“I am a dead woman”

Embodying and resisting dependency among women living with HIV in Papua New Guinea

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Abstract: HIV/AIDS can be understood as “an epidemic of signification” (Treichler 1987) not only about dangerous sexuality but also about dangerous relations of dependence. I begin by examining newspaper articles and nongovernmental organization reports to show how they pose alarmist questions about AIDS-related dependency, such as who will care for “AIDS orphans” and how will labor deficits be managed. I then turn to the Papua New Guinea context and focus on the experiences of women living with HIV who often narrate themselves as embodying state dependencies on foreign aid for their antiretroviral medications. In contrast, they typically resist their kin’s attempts to position them as wayward dependents who should be grateful for being given food and shelter.

Keywords: antiretroviral therapy, dependence, gender, HIV, Papua New Guinea

Thirty years ago, Paula Treichler wrote a now classic and canonical essay in which she spoke of AIDS as an epidemic of signification. As she put it, “the AIDS epidemic—with its genuine potential for global devastation—is simultaneously an epidemic of a transmissible lethal disease and an epidemic of meanings, or signification. Both epidemics are equally crucial for us to understand, for try as we may to treat AIDS as “an infectious disease” and nothing more, meanings continue to multiply wildly and at an extraordinary rate” (Treichler 1987: 32). At that point in time, the proliferating significations were largely clustered around sexuality: depending on which “risk group” was being represented, their sexual desires and practices were characterized as excessive, perverse, or immoral.

While the moral panic around sex endures, I suggest that, in fact, AIDS has always also been a moral panic and epidemic of signification about dependency. This alarm about dependency manifests at multiple scales, from the global and institutional to the corporeal and intimate, and focuses on such issues as: who will and who should care for the dependent sick and dying, who will and who should care for the young and old dependents who remain, what new and dangerous international and familial relations of dependency will be created, how will the state be burdened, which nongovernmental (NGOs) and corporate actors will help shoulder the burden, and so on. Indeed, the independent/dependent binary suggests that these two epidemics of signification are

deeply connected: the moral panic around sex is, at least in some contexts, a moral panic about excessive independence (that is, the independence or freedom to engage in what is considered unrestrained, selfish, or transgressive sex), which has, in turn, led to a moral panic about excessive dependence (that is, the dependence of people living with HIV on medicines, health care systems, food supplementation, state financial assistance, etc.).

In this article, I first trace a few ways in which the theme of dependency permeates discourses about the AIDS pandemic across a range of locations. Then, turning to the Papua New Guinean context, I examine how the state's dependency on both donor organizations and corporate social responsibility initiatives to fund AIDS prevention and treatment is funneled down to the community level and becomes embodied in HIV-positive patients, who are constructed as the dependent recipients of outsiders' beneficence. Indeed, some of the women I interviewed described themselves as "dead," by which they meant that only an unreliable supply of anti retrovirals (ARVs) from elsewhere kept them alive.

Their families, in turn, often tried to discursively position them as formerly wayward, but now chastened, dependents who, in their weakened and discredited condition, should be grateful for being taken in. This discursive positioning sometimes intersected quite brutally with a social organization of gender in which women do not own or control the land they farm or the houses they live in. As the owners of land and houses, male heads of household had the power either to evict HIV-positive female kin or give them a safe haven. Nevertheless, women living with HIV often resisted being positioned as disgraced dependents who owed their families remorse and gratitude. They asserted counter-narratives in which their kin were to blame for their HIV infections because of past failures to provide support and nurture; consequently, they argued, their families owed them a debt of care and were obliged to take them in.

