GENDER, WOMEN AND MOTHERS: HIV/AIDS IN THE PACIFIC

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Working Paper No. 7

ISSN: 1447-5952 (pbk); 1835-6133 (online)

This work-in-progress paper is a revised version of a presentation to the Gender, Sexuality and Culture seminar series co-organised by the Gender Relations Centre (RSPAS) and women's Studies (Faculty of Arts) on (Friday 7th September 2001). It is currently under further revision as a chapter for the forthcoming collection, *Engendering Health in the Pacific: Colonial and Contemporary Perspectives*, edited Vicki Lukere and Margaret Jolly. The author welcomes any comments or criticisms. Email vicki.luker@anu.edu.au

This paper attempts two tasks. First, it addresses a few uneasy thoughts about the ways in which women are often portrayed in the contexts of health. Secondly, it sketches a picture of HIV/AIDS in the Pacific. While this region tends to be elided from international coverage of HIV/AIDS, the unease relating to the former task stems from a reductionist equation implicit in much health-related literature. It goes thus: "gender equals women equals mothers." Many texts, of course, would fail to demonstrate this equation. Nevertheless, it does concatenate certain tendencies that are both common and, to some researchers, objectionable.

Women's health is most often framed in terms of their childbearing. Some feminists argue vigorously against "essentializing" women as mothers, and "biologizing" social and cultural ideals variously associated with that function (Inhorn and Whittle 2001). In, say, reducing women's health to the childbearing experience of a socially or culturally ideal mother, other kinds of experience and a variety of women can be neglected. Oversights might include broader issues in women's sexual and reproductive health, such as sexual health services to young, unmarried women; cancers of female reproductive organs; issues of menopause. Other oversights might relate to more general shifts in longevity and disease, like osteoporosis and other conditions associated with advanced old age; non-communicable diseases like diabetes; or tobacco related illness; and so forth. Still others might relate to the broader definition of what constitutes a "health matter." Domestic violence, for instance, is increasingly cast, not just in legal and social terms, but as a health issue. Lewis (1998) has canvassed all these concerns for the Pacific.

While reducing women to mothers is problematic, reducing gender to women disregards or marginalizes men. Some writers aver that health and health services have always concentrated on men anyway, so therefore research under the rubric of gender should redress this through a female focus (Pollock n.d.). Moreover, arguments as old as the earliest attempts to improve the health and status of women

contend that such efforts go beyond the women themselves by benefiting their children, husbands, families, communities and ultimately—depending on the discourse—collectivities like nation, race or humankind. These theses will not be addressed in detail here, except for a few casual asides. Official interest in women's health is earlier than some seem to imagine, though admittedly this interest was in women as mothers. From the late nineteenth century in most Western countries, mothers acquired a new significance in political discussion and the provision of state health services. These developments also contributed to the early interest of many colonial administrations in maternal and child health. From the late 1800s in the Pacific, the administrations of Guam and Fiji, for instance, passed laws and implemented medical programs in the name of indigenous mothers and babies (Hattori n.d.; Lukere 1997). Predating the work of colonial administrations in maternal and child health, nearly everywhere missionaries dedicated medical attention to mothers and children (see, e.g., Denoon 1989). Nor should one forget that if much of the thinking and doing of Western medicine has been informed by a masculine norm, this norm can do disservice to men whether they do or do not conform to it. Feminist research was sooner to publicize the disadvantages to women deriving from unquestioned masculine stereotypes, but explicit, self-conscious research exploring masculinities and health is much more recent—and in the West greatly in debt from the 1980s onward to gay responses to AIDS. Since then, the need for greater attention to the special health problems of men, and to the social and cultural determinants of men's health, has gained a cross-section of advocates (Connell et al. 1999).

An uneasy relationship between health agenda focused on women as against men is sometimes discernible. Objections have been raised, for instance, to the female ownership of "gender" in international health and development literature. Men need explicitly to be considered too (White 1994). The 1998 *World Health Report* illustrates a common problem. Its index has numerous page citations under headings and sub-headings of women, mothers and female, but no headings or subheadings for men, fathers or male (WHO 1998, 233–41). The characterization of men often implied in such texts has also been challenged. Watson protests that the approach to gender equity in the Women's and Health Development Programme of the United Nations (UN) assumes that masculinity is undifferentiated; that all men benefit equally from patriarchal systems; and that men are deficits (Watson 2000, 41). Against the assertion (often reiterated, though many female researchers now reject it (e.g., McDonough and Walters 2001), that women suffer a generalized health disadvantage, research in the last decade has re-emphasized some areas of generalized male disadvantage (Connell et al. 1999; Healey 1999; Watson 2000). These include, poignantly, shorter lives.

