Staking out the middle range between the macro- and micro-disease in the social structure

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Abstract

Social scientific, public health and biomedical research and writing still largely neglect "middle-range" social forces that shape transmission dynamics of STDs and HIV. Those include marriage, residence, and inheritance rules; kinship systems and dynamics; divisions of productive and reproductive labor; and structured and socialized sexual rules and regulations, punishments and pleasures. Unfortunately, the other ends aren't covered much better. On the micro-level, we still lack certain kinds of data that can be generalized between studies and locales because we too infrequently investigate intimate human behaviors ethnographically and prefer quantitative to qualitative methodologies. This maintains "underground" the very behavioral mores and dynamics (including those of researchers themselves) that we need to understand more clearly in order to avoid merely "sitting on a volcano which is about to erupt."[1, p. 48] At the other end, on the macro-level, not enough of us have sufficiently considered the over-arching, global systems within which these micro-level, "individual" sexual and other behaviors take shape and have meaning. A conceptual focus upon social structure, upon the degree to which individuals exhibit "sexual citizenship," might help to join these two extreme levels together, to document better the micro-ethnographic aspects of sexuality, to unravel the structural forces that shape them, and perhaps to forge new, safe, pleasurable, and health-inducing sexual cultures.

Introduction: is sex a citizenship issue?

During 1990-92 I spent the bulk of nineteen months in Papua New Guinea conducting anthropological field research on Daru island, capital of Western Province. Several of my conceptual paradigms were challenged to the point that I eventually discarded them. I learned that anthropologists cannot really *describe* reality, no matter how profound their training, fine their fieldwork technique, or how careful their analysis. Peoples have multiple, often conflicting and unstable identities, for themselves and to others. A woman's sexual "partner" might be referred to on the same day, much less over time, by two or more different relationship status terms, as a "husband," "customer," and "boyfriend," depending upon context and/or the nature and tone of the researcher's questions. I have accepted that we cannot "represent" fairly what we learn about empirically, for reality is not directly perceivable, but that we can still bear witness, that "good enough" ethnography, as some anthropologists have called it, is morally imperative. I believe that "risk" is one of the most loosely used and potentially wrong-headed concepts that we have in anthropology, public health, epidemiology, and clinical medicine. In lazy, mainstream usage it hides behaviors and their determinants more than it reveals them, it excuses culpability far more than it locates and demands recognition of it, and it homogenizes those who are most inherently heterogeneous — human beings.

My research on Daru focused on different forms that "sexual networking" takes, and on the centrality of sexual networking to the overall political economy. The structure of Daru's "sex industry" is more unique and perplexing ethnographically than is its function sociologically, though sex industries are common around the world and throughout history. Sex industries flourish in communities in which some people can deploy other people's bodies sexually, in which differently embodied persons relate differently to the means of production, and which are fractured by sexual double standards and other social contradictions. Like others, Daru's sex industry is composed of different forms and locales, buyers, sellers, and brokers of multiple sexual services that are given, exchanged, promised or paid for by money, food, alcohol, tobacco, clothing and other material items and gifts. Lisa Law researched the Cebuan sex industry in the Philippines and found 96 different establishments, registered and unregistered.[2, p. 40] In Shan State in Myanmar/Burma, Doug Porter found that "the sex industry" was more "camouflaged" in a "world of homes, hostels, parlors, trucks, clubs, bars, restaurants, 'laundry services,' truck stops, and hair salons."[3, p. 223] Daru's sex industry is both sharply patterned *and* camouflaged, composed of different locales and labor forms, but without any bikini, karaoke, and music bars, hidden to some, obvious to others. There are geographically stable, repeatedly used locales,

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such as the public tavern and hotel lounge bar, one outdoor bush prostitution area, and several storefronts, private houses, and compounds. There are many less frequently used sites, including abandoned buildings, bush areas, other private houses, school grounds, and construction sites. Then there are individual instances of sexual networking (on a road at night, behind a disco dance party, in a cargo barge's bunk house) that perhaps lack form, but which still demonstrate clear function in a political economy.

To and from sex industries circulate buyers, sellers, and brokers of sexual services, and they do so in both fascinating, largely random, and often strikingly patterned ways. Sex industries are supported by economic, social, and cultural demands, for example, that women must marry in order to avoid stigma and to obtain material support. Men are often alleged to have higher sex drives than women, and so are allowed more leeway in satisfying them; elsewhere, women are alleged to have higher libidos, but are punished when they express them. Sex industries are powered historically and shaped politically and economically by high unemployment rates, SAPs (Structural Adjustment Programs), warfare, politicians, tourism agencies, religious figures, discouragement of female political power, legal double standards, and highly gendered divisions of productive and reproductive labor. Throughout sex industries circulate new technological developments, for instance, the explosive increase in the use of the Internet and other electronic media to advertise and facilitate sexual networking and sex tourism. "Affection connection," "pen pal," and "chat room" services connect male customers with "mail-order brides," escorts, and other kinds of sexual partners.[4,5] New electronic media are combining with old social structural imperatives to forge new social relations and to change the face of sexuality itself.