AIDS and dependency panic

While many of the early newspaper articles about AIDS in North America focused on the wild excesses of "gay bathhouse culture," somewhat later articles examined the devastating toll that AIDS was taking on the productive, wage-earning, tax-paying demographic in sub-Saharan Africa and the profound impact this was having on both private enterprise and public services. For example, a 1990 *New York Times* article asked, "What does it mean if a mine loses 20 percent of its skilled workers, an army 20 percent of its troops? How far is society set back when many scarce teachers, doctors and engineers die prematurely?" (Eckholm and Tierney 1990). Another *New York Times* article from 1998 reported, "In nearby Zimbabwe, a personnel officer confesses that he has hired three people for each semiskilled job, expecting two to die in training," and it observed, "The damage at the family level is easy to grasp. The typical breadwinner in Africa has 10 dependents, and outside South Africa there are no welfare systems . . . the cost of medicine and a funeral means they often have to eat less, sell land or cattle, or take healthy children out of school. That returns a once-ambitious family directly into the hopeless cycle of poverty at its nadir—illiterate, ill-nourished children hoeing small plots of corn to avoid starvation" (McNeil 1998). And, a 2003 Harvard Business Review article very bluntly asserted, "Why should executives be concerned about AIDS? Very simply, AIDS is destroying the twin rationales of globalization strategy: cheap labor and fast-growing markets. . . . Rising absenteeism and higher employee turnover due to HIV/AIDS have forced companies to employ and train more people than usual. For instance, managers in companies in Zambia and Congo invest in training each worker to handle two or three tasks, or they hire two or three workers for every job on the expectation that at least one will die" (Rosen et al. 2003).

This kind of reporting emphasized wasted training, undependable labor, inefficient and potentially unprofitable businesses, the crum-

bling of already unreliable social services, and the loss of a generation of consumers. Not always explicitly articulated, but underpinning these narratives, were fears about "developing nations" falling off of their developmental trajectory and becoming even more dependent than they already were on bilateral and multilateral aid. Conversely, many scholars observed that the structural adjustment policies mandated by the World Bank and the International Monetary Fund exacerbated the AIDS crisis in low-income countries by requiring governments to remove subsidies on food, fertilizer, and fuel and to implement "user fees" for health care and education, thereby aggravating economic precarity, food insecurity, and the chronic parasitic conditions that contribute to HIV transmission and infectiousness (Schoepf et al. 2000; Stillwaggon 2005). In this view, it was not AIDS that derailed economic development and created dependency; rather, it was development policies themselves that had precipitated the AIDS crisis and worsened relations of dependence at multiple scales.

In the domain of the familial, an iconic image of AIDS in Africa in the 2000s has been the elderly grandmother caring for the orphaned children of her deceased adult children. The significance of the "AIDS orphan"/grandmother dyad is that of a kind of dependency squared, as it were: the dependent elderly caring for the dependent young, in an environment in which the demographic segment that is usually constructed as "independent"—that is, the productive and income-earning—are missing. A 2007 UNICEF report says, for example:

The strain of caring for orphans is telling on female-headed households, which have among the highest dependency ratios. Many of these households are headed by elderly women, often grandmothers, who step in to raise orphans and vulnerable children when their own children sicken and die. Grandparents—particularly grandmothers—care for around 40 per cent of all orphans in the United Republic of Tan-

zania, 45 per cent in Uganda, more than 50 per cent in Kenya and around 60 per cent in Namibia and Zimbabwe. . . . HIV/AIDS is straining elderly people already struggling to make ends meet. (UNICEF 2007: 30)

Here we can see that gendered relations of kinship and care are narrated as an intensification of dependency and measured as a dangerous distortion of "dependency ratios." At a population level, the dependency ratio is conventionally defined as the number of dependents—that is, persons aged zero to 14 and over the age of 65—to the number of independents—that is, persons aged 15 to 64. What this report is suggesting is that at the household level, the dependency ratio of AIDS-affected families is becoming frighteningly unmeasurable since the number of independents is zero, while the number of dependents, both old and young, is ever-increasing. The outcome, as studies from a range of disciplines indicate, is declining agricultural productivity, poor educational outcomes for the younger generation, and deteriorating physical and mental health for both older and younger generations (Block 2014; Bock and Johnson 2008; Chazan 2008; Drah 2014).