Discussions of suicide can further illustrate this tension. Worldwide, men are reported to kill themselves in greater numbers than do women (WHO 1998, 80). In some contexts this masculine characterization of suicide obscures a female problem. Booth has argued this for Samoa, where in specific age brackets female suicide equals or exceeds male (Booth n.d.). In other contexts an emphasis on female suicide can obscure that of male. One example from the mainstream press is a 1994 article in the *Sydney Morning Herald's Good Weekend,* then edited by a prominent Australian feminist. Data in the article made clear that many more teenage boys kill themselves

than teenage girls, roughly four to one; but the magazine cover imaged, misleadingly, a suicidal girl (Barrowclough 1994).

The equation “gender equals women equals mothers” disturbs me, not least because my own work has tended towards this reductionism. Yet my discussion here—in the voice of a Western, female historian—will again demonstrate this tendency, to which my concluding comments return.

HIV/AIDS in the Pacific

Let’s begin with a map (figure 1). Here are diagrammed the absolute numbers of HIV/AIDS cases ever notified in the Pacific Islands states and territories which belong to the regional organization, the Pacific Community. The country data date from early 1999 to late 2001, so are not exactly synchronous (NAC 2001, 3; SPC 2001). They come to a total of 4,899 notifications for HIV (including AIDS). The populations of the countries cited total over 7 million.

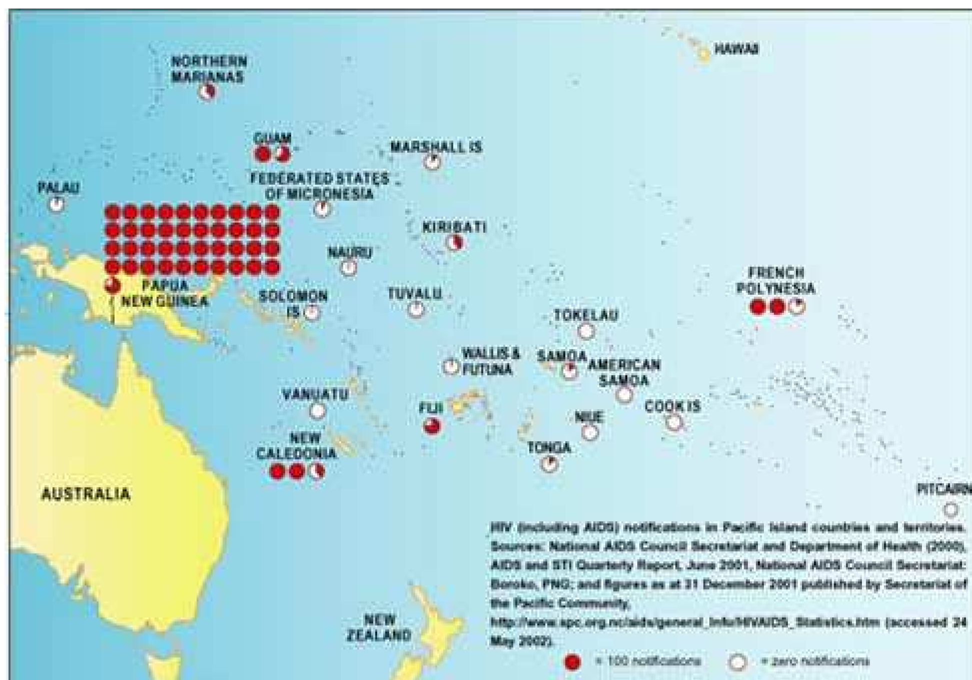

Figure 1

But this map makes some notable omissions. Papua (formerly Irian Jaya) is excluded as part of Indonesia. So are Maori and Hawaiians. So too are Micronesians and Polynesians who now live in Hawaii, California, New Zealand, and Australia. (Ward estimates that 40 percent of those with a recent Polynesian ancestry live in the latter three locations (1999, 4).) The discussion here cannot therefore suggest the dimensions of the greater demographic and geographic experience of Pacific peoples and HIV.

Due to limited surveillance and other factors, official notifications are said to be underestimates (UN 1996, 9–14). But in a world where, at the end of 2001, an estimated 40 million people were infected with HIV, the Pacific’s total contribution

to the global HIV/AIDS burden is paltry (UNAIDS 2001). On the basis of UN statistics, the percentage of adults living with HIV in Pacific island countries is also very low by international standards (UNAIDS 2000a, 5). So insignificant is the island Pacific from a global AIDS perspective that it is often not even mentioned. Usually the Pacific Islands are grouped with East Asia**,** or with Australia and New Zealand, and are given no distinctive profile of their own (UNAIDS 2000a, 5; Mann and Tarantola 1996, 9–10).