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Sexual networking has complicated, often seriously misunderstood behavioral dynamics and health consequences to it.[6-7] The factors above promote organized sexual networking, but little light has been shone on the second-class status of females and other sexual minorities when it comes to "sexual citizenship." Neither public health, biomedicine, nor social science have yet squarely, consistently, and effectively addressed this important drag on the public health. "Sexual citizenship" is a concept employed by feminist researchers and activists to refer to a "broad constellation of individual, political, medical, social, and legal rights designed to protect bodily autonomy, bodily integrity, reproductive freedom, and sexual equity."[8, p. 992] It comprises a person's *relative* ability to 1) initiate sexual expression freely (*after* one's body and sexual parts have fully matured); 2) obtain and use harmless, inexpensive forms of contraception; 3) choose the timing and meaning of sexual activities, including the freedom to say "no" (or "yes") to any or all such without stigma or material loss; and 4) obtain timely, effective treatment for genital or reproductive tract ailments.[9-10]

Looking at public health issues this way suggests a different set of concerns than usually circulates in the mainstream. Proponents of one or another version of sexual citizenship have theorized that sexual intercourse is seldom if ever *safe* for heterosexual females, the less so the younger and poorer,[11,12] much less fully *consensual*, in cultures of male domination. Health messages that promote sex as being "safe," even "safer," that assume "consent" with respect to the "negotiation" of condom usage, are therefore flawed and wasteful of resources. Those who have significant comparative ethnographic experience have shown that, increasingly, "the face of AIDS is a woman's face," that "the cumulative effects of lives of poverty and sexual exploitation force many women into circumstances where sex becomes a survival strategy."[13, p. 39] Trying to survive in a "faithful" coupling too often means to risk pathogenic transfer and physical and sexual violence. Monogamous heterosexuality is for many women the problem, not the solution.

The structural forces of normalcy

In this essay I want to discuss in more detail some of these issues of the public health. My thesis is that under conditions of 1) compulsory heterosexuality; 2) male dominance; 3) culturally sanctioned norms of and for monogamy; and 4) strong discouragement of non-penetrative forms of erotic expression, *simply being heterosexual and monogamous presents for females and other sexual minorities serious health risks*. This may sound counter-intuitive—we are told constantly that to avoid AIDS is to become or remain heterosexually monogamous, trusting, and faithful. Not only is critique of middle-range norms and rules frequently absent from mainstream biomedical, public health, and even social science writing, but their seeming normalcy misconstrues what are often highly gendered health risks and outcomes.

Some of the problem is due to the academic and practical, occupational and intellectual lines that divide us. Nancy Goldstein has hit on two; for the disciples of immunology, AIDS is a syndrome, not a disease; the goal is to prevent people from contracting HIV in the first place or to help HIV-infected people maintain health. Virology, on the other hand, takes a microscopic view of AIDS in which 'HIV disease' begins the moment a person is infected with HIV . . . Hence, one's choice of paradigm is no small matter, affecting as it

does one's governing conception of HIV/AIDS, its manifestations, and the path oneself and one's culture should take in combating it.[14, p. 3]

Out of the many other versions that could be cited, in neither of these two are social structures or structural forces really implicated. This locks us into committing a number of what philosophers of science refer to as "naturalistic fallacies," that is, confusing what *ought to be* with what *is*. For instance, we assume that sex *is* safe for women under "normal" conditions (that is, *being* married, monogamous, and heterosexual, *having access to* contraception, and so forth) either because it *ought to be* or because, more likely, it already is so, but *for men*. We also promote gender-neutral health education materials, when what we and our clients and patients need is information *specifically gendered* and *specific to genders*—not just to two of them, either. We show the same disdain today for the prostituted women we dub members of "high frequency," "core transmitter groups" and as "pools of infection" with HIV, as infective "bridges" to "the general population," as we did in the nineteenth century, in India, the U.K., the U.S., South Africa, and Hong Kong, regarding venereal diseases. As during the nineteenth century, during the time of AIDS, prostituted women and members of other sexual minorities have been locked up, experimented upon, and put under surveillance, and upon them have been blamed local and regional outbreaks of disease. They connect "home" rhetorically with "outsiders," with "foreigners," by the "riskiness" of their persons and sexual activities—indeed, they bear huge explanatory burdens for everyone. We miss thereby both how little agency they often have, and how much agency they sometimes exhibit by demanding condom usage more frequently than most non-prostituted housewives, by promoting STD awareness, and by doing sex as safely as they can,[2] and thereby educating others. Too many health promotions and too much popular knowledge valorize virginity, youth, housewives and housewifery, trust, love, and faith. Too few of us can imagine the degree to which these institutions, states of being, and values can disempower and disable the marginalized. Few researchers have begun with the assumption that marriage is related dialectically is to prostitution, virginity to promiscuity, faith to risk, monogamy to danger.