Jean Comaroff has suggested that the AIDS pandemic has "affected our very sense of history, imposing a chronotope of its own" (2007: 197). If so, the Time of AIDS has entered a new period: the Era of Treatment. And arguably, in this era of treatment, the epidemic of signification regarding dependency is intensified, not ameliorated—there are now concerns about who is going to feed and care for not only the orphaned children but also for the people who are HIV-positive and continue to live and are in treatment but are weakened and may not be able to engage in hard or sustained physical labor—may not, in other words, be able to embody the cheap labor force essential to the globalization strategy, as the Harvard Business Review article would have it. Moreover, the crisis about dependency in the era of treatment is a crisis about kinship, generation, and gender: the question

of who will and should care for dependents is often, more concretely, a question of who has female kin to care for them and who does not. Are there enough able-bodied, elderly women to care for others?

It is perhaps in part because of moral anxieties about dependency that there are now many articles and policy documents about ARVs intensifying hunger and increasing people's caloric and nutritional needs (Kalofonos 2010). While this is factually true, it is also the case that the personage of the HIV-positive patient-in-treatment has come to be figured as a hyper-dependent—a person who cannot produce as well as other adults but consumes more than other adults. Notably, the ethnographic research about ARV hunger and the free food supplementation provided to people living with HIV by humanitarian organizations often reveals moral crises occurring at the nexus of kinship, household food insecurity, and humanitarian intervention. Specifically, the moral logic behind food supplementation for people living with HIV is often unclear to the household members who have taken them in and cared for them, since all members are suffering from hunger, and the HIV-positive are sometimes seen as the most morally suspect and undeserving (Kalofonos 2010; Prince 2012). They embody, as I have suggested, the morally problematic excesses of both independence and dependence.

AIDS in Papua New Guinea

With a prevalence of approximately .9 percent, the HIV epidemic in Papua New Guinea has recently been characterized as “mixed” (PNG DOH 2018), a term that is meant to indicate that in some regions of the country it is a “concentrated” epidemic, in which HIV is primarily found in key vulnerable groups, such as sex workers, but has not greatly affected other people, while in other regions it is a “generalized” epidemic, which is defined as a prevalence of one percent or more in the general population. Countries are typically categorized as one or the

other, and a country's categorization informs its national HIV/AIDS policies and resource allocation. By describing its epidemic as “mixed,” Papua New Guinea signals that prevention and treatment strategies need to be tailored according to specific geographical location. Tari, Hela province, the site of my research, is near some of the nation's most valuable resource extraction sites, such as Barrick's Porgera Joint Venture gold mine and the Papua New Guinea Liquid Natural Gas project, jointly operated by Exxon-Mobil, Oil Search Ltd., and a few smaller companies. Proximity to resource extraction sites produces greater HIV vulnerability (Hammar 2010; Shih et al. 2017; Wardlow 2020), and typically, HIV prevalence is higher in these areas.

In this article I draw primarily on interviews with 30 women living with HIV. Far fewer men were seeking out testing and treatment during the years of my research from 2010 to 2013, and of the 8 formal interviews I had with men, I cut 4 of them short because I felt they were too sick to continue (this was not true of any of my interviews with women). Most of these men had refused to seek help until they were so unwell that others made the choice for them, and two of them died over the course of my research, while none of the women did. The reluctance of men to seek out HIV testing and their typically much later, and sometimes too late, entry into care, is a widespread global problem (Shand et al. 2014) and is attributed to a range of factors, including men's aversion to acknowledging vulnerability or dependency. Notions of dependence have, in other words, life-and-death consequences.