More than 80 percent of the infections diagrammed belong to Papua New Guinea, with 4,075 notifications as of June 2001(NAC 2001, 3). New Caledonia, French Polynesia and Guam comprise the second league, with 237, 216, and 168 notifications respectively. Several countries on this map have empty, or nearly empty circles. American Samoa, Cook Islands, Pitcairn, Tokelau, and Vanuatu have no reported cases and the Solomon Islands only one—who was rumored to be an outsider (Burslem et al. 1998, 13). Many of these figures are probably misleading. (For example, though American Samoa still has no official cases of HIV/AIDS, by the mid-1990s other sources reported that at least four AIDS sufferers had returned to the care of their families in these islands (UN 1996, 11).) Moreover, as Dr. Clement Malau has stressed, given the poor state of surveillance in the Pacific, no Pacific Island country can be confident that it is free of HIV (Malau quoted in Wright 1999). But, significantly, the Solomons and Vanuatu—the third and sixth most populous countries in the Pacific with many predisposing characteristics, including poverty, youthfulness, inadequate medical infrastructure and, in the case of the Solomons, military upheaval—appear scarcely touched by the virus.

The map says nothing about introduction, trends, and modes of transmission. AIDS was first identified in the United States in 1981 and HIV was named in 1983 (Grmek 1990). The Pacific's first identification of HIV was in the Northern Marianas in 1982. French Polynesia followed in 1984, Guam in 1985 and New Caledonia in 1986. These islands were the epidemiological outliers of France and the United States, with one or more of the following: military personnel, significant expatriate populations, or tourism. Homosexual transmission, and to a lesser extent intravenous drug use and contaminated blood products were mainly responsible for the early infections (Sarda and Harrison 1995, 10–12). Though heterosexual transmission now accounts for a greater proportion of HIV notifications in these countries (especially New Caledonia), homosexual transmission remains important. And though, by Pacific standards, French Polynesia, Guam, and New Caledonia are still significant sites of infection, figures from the Secretariat of the Pacific Community (SPC) suggest that the number of reported new cases each year are showing no clear upward trend (SPC 2001).

Cases in the tiny nation of Kiribati, with its first recorded in 1991, increased thirty-three-fold by 2000. This increase triggered alarm, and heterosexual transmission seems heavily implicated (Anon. 1999; Brewis 1996, 68–69). Recent increases in Fiji have also caused concern, with a story about one man who was believed to have infected several women attracting intense media attention in early 2001 (Dr. Seini Kupu, pers. comm., 8 October 2001).

But the greatest anxiety is felt for Papua New Guinea (PNG). The first PNG national to die from AIDS is said to a be policeman, whose death in 1987 was succeeded by those of his wife and child (Hammar 1998, 264).[1] From the start, HIV

appeared predominantly heterosexual and PNG was seen as the Pacific nation most vulnerable to a severe, sub-Saharan-style HIV epidemic. The UN survey of HIV in the Pacific of 1996 and the corresponding SPC report of 1997 published strong predictions of the possibly destructive impact of HIV/AIDS on the *entire* Pacific (SPC 1997, 10; UN 1996, vii, 21, 23, 51). Yet even by then, PNG was said to have passed from "slow burn" into explosive growth (UN 1996, 13). Growth climbed very steeply in the late nineties (NAC 2001, 5). Out of a total population of just over 5 million, estimates of those infected with HIV can range as high as 200,000 (O'Callaghan 1999, 3). The government prefers an estimate of 10–15,000, and one recent study calculates a number close to the top of that range (CIE 2002, vii).

Why PNG alone among the Pacific island nations has experienced this trajectory is not a question I can answer. Caldwell has stressed the relatively large size of PNG's population and capital city as factors (Caldwell 2000a, 7). Others are featured in the discussion that follows. Given that PNG is the Pacific nation with by far the largest number of people, and by far the largest number of HIV/AIDS notifications, it is in this setting that I will discuss HIV/AIDS in terms of women and mothers.

Women and Mothers

Worldwide, men infected with HIV outnumber infected women (UNAIDS 2001)—and in the West men still comprise the great majority of cases. The global lead of men over women is however slim. In 2000, 47 percent of people living with HIV were women, while in sub-Saharan Africa 55 percent were female (UNAIDS 2000a, 5). In the Pacific, official figures suggest that men with HIV overall outnumber women. In PNG, though numbers are roughly equal, men appear to have a slight lead (SPC 2001). This may vanish in the future; and the lead is reduced, if one adds to the adult female component their HIV-infected children.