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Because we misidentify the extent of the risks to which "normal," monogamous women are subject, we often fail to locate the appropriate site of bodily, geographical, and behavioral interventions. We have assumed that women and other sexual minorities can "just say 'no'" to unsafe sex, much less just say "yes" to that which is healthy and pleasurable. We assume that women are as likely as men to be able to "negotiate" barrier methods of protection and that "female" condoms provide an appropriate equivalent to the "male" condom, because "it is a method that women control," as if negotiation were all that easy and risk-free. We promote "self-empowerment" among those who aren't allowed them. We appear to believe that coming to STD or other clinic and medical settings presents no special problems for women as against those of men, for single as opposed to married women, and for sex workers as opposed to housewives. When women don't even attend, or when they abscond from clinics, we chalk it up to "cultural" or "linguistic" obstacles, not to structural constraints such as cost, geographic distance, and likelihood of sexual predation. We seem complacent and unquestioning in our beliefs that good health is *maintained*, when good health is nothing if not *produced*.

How might we better see the social structural forces that make ill the health of those who lack full sexual citizenship? To focus upon "sexual citizenship" requires that we look "up" from microbes and "down" from global relations of domination. Lacking or absent sexual citizenship can be seen most clearly in view of the following behavioral domains: 1) sexual violence, particularly that which is becoming eroticized by new media; 2) "domestic" violence, or wife- and girlfriend-bashing, that builds upon "traditional" forms; 3) homophobia and anti-gay and anti-lesbian violence; 4) the discouragement of female sexuality *per se*; 5) the sanctioning of penetrative-only forms of sexual pleasure; 6) double standards regarding number of sexual partners allowable (concurrently and lifetime); 7) gendered barriers to health care, including contraception and the right to abortions; 8) social stigmatization regarding issues of the body and sexuality, particularly genitalia; 9) unequal representation on local and national political levels.

Why have these issues been dealt with more by deafening silence than by struggle and debate? Part of the reason is that health workers have been far too shackled by an often mis-understood and mis-applied cultural relativism that stops at the borders (though pathogens don't) and that winks at perpetrators of harm instead of halting them. Ethnocentrism is alleged when concern is exhibited across national borders regarding sexual violence, wife-beating, poverty, and STDs, despite that each of these cross all known cultural, linguistic, and geographic boundaries. I sense that when this concern is exhibited, particularly by less well connected individuals, "outsiders" such as myself, the charge is too often that it is being *necessarily* imperial-

ist. Though each of these *are* culturally sensitive issues, sexual expression is a human right, and it doesn't have to be so dangerous. I think that cultural *sensitivity* around certain issues is often more about social contradictions and cleavages, uncomfortable silences *in* those cultures in question—what is the phrase, "*cultural* sensitivity" euphemizing, anyway? It almost never refers to the sensitivities of the disadvantaged, but rather, is a notion *deployed by* elites, whether those be of class, gender, sexual identity, occupation, politics, public health, business, or religion.

Indeed, full sexual citizenship, the right to sexual pleasure, should be everyone's natural birthright. Sexual expression can by itself, as members of many cultures recognize, induce good health and welfare. As members of myriad human communities, we should have decided by now that sexual violence is wrong, that it is a drag on full human development, and that it represents a pernicious, degrading human rights violation and also a significant public health problem. It deserves zero tolerance from each and every one of us, as individuals, and as members of communities, cultures, and organizations. We can affirm the vibrant, pulsating diversity that characterizes world culture and world cultures without negating the similarities that bind us together, that shape and define our common humanity.