AIDS and nation-state dependencies

On a national scale, Papua New Guinea contributes very little financially to its own AIDS programming and is almost completely dependent on bilateral and multilateral aid for its HIV prevention, testing, and treatment initiatives (Nitsoy 2012). Indeed, this dependency has enabled new non-state entities to establish offices in the country and become important actors

in national HIV/AIDS policy formulation and program implementation. Historically it was primarily Australian AID (AusAID) that strongly influenced Papua New Guinea's national policy about HIV and paid for its testing, treatment, and prevention programs. Within the last 10 to 15 years, however, the Asian Development Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and PEPFAR have also stepped in to fund specific projects or program components.

So dependent is the country on external entities for its HIV/AIDS programming that for many years it was actually an oil company—not the national Department of Health (DOH) or an international NGO—that served as the official Principal Recipient for Global Fund grants worth tens of millions of dollars, a highly unusual situation. The DOH had mismanaged the first Global Fund grant, jeopardizing possible future assistance. As one Global Fund audit report put it, the weaknesses of the DOH “included non-compliance with the grant agreement, lack of supporting documents, unreconciled differences and weak monitoring, which led to US\$2.7 million worth of unsupported and ineligible expenditures being recovered” (Global Fund 2019: 11). Furthermore, it was determined that no NGOs in the country, national or international, had the technical capacity at that time (the mid-2000s) to apply for or manage the next round of funding. And so Oil Search Ltd. created the Oil Search Health Foundation in order to manage money from the Global Fund and to monitor other recipient organizations' projects in Papua New Guinea for the Global Fund.

As this information suggests, HIV can create dependencies not only between the state and its bilateral or multilateral donors but also between the state and corporate actors. Moreover, much as in other countries, mineral, gas, and oil extraction sites create HIV vulnerability in Papua New Guinea, but it is also mineral, oil, and gas extraction companies that distribute much of the ARV treatment. In Tari, the Oil Search Health Foundation significantly scaled up testing and treatment throughout Hela province, both in

and beyond the project areas affected by its resource extraction activities, by building the technical capacity of small health centers and by maintaining provincial physical infrastructure, such as roads and bridges. Indeed, what made it an effective health project implementing agency, in part, was that its parent mining company, Oil Search Ltd., maintains roads, bridges, and airstrips in the country in order to transport its labor and supplies, and the Oil Search Health Foundation was able to piggyback on this infrastructure to access patients in Hela province and to create and maintain ARV distribution networks. In sum, not only is the state highly dependent on donor aid for its AIDS programming, but also clinical staff and patients are dependent on corporations for delivery of their essential AIDS medicines and for the infrastructure that enables this delivery. In short, at the national level, the dependencies created by HIV facilitate the production of new kinds of assemblages of care composed of corporate, humanitarian, and governmental elements.

Embodying state dependencies

At the provincial and community scale, health workers, at least the ones I spoke with in Hela province, were well aware of the state's dependence on bilateral, multilateral, and corporate assistance for its AIDS programming, and they occasionally used this information to try to discipline their HIV-positive patients. For example, I heard clinic staff inform newly diagnosed patients that it was their duty to adhere to the ARV regimen because: “Foreign donors have made these drugs available to you. The Papua New Guinea government doesn't pay for your drugs. Other countries, because they are sorry for people in Papua New Guinea, are paying for these medicines. So be reliable, don't waste them, don't be defiant.” In other words, they attempted to cultivate obedience in patients by positioning them in a global biomedical-moral assemblage in which the pity felt by the foreign donor for the distant, suffering, dependent other

motivated a life-saving gift that had to be repaid through dutiful compliance with the drug regimen. The implication was that patients owed their very lives not to the nation-state that was providing them with clinical care but to the foreign entities that paid for their ARV medicines.