Biologically, women are more susceptible to infection. In a single act of vaginal intercourse between a healthy man and woman, the chances that she will transmit the virus to him are perhaps one in a thousand, but the chances that he will transmit the virus to her are perhaps one in 300 (Caldwell 2000b, 120). Several factors may further increase female receptivity. These include physiological immaturity, for the lining of the vagina of a young adolescent woman is more vulnerable; rough sex causing vaginal abrasion and tearing; some methods of cleaning or treating the vagina which cause irritation may facilitate infection; and the co-presence of other sexually transmitted infections (Vuylsteke et al. 1996).

Lastly, to incur infection heterosexually, a woman must have unprotected intercourse with an infected man. Her chances of doing this are increased, if she has sex with many partners or if her partner has multiple partners.

How are these vulnerabilities realized in PNG?

First, young women in PNG, in keeping with a global pattern, tend to have sex with older partners and tend to contract HIV at an earlier age than men, as graphs of the age distribution of male and female cases show (see, e.g., PNG Government 1998,

7). This differential may also reflect other possible risk factors for women at this age, including physiological immaturity.

The extent of tearing or abrasion caused in the act of sex are difficult to estimate. Quite striking numbers of admissions to PNG hospitals of women internally injured during sex have been reported (Borrey 2000, 107). In some circumstances injury may be implicated with the woman's physiological immaturity, or with inexpert, rough or prolonged intercourse. While such sex can be consensual, male violence figures strongly in the literature on contemporary sexuality and gender relations in PNG (see, e.g., Bradley 2001; Macintyre 2000; PNG Government and UNICEF 1996, 11–12, 122–44).

Concerns about "feminine hygiene" practices that may contribute to vaginal abrasion or irritation have been extensively discussed in the African context, where they are linked to a cultural preference for "dry sex" (Ezzel 2000, 74). This preference has been identified in some Pacific cultures too, and in Kiribati, for instance, is similarly associated with cleansing and other procedures (Brewis 1996, 70; Toren 1999, 137). Research findings do not indicate such a preference in PNG (UNAIDS 2000b, 48–49). Hammar, however, has noted the liberal use of Dettol and bleaches, "to keep the vagina clean" as potentially risky (1998, 269–70). The extent of such cleansing practices remains unclear.

We can be surer on the subject of sexually transmitted infections. These, according to Malau are out of control and have been "rampant" since colonization (quoted in Guy and Crofts 2000). In 1996 the Department of Health claimed PNG had one of the highest incidences of sexually transmitted diseases in the world (PNG 1996(c.), vol. 1, 51). Jenkins and Passey argued, in 1998, that this incidence had only risen during preceding decades (1998, 242). Deteriorating medical services throughout the eighties and well into the nineties doubtlessly hampered efforts to check sexually transmitted infections (Connell 1997; Koczberski 2000). But it may be worth investigating the hypothesis that the severity and incidence of most common STIs in PNG are due partly to the relative recentness of their introduction compared with other parts of the Pacific, especially Micronesia and Polynesia.[2] Generally, pathogens and populations evolve a more moderate relationship over time (but see Nesse and Williams 1995, 57–61) and, as Riley has observed, the force of the first wave of STIs introduced to PNG, dating from perhaps as early as the 1830s, is even now "by no means spent" (Riley 2000, 2).

Ulcerative STIs are the most efficient co-factors of HIV transmission. In PNG, syphilis, donovanosis, and genital herpes are the main concerns (Hudson et al. 1994). In the Highlands—where some of the country's highest population densities are found—epidemics of syphilis followed the eradication of yaws, which had formerly given some immunity to syphilis, and the construction, in the late 1960s, of the Highlands Highway (Garner et al. 1972; Hughes 1997, 238–39). HIV travels the same route.

Yet non-ulcerative STIs are also of concern, for they too increase women's susceptibility to HIV. Gonorrhea is widespread, with the highest rates now reported in the Highlands provinces (PNG 2000, 146). More recently, both internationally and in PNG, attention has focused on the effects upon women of STIs like chlamydia and trichomonas. These synergize with HIV/AIDS too (Passey 1996; Suarkia and Lupiwa 1998; WHO 2001). Surveys in recent years found high levels of chlamydia (23

percent) and trichomonas infection (19 percent) among pregnant women in Port Moresby General Hospital, and even higher levels (26 and 46 percent respectively) among women in the Asaro Valley of the Eastern Highlands Province (Klufio et al., 1995; Passey 1996; Tiwara et al. 1996). Both groups were regarded as low risk for STIs. Aside from shortcomings in medical services and the stigma associated with STIs, especial obstacles prevent women from being treated. These include the fact that many common infections go unnoticed or else their symptoms are regarded as normal or trivial (Lemeki et al. 1996; Passey 1996).