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Starting in the middle

To understand these issues better I want to tease out Samuel Friedman's suggestion[15] that AIDS-related work must focus more acutely upon "middle-range social forces." He and other researchers[12,16,17] have chastised the simplistic approaches taken no less often by social scientists as by epidemiologists as by public health specialists and clinicians. This is why we need to take care that we develop ourselves and our work theoretically, too. In cultural anthropology and kindred fields we have tended to promote over the past couple of decades notions of "resistance," of "counter-hegemonic" behaviors (political protest, flight, subversion, foot-dragging, and so forth). Nevertheless, these theoretical developments drawn often from ethnographic insights can have the effect of overemphasizing the extent and effects of individual agency, such as "Rational Choice" theories and the Health Belief Model, and of individual-centered "solutions" proffered by "development" discourse (for example, making small loans to women).

Correspondingly, those who prefer less individualizing conceptual frameworks make the same mistake, but in the opposite direction: all structure, no agency. Medical anthropologists, for instance, when they try to account for health problems and their underlying causes, sometimes tend toward *theoretical/conceptual* over-criticism without pointing to specific, feasible and effective solutions. However understandable this impulse may be, it doesn't necessarily lead to the implementation of "harm-reduction principles," at least not ones to which we can adhere while in the field or promote from the armchair when we return. Implementing sexual citizenship is one such case in point—it is easier said than done.

On the other hand, clinic-based medical, and even many epidemiological, models almost by definition can't and don't get at analytical units much larger than the individual, despite epidemiology's grounding in "population" comparisons. In terms of the international readership of this journal, I'd like to suggest that people and organizations think twice about promoting "wellness-seeking," "health-seeking" *behaviors* by largely individuals, without first attempting to find out what makes people sick in the first place. This tendency blunts even the best intentioned shifts that those who are more quantitatively oriented are beginning to advocate. Think about who is going to be blamed, given this individual-centered approach, when the person either can't "seek out" health and wellness, or is still sick after the treatment.

For instance, Jacques du Guerney and Elisabeth Sjöberg's editorial review is a step in the right direction. Nevertheless, it advocates as if it were a new thing, the kind of "gender analysis" that feminist scholars and activists have been calling for for at least two decades. Moreover, du Guerney and Sjöberg's analysis of "sex roles" is painfully gender-"neutral" precisely when it ought to be gender-saturated; women *are* assigned these roles, men *are* assigned those roles, men *have* leadership roles, women *lack* them, and so on.[18, p. 1028] Women and girls are "under pressure" to give up employment and education, though it is not stated *by whom*; the duties of caring for the ill *will* fall to elderly women and girls, and overburdened women are *forced to sacrifice* other activities. They never say by whom.[18, p. 1029] Oddly, though individual men *per se* are never implicated in this article, nor are males in any kind of gendered sense, the suggested "solutions" are as often as not pitched at the level of the individual, in this case, at women's *self*-empowerment.

Their call is really for *self*-empowerment of women in context of HIV transmission and sexual labor, therefore, but without paying sufficient attention to the analysis of *how things came to be what they are*. One critic of such calls recently pointed out that "[m]odern epidemiology is oriented to explaining and quantifying the bobbing of corks on

the surface waters, while largely disregarding the stronger undercurrents that determine where, on average, the cluster of corks ends up along the shoreline of risk."[19, p. 103] Paul Farmer[20, p. 101] points out that in Zaire during the 1980s and 1990s, "one's likelihood of coming into contact with unsterile syringes is inversely proportional to one's social status." In other words, "individuals" don't necessarily *take* risks all by themselves, but rather, behave and act in ways the limits and parameters and consequences of which were set out well before they arrived on the scene—Zairians don't need self-empowerment to avoid needle sticks and over-antibiotification. However well-intentioned, hard-working, and committed the physician may be, therefore, she or he treats individuals one at a time—and by definition, too late to consider, much less do anything about the structural forces and factors that preclude, obviate, or at least complicate prevention. As Peter Brown puts it, "clinical medicine is not well equipped to be effective on a larger, social level. The tools of clinical medicine are not designed to prevent health problems from occurring in the first place."[21, p. 434] Kaja Finkler compared Mexican Spiritualism and biomedicine as practiced in Mexico and demonstrated the same dynamics at work: "biomedicine, by treating individual bodies without transforming people's lives, fails to contribute to new social forms for the collectivity. It succeeds only in maintaining its hegemony as the major authorized provider of health care legitimate by the state."[22, p.126]

The problem is thus one of swinging analytically between *either* the structures of global domination—capitalism, racism, sexism, religious fundamentalism, the state, and so on—*or* the often micro-sociological, psycho-behavioral, immunological, and virological approaches that are taken down to the level of the individual, if not further down to the level of the individual's body, body parts, and parts of body parts. This latter style of approach is what Peter Duesberg labels "misguided microbe hunting."[16, p. 463] Sherwood Gorback and John Bartlett[17, pp. 107-08] refer to this problem as resulting from philosophic models of infection that are based on concepts of microbial monoetiology [single causes]. Pasteur demonstrated that certain microorganisms were responsible for specific syndromes. This concept was formalized into its present liturgical style by Robert Koch in his famous "Postulates." The concept of monoetiology applies to infections such as lobar pneumonia, typhoid fever, diphtheria, and cholera. But this classic design does not fit most infections associated with anaerobic bacteria. Models of bacterial synergy are perhaps more applicable to such mixed infections.