This dependence was felt all the more acutely during one of my fieldwork periods in 2012 when the country ran out of ARVs. When I interviewed them, some patients had been without their medicines for three months, and none of them assumed that their access to ARVs would resume. ARVs only became freely available in Papua New Guinea in 2007, and they were thus still relatively new in Hela when I began my research, and they were most certainly not taken for granted by the women I interviewed. Moreover, most of these women were widows, and the arrival of ARVs marked a turning point for them between death and life. As they often put it, “My husband died before the AIDS medicines came. The medicines didn’t come in time for him, but they came in time for me.” In the Ugandan context, Susan Reynolds Whyte and Godfrey Etyang Siu have described this as experiencing a kind of “historical contingency”—that is, a sense that one’s very life has depended on specific historical events, such as the arrival of ARVs: “For the HIV-positive people who managed to access treatment, a kind of generational consciousness emerged—an awareness that they differed from their predecessors, for whom there was no Second Chance. . . . Historical contingency was evident as well in the way a few worried about whether their treatment programmes would continue” (2015: 21). In Tari, it seemed pure luck to the women I interviewed that effective drugs became available when they did, and most believed that ARVs could vanish just as quickly and unexpectedly as they had appeared.

Some of these women spoke of themselves as “dead”: “I’m a dead woman,” they would say, “only the medicine is keeping me alive.” Through such assertions they were sometimes expressing wonderment and gratitude that ARVs had arrived in time to save them. But they were also

trying to convey their utter ontological dependence on ARVs. During their months without medicine, as they began to experience repeated bouts of malaria, respiratory infections, and skin ulcers, these patients expressed doubt that the nation-state would be capable of doing whatever might be required to entice foreign donor organizations to resume their assistance. Their assumption was that it was the state that had somehow defaulted in its dependency relationships and was ultimately responsible for the lack of ARVs in the country, and in this assumption they joined a chorus of Papua New Guinean citizens who have expressed consternation or resignation about the negligent, ineffective, or absent state (Knauff 2019; Street 2012). In short, patients experienced themselves as the embodied outcomes of state-level dependencies: if the state maintained its relations with powerful benefactors, they might live; if the state failed to do so, they would die.

The families of some of the women I interviewed reinforced their feelings of ontological indeterminacy by cruelly reminding them that they were dependent on possibly evanescent medicines or telling them that they weren’t “really alive.” Such assertions constructed ARV therapy as an unnatural life support in pill form and implied that women living with HIV inhabited a liminal space between life and death. Often what seemed to trigger such angry outbursts were vexing entanglements of interdependence in which women living with HIV were cast by their kin as dependent, and they, in turn, struggled against being viewed in this way. As previously mentioned, most of the women I interviewed were widows, and typically their husband’s kin had refused to permit them to continue living on his clan land after his death. Their recourse was usually to ask married siblings to take them in. Such requests were sometimes brutally rejected. For example, after Shelly’s husband died, her brothers refused to let her move back home:

My family yelled at me and called me an AIDS woman in public. They wouldn’t

take me in—they evicted me, they insulted me, they hit me, they told everyone I had AIDS, they cut me with a bush knife (she showed me a large scar on her shoulder) and forced me out. They said, “You yourself found this sickness. Where you found it, we don’t know, but you have it and you brought it back here. Take it away. You cannot live here.”

Ostracized by her family, Shelly was homeless when I met her and carried a plastic tarp with her so that she could sleep in people’s fields when necessary, a situation I had never before encountered in the Tari area, although Lawrence Hammar has described similar kinds of expulsion and abandonment of people living with HIV, especially women, in other areas of Papua New Guinea (Hammar 2010). This was an acutely gendered predicament. Although the men I interviewed experienced social rejection in other ways, none of them were forcibly expelled from their homes or land, precisely because it was their home and land. In contrast, because Huli women do not own land, or the homes built upon it, they can be forced out, and a few of the women I interviewed had been physically expelled from their homes without their belongings. Remaining household members took their pigs and harvested their crops.