Now let us consider, schematically, two positions of risk: that of a woman who has many sexual partners, or whose partner has many sexual partners.

In PNG, women's participation in sex work—a polymorphous and disorganized activity—has proliferated (NSRRT and Jenkins 1994, 113–19; Hammar 1998, 275–85). As women are less educated than men and have fewer opportunities for waged employment, prostitution is often the female doppelganger of men's waged employment, as illustrated in the growth of commercial sex around large development projects (Macintyre 1988, 216–17, 219–22; Clark and Hughes 1995; Hughes 1991). Some women are also prostituted by their menfolk and families. Whether controlled or uncontrolled by the individual women themselves, their increasing participation in commercial sex can be seen in terms of the commodification of female sexuality which is also implicated in the growing commercialization of marriage and bride-price (Jorgensen 1993; Lepani 2001, 73–74; Rosi and Zimmer-Tamakoshi 1993, 175–204; Zimmer-Tamakoshi 1993a).

Here it is enough to say that the economic pressures and limited choices that compel or induce many women to exchange sex for money or goods, place them in a vulnerable position for STIs. A survey of sex workers in Port Moresby found 17 percent were HIV positive and had high rates of other STIs (UNAIDS 2000b, 36). Sex workers who live in urban areas may be closer to STI services than women in most villages, but many of the common obstacles to the treatment of STIs in women still apply, while sex workers further complain of harsh treatment from nurses and doctors (2000b, 28, 32). The very diffuse and multifarious character of transactional sex in PNG also makes STI and HIV prevention campaigns that promote the use of condoms much more difficult to implement than in countries with highly institutionalized sex industries like Thailand (Phoolcharoen et al. 1998; UNAIDS 2000b, 25).

Group sex *(lainap)*, involving one woman and several men, also needs comment. The practice, though not unique to PNG (Buchanan-Aruwafu 2001; Jenkins 1996, 200–1; Kaitani 2001; Salomon 2002, 94), is reportedly common and usually involves coercing the woman. In the survey by the National Sex and Reproduction Research Team (NSRRT), of the seventy male informants with whom group sex was discussed, forty-four recounted their participation in such events and four spoke as eyewitnesses (NSRRT and Jenkins 1994, 102). Traditional precedents exist for the practice in some PNG cultures.[3] In contemporary conditions, the part played by the desire for male bonding, an urge to assert male superiority over women, the intent to punish, and an ethos of sexual opportunism and violence are all

stressed (Borrey 2000; NSRRT and Jenkins 1994, 101–7; Zimmer-Tamakoshi 1993b).

Aside from questions of law and human rights, *lainap* raises issues relating to HIV transmission. Chances of men contracting the virus by participating in such an event, if one or more of their number is infected, increase exponentially. The usual distinction between heterosexual and homosexual transmission is, as Jenkins notes, in these circumstances blurred: a man is far more likely to contract HIV through contact with fluids, in the woman's vagina, from one of his fellow participants than he is from the woman herself (NSRRT and Jenkins 1994, 105). Similar risks obtain when a group of seafarers have sex sequentially with a prostitute, a not uncommon occurrence on board ship (Jenkins 1994 cited in UN 1996, 46).

The risks of infection to the woman, so much higher to begin with, are magnified even more in group sex, not just by exposure to many partners, but by resulting vaginal injury. *Lainap* highlights women's vulnerability, more starkly perhaps than commercial sex, in a politics of sexual power and female objectification. As Hammar has remarked, pack-rape often simultaneously "marks" a woman with a sexually transmitted infection, and "marks her down" for future sexual use by men in this way (1998, 269). One particular case in the Highlands can serve as symbolic. Five men in the Enga Province pack-raped a woman dying of AIDS. Quite conceivably, she had earlier contracted HIV in such circumstances. Her rapists then sued for compensation on the grounds that she may have infected them (Anon. 1994). In response to similar cases, the police promulgated advice to men to desist from pack-rape, because of the dangers posed to themselves of contracting HIV (Anon. 1998). This message has had to be communicated to police themselves, with one survey in the mid-1990s finding that 10 percent of the policemen interviewed had participated in *lainap* the previous week (UNAIDS 2000b, 42–43). Concern for the woman appears absent from these warnings.

On the other side of this schematic presentation is the predicament of a woman who has, say, one sexual partner, but this partner has more than one. And here we must address contemporary expressions of polygyny.

