fault lines that are emerging in the rapidly changing conditions of the contemporary Pacific. It is also our hope that those national and international organizations that are fashioning the response in the Pacific will be inspired to recognize the indispensability of this kind of research in making sense of AIDS.

and negate responsibility for action and the imperative for change. However, it is also important to consider how articulations of cultural identity, even if reified, might be engaged pragmatically as a resource for mediating HIV prevention and enabling transformation. When people obtain a confident conceptual grasp of the workings of the invisible virus in relation to their socially constructed realities, then transformations of practice are more readily imagined and realized. HIV prevention approaches that uphold the potency of place in mediations of change, and proceed from a common ground of discourse that brings together collective identities in participatory processes of information sharing, have greater potential to turn the process of knowing into the practice of knowing and doing.

Notes

Introduction

1. Caution is needed, however, when making comparisons, since the AIDS epidemic is "both like and unlike past epidemics and disease states" (Lindenbaum 1992, 323, 1998; see also Brandt 1988 and Whiteside and de Waal 2004).
2. The first cases reported in New Caledonia and Papua New Guinea were in 1986 and 1987, respectively. For the Pacific more generally, the first case was reported in the Northern Mariana Islands in 1982, followed by French Polynesia in 1984 and Guam in 1985.
3. The UNAIDS and WHO statistics for 2005 (2006, 61) estimate the adult HIV prevalence rate for Papua New Guinea as 1.8 (0.9–4.4) percent, indicating that the number of people over fifteen years of age living with HIV is somewhere within the bounds of 31,000 to 140,000. The incredible breadth of this range indicates the problematic nature of estimating prevalence rates in the region. Apart from the difficulty of discerning an infection that manifests itself through illnesses that are not exclusive to it, in Papua New Guinea poor surveillance procedures and the lack of a formal notification system mean that only an estimated one-fifth of HIV infections are reported and many AIDS deaths go unrecorded (Moodie and Fry 2000, 5). Similar problems beset Papua and some other countries of Melanesia, where there are large rural populations with limited access to testing facilities.
4. UNAIDS (comprising UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, WHO, UNESCO, and the World Bank) sometimes recognizes the region Oceania (on its website, for example), but administratively, Asia and the Pacific are grouped together under a regional directorship, and publication and fact sheets often reflect this amalgamation.
5. These designations are contested. See Thomas (1989), Hau'ofa (2000, 471), and Finney (2002, 26). By "Melanesia" we mean Papua, Papua New Guinea, the Solomon Islands, Vanuatu, New Caledonia, and Fiji.
6. Despite considerable cultural affinities with the other countries of Melanesia, Papua is usually excluded from Pacific-wide forums and interventions; as a province of Indonesia, it is considered part of Southeast Asia.