More commonly, women were taken in by family members, but they were made to feel as if they were dependents who should be grateful for the household’s generosity, a situation which they chafed against, discussed later in this article. Commenting on James Ferguson’s argument that, in South Africa, relations of social dependence have long been “the very foundation of politics and persons alike” and that seeking dependence can be analyzed as “a mode of social action” (2013), Tania Li suggests that modes of social incorporation might be a more productive analytical framework for assessing how people try to make claims on others and how these claims are accepted, negotiated, or rejected (2013). Li suggests there are multiple ways in which people seek social incorpora-

tion—as dependents, laborers, caregivers, and so on. I suggest that in the case I am analyzing here, widowed or divorced women living with HIV ask to be incorporated into the households of kin as adult female persons who have typically fulfilled their obligations by bringing in bridewealth for their natal families, producing children for their husbands’ families, and caring for pigs and sweet potato fields. However, the moral suspicion attached to their HIV-positive status (Wardlow 2017, 2020; see also Hammar 2010 and Lepani 2008) often overwhelms other aspects of their personhood, and they are instead ascribed the more precarious position of a dependent whose ability to remain in the household is contingent on her behavior.

Such ascription is equivalent to a demotion from full personhood. As Michael Main has argued, Huli people value “a staunch individualism that respects and celebrates autonomy of expression and choice” (2020: 119), and while autonomy may be more circumscribed and less celebrated for women, feeling free to speak one’s mind is nevertheless a fundamental aspect of full personhood regardless of gender, an aspect that is curtailed when in a position of dependence. The women I interviewed often emphasized that being cast as a beholden dependent entailed silencing themselves. Discursively constructed as less valuable and perhaps even dangerous household members, they often censored themselves, fearful that too strong a show of autonomy or opinion might lead to their eviction.

Resisting the ascription of dependence

The women I interviewed seemed resigned to being ontologically dependent on their medicines and, by extension, on the beneficence of foreign donors and the competence of the nation-state in managing its political relations. In contrast, they typically resented being ascribed a needy, dependent role by the kin who took them in, and they pushed back against these constructions of their identity.

One way in which they resisted ascriptions of dependence was by incorporating themselves into these households as crucial laborers. For example, they would take on the full responsibility for washing the household's dishes and clothes. Even those who said that they felt too weak or tired to do more arduous labor, such as tending to sweet potato fields, caring for pigs, or fetching buckets of water from a stream, said that they were well able to sit in one place and wash things. The ascription of dependence was a constant battleground, and household labor was a key way in which women living with HIV tried to demonstrate that, far from being dependent, they were essential and productive household members.

Another important way in which they rebutted attempts to cast them as household dependents was through implicating their kin in their stories about how they came to be infected, often suggesting that their kin were ultimately responsible. Specifically, they asserted that their kin were *tene* of their HIV infections. *Tene* is the Huli word for tree roots, cause, or origin, and just as a tree trunk emerges as a unitary form from a mostly unseen web of tangled roots, an event—such as becoming infected with HIV—may initially appear to have a singular cause but will reveal itself as having emerged from a complex web of past interactions (Goldman 1983). Thus, according to my interlocutors, other people, often family, played a part in creating the situation in which a person came to be HIV-positive. Ultimate culpability for HIV infection, therefore, was sometimes attributed not to the infected person's own individual acts, or even to the infecting sexual partner, but to their kin's failures of care.

For example, Sarah, a woman in her late teens, was infected with HIV when the bus she was on was held up at gunpoint by a gang, and the female passengers were raped. Rather than blaming these men for her infection, she blamed her mother. She had been sent by her mother to buy betel nut and wholesale cigarettes in Mendi, the closest large town, to sell for a profit back in Tari. Her mother did not go herself because she

suffered from chronic back and leg pain and did not feel she could cope with the six-hour jarring round-trip journey on a hard wooden bench over a rutted dirt road. As Sarah explained it, her mother should have known—did, in fact, know—that Sarah was too young to be sent alone on a daylong journey on a road that was plagued by crime: “I told her, ‘It is your fault that I have this sickness. You were the one who did this. You were the one who told me I had to go to Mendi and buy those goods. It is because of you that I was on the road and I found this sickness.’” Sarah was clearly traumatized by what had happened to her and had become fearful about leaving her household; she was only willing to sell betel nut just outside the family gate. When her mother scolded her for not going to the larger Tari market where she would find more customers, Sarah was quick to respond that her mother was the *tene* of all her current woes because of her failure to prioritize Sarah's safety.