Polygyny is still formally practiced in some parts of PNG. The 1996 Demographic and Health Survey found polygyny most common the in the Highlands, with 25 percent of women in polygynous marriages; the Islands region and Momase followed with about 7 percent; and the Southern region had the smallest proportion with only 6 percent (Pala 1997, 60). In some Highlands pockets the incidence of polygyny is much higher and going higher. Thirty six percent of women in Kramer's sample at Porgera, Enga Province, were in polygynous marriages, as were almost 40 percent of the women in Kaimui-Daribi area of Simbu surveyed by Groos and Smith (Groos and Smith 1992, 86; Kramer 1995, 181). Simbu Province is one area in which polygyny may in fact be increasing (Garap 2000, 161). In other parts of PNG formal polygyny has virtually died out (Carrier 1993).

Nevertheless, it is said to be widely, if tacitly, accepted that a married man will have sexual relations with more than one woman. Elite men are always likely to have been the greatest polygynists, and Malau has commented that the traditional "big man attitude" prevails with a modern twist. "In tribal society a 'big man' would marry four or five wives who, for the most part, he was faithful to, but these days 'big men' include wealthy businessmen, bureaucrats and politicians who may be

having sex with their wives, mistresses and sex workers, leaving everyone open to HIV infection" (Malau quoted in Guy and Crofts 2000).

Under traditional conditions, even those labeled "polygynous," many ordinary men may have had, in effect, just one wife (cf. Lukere 1997, 51–71). In PNG societies, as elsewhere, a prohibition on sex between a man and his wife while she was breast-feeding was necessary to improve the chances of the child's survival (see, e.g. Gray 1994). While a polygynist could resort to another wife, other men were no doubt required, like their wife, to remain celibate during this period too. Some men in PNG indeed still believe that their own sexual abstinence is necessary for the health of mother and child during this phase (NSRRT and Jenkins 1994, 39, 109–10). Such a belief would be consistent with many men traditionally having lacked more than one wife or much sexual access to other women.

The withdrawal of a woman from sexual relations while she is breast-feeding is now a common reason for men to seek other partners. Another is work that takes men, for shorter or longer periods, away from their wives or regular partners to urban centers or enclaves of male employment. Married men, according to the NSRRT survey, engage in commercial sex more often than bachelors (NSRRT and Jenkins 1994). Circular migration, whereby men return from places of employment to their villages, promises to further spread HIV from the "hot spots" of Port Moresby, Lae, and Mt. Hagen (Caldwell 2000a, 6; Malau 2001a). The case of the late HIV educator Joseph Berem illustrates many features of the patterns described. A leader in his Mt. Hagen community, he had three wives and six children, but moved to Port Moresby to work as a bus-driver, returning home for visits. In the capital he contracted HIV and passed it on to two wives before learning that he was seropositive (Rarambici 2000).

Sexual networking and mobility in PNG are thus more ramified and extensive than before. Our hypothetical woman, faithful to one partner, is therefore in a position of vulnerability although her personal sexual behavior might be described as "low risk." Such "low-risk" women have been noted among the casualties of HIV since the start and are bound to account for a growing proportion of cases as the epidemic matures (UN 1996, 27). (In Africa, roughly half the women living with HIV are thought to have received the virus from their husbands (Caldwell 2000b, 131).) Headlines such as "Housewives hit hard by AIDS" may suggest this trend in PNG (Anon. 2001). There is a further irony in characterizing such women as "low risk." Though women who sell sex are often seen as powerless and "high risk," in some respects, as Hammar has noted, they may be better placed than wives to negotiate, for instance, the use of condoms (Hammar 1999, 114). But this contrast cannot be pushed too far. The factors that put women in positions of vulnerability to HIV infection in PNG indicate a complex of disadvantage.[4]

Motherhood again demonstrates women's distinctive biological and social vulnerability. In PNG, as for the majority of the world's women, children are desired, signify a woman's attainment of adulthood, and constitute a resource. Childlessness causes grief, shame and a kind of poverty. Yet, as many have noted, the only available means for preventing the sexual transmission of HIV to a woman—the condom—also prevents conception. Simultaneous desires for safe sex and reproductive sex are therefore not easily resolved (Lepani 2001, 18–19).