7. This creates problems when trying to represent the perspectives of other cultures, where the finer distinctions of biomedical and epidemiological knowledge are not recognized. While we have attempted to follow UNAIDS conventions on terminology in this volume, this has not always been possible or indeed desirable. Not only does the biomedically correct terminology impose a biomedical reality that often does not exist for the people being written about, but the absence of a satisfactory and officially sanctioned overarching term for the entire phenomenon (virus plus syndrome) makes for clumsiness of expression. When necessary, we have adopted the commonly used and widely understood term "AIDS" to refer to the entire phenomenon, despite its not always being strictly correct.
8. Enunciated in the Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa, November 17–21, 1986. See also the Declaration of the Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 1978. For critical commentary, see B. D. M. Wilson and Miller (2003) and Campbell and Cornish (2003).
9. UNAIDS defines ABC as follows: A, abstinence or delaying first sex; B, being safer by being faithful to one partner or by reducing the number of sexual partners; C, correct and consistent use of condoms for sexually active young people, couples in which one partner is HIV-positive, sex workers and their clients, and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure (UNAIDS and WHO 2004b).
10. On striking a balance between structural factors and agency, see Law (1997, 2000) and Porter (1997). For an excellent discussion of the issue of sex work and agency, see Wardlow (2004, 2006b).
11. More recently Pacific island scholars are seeking to go beyond mere opposition to colonialism, to formulate philosophies based on broad acceptance of regional values and knowledges (see Diaz and Kauanui 2001; Thaman 2003).
12. The rural populations constitute approximately 87 percent of the overall population for Papua New Guinea, 83.5 percent for the Solomon Islands, 77.2 percent for Vanuatu, and 29.7 percent for New Caledonia (WHO WPRO 2005, 255, 316, 360, 207).
13. However, there are now many Muslims in Papua as a result of Indonesia's policy of transmigration, as well as small numbers of Muslims in other countries and a sizable Hindu population in Fiji.
14. Such changes were encouraged through the efforts of AIDS activists and advocates from the Pacific, such as Maire Bopp, Clement Malau, Anita Jowitt, and Steve Vete, who have engaged in dialogue with the churches (see Vete 2003).
15. The doom and gloom of much public discourse on the AIDS epidemic reinforces the fundamentalist worldview: the epidemic is a sign of the "end times," the period of disaster and destruction preceding the end of the world, and serves to confirm the truth of these predictions (Eves 2003, 255).

16. For the Pacific, among the many, see Besnier (2002); Herdt (1981, 1984); Knauff (1993); Mageo (1998); Shore (1981); and Wardlow (2006b).
17. Foucault broadly defines government as the "conduct of conduct" or the art of "acting on the actions of individuals, taken either singly or collectively, so as to shape, guide, correct and modify the ways in which they conduct themselves" (Burchell 1996, 19; see also Gordon 1991, 2–3). Governmentality in Foucault's sense is, thus, concerned with the "practices, techniques and rationalities through which governing is accomplished and authority exercised" (Dean 1999, 133).
18. Scholars such as Lawrence Hammar, Gilbert Herdt, and Carol Jenkins have worked on the issue for many years.
19. No ethnography of AIDS in any part of the Pacific exists, such as Farmer's *AIDS and Accusation* for Haiti (1992), Hyde's *Eating Spring Rice* for China (2007), or Setel's anthropologically informed demographic study of the Kilimanjaro of Tanzania, *A Plague of Paradoxes* (1999). There are no volumes that combine advocacy and academic analysis, like Murray's volume on sex work in Jakarta, *No Money No Honey* (1991), or her *Pink Fits: Sex, Subcultures and Discourses in the Asia-Pacific* (2001). Neither are there any volumes detailing the failures and inadequacies of prevention campaigns, like Campbell's "*Letting Them Die*" (2003), or examining the changing nature of sexuality in the context of HIV/AIDS, like Carrillo's *The Night Is Young* (2002). There is also a need, and a great potential, for more extensive collaborative research with AIDS activists, such as those working in a burgeoning civil society—with theater groups such as Wan Smol Bag Theatre Group in Vanuatu; with people living with HIV (PLWH); and with other groups, like PIAF (Pacific Island AIDS Foundation), whose innovative methodologies are producing effective results.

1. When There's No Accessing Basic Health Care

1. Unless otherwise stated or used for emphasis, italics indicate the Duna language. The interviews cited here were undertaken at Lake Kapiago in 2004.
2. Sekewa's letter drew a long, critical editorial response entitled "HIV/AIDS: The Bat-Squeak of Dissent" in the following issue of *The National* (2004).
3. The figure of one hundred thousand is based on calculations from Bourke and colleagues (1995) and the Papua New Guinea national census in 2000 (PNG NSO 2002).
4. In 1995, Papua New Guinea commenced a ten-year education reform plan, the core component being the establishment of Tok Ples (Tok Pisin: local language) elementary schools to provide the first three years' schooling.
5. Community schools typically go to grade six, and top-up primaries to grade eight.
6. Vaccination of children under the age of five in Kapiago is far below both the