Similarly, Lucy, a woman who looked to be in her early fifties when I interviewed her in 2012, blamed her older brother for her HIV-positive status, not the man who infected her. She had a disastrous marriage when she was much younger, and upon the dissolution of this marriage, she moved into her brother's household and dutifully cooked and cleaned for him and his children for a number of years. And then, one night, they had an altercation and he beat her. As she explained it, “He didn't like the way I'd prepared his dinner. I'd been caring for his household for years, and then one night he lost his temper about having to eat sweet potato all the time, and he hit me. So I left. . . . I went to a *dawe anda*,¹ I befriended a man there, I went home with him, I stayed, and I caught AIDS.” According to Lucy, this man had been her only sexual partner after more than a decade of abstinence, and he was the one who had transmitted HIV to her. However, she blamed her brother for this infection. He was the one who had unjustly beaten her, triggering her own outraged exodus from his household. Furthermore, Lucy explained, their mother had died when they were young, and being the firstborn daughter, she had

felt obliged to drop out of school and care for her younger siblings. She had therefore “been like a mother” to her brother, and yet he had lost his temper and hit her. It was his fault that she went to the *dawe anda* in the first place, she said, and thus his fault that she became infected.

My interlocutors deployed such narratives to suggest that their kin were obligated to help them. Since failures of care on the part of kin were responsible for their being infected, these kin now owed them a debt of care. The story about infection became, in a sense, a duel about who owed whom in the relationship: was the person living with HIV a wayward and chastened dependent who was indebted to kin for being willing to take her in, or did kin owe a debt to the person living with HIV because of their negligence and abuse in the past? How a woman came to be infected constituted a narrative battle that could determine whether she was seen as a beholden dependent or as someone to whom amends needed to be made.

The women I interviewed did not always win this narrative battle. Lucy’s brother, for example, refused to accept that his violent behavior had played a role in her infection. But, this strategy often did work for women who had been infected by their husbands when it was their parents or brothers who had chosen the husband, particularly if women had sacrificed their own choice of marital partner in order to abide by the wishes of family. In these cases, kin often did accept that since they had chosen a woman’s spouse, they bore part of the responsibility for her infection, and so they did, in fact, owe a debt of care.

Conclusion

The era of treatment creates complex assemblages of testing, diagnosis, and care in which people living with HIV are dependent on distant others for their medications and, thus, for life itself. Indeed, the Papua New Guinea state is highly dependent on donor and corporate assistance, and people living with HIV may come

to experience themselves as the corporeal manifestations of these state dependencies. At the household level, the family members of women living with HIV may attempt to position them as formerly wayward and excessively independent persons who are now problematically dependent on others’ generosity and forbearance. Indeed, in some cases, families view their past excessive independence as having brought about their current excessive dependence, and they are therefore viewed as embodying both—that is, dependent on family and clinic, but liable to engage yet again in reckless, risky, independent behavior that might endanger others. The women I interviewed resisted such ascriptions. With their health and strength largely restored, they were eager to be viewed as “normal”—that is, like any other person, and not as someone whose personhood is determined by their HIV status or who imposes some sort of extraordinary burden on their kin (Wardlow 2020). Thus, women living with HIV often narrated their trajectories quite differently—not as an arc from irresponsible independence to chastened dependence but rather from a failure of kinship care to a situation in which the debt of care to them either was being paid or was not.

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Notes

1. *Dawe anda* are an interesting hybrid of male ritual spaces and brothels (Wardlow 2006: 193–195).

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