The implications of HIV for maternity are twofold. On the one hand, HIV reduces the capacity of a woman to conceive, but on the other, if she does, entails the chance of her transmitting the virus to her child. The proportion of HIV cases in PNG attributable to perinatal transmission is growing. By December 2000 it had increased to 9 percent from 4 percent two years earlier (Malau 2001b, 35). Mothers with HIV, in countries like PNG, are limited in the measures they can take to reduce their chances of passing HIV to their child. Drugs are, at the time of writing (early 2002), unavailable. Often, so too is medical attention at birth, which can minimize complications and thus reduce the likelihood of mother to child transmission at this juncture. Though figures are controversial, Malau estimates that only 44 percent of deliveries in PNG are medically supervised, and by global standards PNG's rates of maternal mortality and morbidity are high (2001b, 34). Breast-feeding can transmit HIV to the infant too. But for women in PNG, as generally in the poorer world, this risk to the child is, in medical opinion, less dangerous than the alternative of artificial feeding.

Lastly, caring for the sick nearly everywhere is mostly women's work, and here too HIV highlights a sorry paradox: how roles which are expected and esteemed in women can involve great vulnerability. A husband with AIDS, or a child with AIDS, may often benefit from a wife's or a mother's care. If the husband is infected first, and then infects his wife, he tends to predecease her. But when she falls ill with AIDS, will anyone give her the care that she gave to others? Little has been written about certain aspects of the female experience of HIV/AIDS in PNG. Some infected husbands have been said to vent their feelings about HIV in violence towards their wives (Elizabeth Cox, pers. comm., 6 October 2001). Some AIDS widows, once they fall ill, have received little or no care from their deceased husband's kin, and cannot return to their own people, for then bride-price would have to be repaid (Susan Crockett, pers. comm., 6 December 2001).

Conclusion

The grim picture drawn above for Papua New Guinea has many features commonly highlighted by literature concerned with HIV/AIDS, and some of these features can be found in other Pacific Island societies affected by the virus. Yet the diverse and divergent experience of the greater Pacific cannot be represented by any rendition of the epidemic in PNG. Moreover within PNG, HIV/AIDS must be seen in the context of the country's overall health needs and other challenges. In terms of numbers, pneumonia and malaria account for most reported deaths—though the Health Department has predicted that deaths from AIDS, currently a relatively minor contributor to mortality, will shortly outstrip them (Dr. Puka Temu quoted in Rouse 2000).[5] There is also the telling story of an AIDS theatre group, visiting remote villages to promote safe sex. The group saved three lives by just dispensing tablets from their first aid kits and discovered an isolated community that, unbeknownst to the wider world, was starving (Sheehan 1998, 9). HIV/AIDS may not have been a priority for these audiences! Westerners need to recognize too their tendency to construe HIV/AIDS in luridly apocalyptic imagery. Though similar imagery, as Eves recounts, can figure in indigenous, Christian understandings of the epidemic, for

Westerners it may owe more to the original shock of the appearance of AIDS in their own midst, than to the destruction it has and is causing elsewhere (Eves 2001). Such imagery has faded in relation to HIV in the rich world, where infection remains fairly circumscribed and increasingly, with the availability of improved drugs, assumes the character of a chronic condition (Griffin 2000, 179–80). But apocalyptic imagery continues to be projected onto the poor world, in parts of which the direst prophecies made a decade ago of AIDS induced devastation may now look, to quote Paul Farmer, like "sober projection" (Farmer et al. 2001, 404; see also Quinn 2001, 1156). Yet the predictions, mentioned earlier, of possibly Pacific-wide disaster have so far not materialized—with the exception of PNG, if that nation is indeed moving toward a serious epidemic as seems likely (CIE 2002). The futures—in the plural not the singular—of HIV/AIDS in the Pacific remain open.

The devolution of my discussion on mothers and, indeed, married mothers, is open to some of the standard criticisms of the equation "gender equals women equals mothers" indicated at the outset of this paper. The emphasis on female reproductive sexuality within the context of a stable relationship can overshadow, for instance, sexual relations conducted by women without reproductive intent or outside approved settings for conceiving and bearing children. Given the young age at which most women contract HIV in PNG, it is likely that many will be infected by a person who is not their husband or habitual partner and that many will carry the virus into marriage. The plight of the wife-infected-by-her-husband, though rhetorically so affecting, should not occlude women in other sexual relations. HIV prevention measures that focus on young unmarried women who want to avoid pregnancy or on female sex workers are anyway less prone to a conflict with reproductive desire and, for other reasons as well, are more promising of success (see, e.g., Caldwell 2000b).

Men figure, hazily though palpably in this discussion, only as agents of sexual gratification, violence or infection. A richer treatment of men's sexual behavior in the context of HIV/AIDS in PNG can be found in other sources (Jenkins 1996 and 2000; Jenkins and Alpers 1996; NSRRT and Jenkins 1994). Such treatments knit nicely with studies over the last decade addressing violence against women, problems of law and order in PNG and beliefs about other sexually transmitted infections (see, e.g., Clark and Hughes 1995; Borrey 2000; Bradley 2001).

Three points are warranted. First, despite the vivid nature of much of this material, its detail confirms an image, that this discussion has also adumbrated, of violent, harmful and impulsive masculinity which is simply too nightmarish to be fully representative.[6] This leads to my second point: to go beyond this lurid image and better grapple with the challenges, neglected aspects of masculinity need research. The predicament is curious. Literature, especially anthropological literature, relating to gender and masculinity in PNG is in some ways immensely rich and theoretically fertile. Yet in other ways, as one report on gender analysis in PNG lamented, work on men, their attitudes, behaviors and impacts is regrettably deficient (Brouwer et al. 1998, 46). Many questions about masculinity and HIV, concerning for instance the intermesh between sexuality and fertility, fatherhood and family—despite the attention which the UN recently encouraged in this direction (UNAIDS 2000c)—have scarcely been asked.[7] Answers might help programs of benefit to everyone: men, women and children. But finally, the challenge to control the spread of HIV/AIDS inheres in more than relations of gender, however intimately or

abstractly they are construed. Larger political and economic factors are crucial, as many of those who have worked on issues of gender and behavior change vividly perceive (Hammar 1998; Jenkins 2000). More radically, some of the solutions anticipated and urged against the epidemic, like en masse vaccination and anti-viral therapies, might logically obviate the need to try changing, in the name of HIV prevention, sexual practices or gendered relations (Kippax 2000; but contrast Farmer et al. 2001)

Let us return, though, to mothers and the problematic emphasis upon them in some frames of women's health. No one could quarrel with criticisms of a very narrow focus on women as mothers or on simplistic biological or socially ideal visions of maternity; and a number of the health needs of women have no links with the bearing and rearing of children. Yet, on second thoughts, surprisingly many do. Indeed, some of the issues—like osteoporosis, diabetes, tobacco related illness and domestic violence —which, in my opening paragraphs, I allowed to fall outside broad definitions of reproductive health, can be usefully considered within even broader definitions of that topic.

Certain calls to move away from a focus on mothers in health research doubtless reflect the ambivalence, which others have explored, about maternity in the currents of Western feminist thinking (Adams 1995; Ross 1995). Wider shifts in Western cultures over recent decades also mean that women of the rich world are less often mothers now, while new technologies make their bodies less necessary to the reproductive process. But calls for a shift from mothers can sometimes amount to their abandonment. Inhorn's and Whittle's proposals for a new feminist epidemiology challenge those habits of essentializing women as reproducers, but their discussion of HIV/AIDS largely glosses the matrix—in more than one sense of the word—of this epidemic (Inhorn and Whittle 2001, 562–63). HIV/AIDS most certainly returns us to a potent concentration—political, cultural, economic, physiological—of far-reaching, female reproductive distress. In trying to decenter the mother one must beware not to marginalize a reality still so socially pivotal, and so significant, vital and fraught for most of the women of the world.

Notes

[1] Mondia states that PNG's first confirmed case of AIDS was diagnosed in Port Moresby General Hospital in 1988 (1990, 81).

[2] In the 1920s Dr. Sylvester Lambert was one of the first to remark that many Melanesian populations were then still in the initial phases of response to introduced infections which had savaged Micronesian and Polynesian populations generations earlier (Lambert 1928).

[3] Some PNG societies, including many of those with matrilineal traditions, view rape as shameful and "unmanly," whereas other forms of violence against women, like wife-beating, are more widely condoned, if now increasingly questioned (Bradley 1998 and 2001; Lepani 2001, 74).

[4] This conclusion is difficult to escape, though the status of women in PNG societies varies, and several PNG spokesmen and women have in the past challenged or qualified depictions of women in PNG as oppressed. See, for instance, Narokobi (1980); Rooney (1989).

[5] The top ten causes of death in PNG are pneumonia, followed by malaria, perinatal conditions, tuberculosis, meningitis, heart disease, cancer, accidents and violence, diarrhea and, finally, anemia. The top ten causes of hospital admissions are obstetrics, malaria, pneumonia, accidents and violence, diarrhea, skin diseases, perinatal conditions, other respiratory conditions, tuberculosis, and typhoid (PNG 2000, 35).

[6] Maev O'Collins' (2000) reflections on violence in Papua New Guinea have point for this discussion.

[7] Though her discussion stressed the importance of exploring women's perspectives, Reid's advocacy of "epistemic responsibility," arguing that effective responses to HIV/AIDS must be grounded in understandings of human experience that develop from questioning assumptions and seeking sources of knowledge other than those more readily accessible, applies here (Reid 1992).

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