Root-Bernstein concludes that "[p]erhaps models of microbial synergy are more applicable to AIDS as well."[17, p. 108] On the socio-behavioral level, our analytic lenses are trained on levels too small and too few in number, ignoring if not outright disdainful of the role of social structure.

No better examples of monoetiology can be found than the mantra-like claim made tens of thousands of times daily such that HIV all by itself causes AIDS. Although this thesis has been disproved in many ways and given up by even its formerly most strident supporters, it still seems to grow in strength every day. Such etiological claims are commonly grafted onto further claims regarding prevention of transmission thereof: "[w]ithin the boundaries of existing knowledge, people's control of their own behavior is the only means to restrain the spread of AIDS."[23, p. 74]

Globally health education materials relevant to AIDS are on this count not really that different. Apart from buying into the kind of monoetiological models of disease *causation* as I have indicated above, they stress individual solutions to disease *prevention*, though these just as obviously spring from structural forces and problems: "Just say 'no'," "Follow God's Law," "Beware the Grim Reaper," "Love is Forever," "Zero Grazing," "Don't Die of Shame," and on and on, assumes the very best of the social structure, that is, that it protects, which is naive sociologically.

We believed in overly simplistic models of disease and disease syndrome causation, because of the legacy of monoetiology and of the sociopolitical power of microbial approaches. We imagined people to be necessarily "in control of their own behavior," because we didn't have the courage to face middle-range, structural problems and potential solutions, much less our own complicity in them. We need to explore more "proactively" the kinds of middle-range forces I have discussed above: "those of us who describe the comings and goings of microbes . . . may one day be subjected to the scrutiny of future students of the subject."[20, p. 105]

These misguided efforts are blunting our health work efforts in the Pacific. First, they enable us to continue to believe that HIV antibody serosurveillance tells us anything about AIDS, much less that HIV itself relates simply, straightforwardly, and inevitably to AIDS. Second, they funnel our public health efforts into models of individual, behavioral, psychological, and motivational, *without structural* change. In the Health Belief Model that, in one form or another, has probably influenced more AIDS-related public health, clinical, and psychological work than any other, conceptual possibilities are too often nipped in the bud. Seldom are conclusions reached but that "[c]hanging habits is hard to accomplish since they are often deeply imbedded in cultural and subcultural backgrounds and personal values and norms."[23, p. 74] No doubt, habits are imbedded in "culture," but where does "culture" come from, anyway?

Social structure and health problems

In the interest of promoting dialog, I suggest that we begin by asking how many of our proclamations assume that *individual empowerment* is *the* rational solution to

lacking or absent sexual citizenship issues. Have such proclamations enabled people to grasp better, to the degree to which they recognize them, their own infective and transmissive risks, however complicated and evolving they can be? Have they enabled those risks from being understood in context on a *structural*, institutional level by health workers of all stripes and colors? Have health education materials forthrightly considered *iatrogenically induced illness*, caused directly and indirectly by medical practitioners, procedures, advice, technologies, and surveillance, directly or indirectly?[24] What also need to be discussed are over-antibiotification, immuno-suppressive blood transfusions, unnecessary surgical procedures, pre- and post- HIV antibody-test counseling that presumes HIV infection is a death sentence, hospital isolation, and iatrogenic infections.

In terms of sociological theory, what I'm trying to get at is known as the classic conundrum of focusing upon *either* "structure" (analytically huge levels such as modes of production, racism, and sexism) *or* "agency" (analytically smaller levels such as individual behaviors, monoetiologies). It is not an easy task to join these two levels together analytically in some kind of synergistic, dialectical way. Nevertheless, we can begin with the observation that with regards to most health problems, structure is seen as *super*ordinate to agency in terms of size of analytic unit, but *sub*ordinate to it in terms of explanatory emphasis. If structure is seen as being composed of just a little bit more than the sum totality of social relationships, still, "risks" are seen to accrue to the lives of *individuals*, who *respond* to and *manage* them, avoid them or senselessly disregard them.

The bulk of research and writing on AIDS-related issues is located on this latter level—all agency, very little if any structure. Mainstream literature in the U.S. still promotes "black sexuality's" culpability in shaping HIV transmission dynamics. Far fewer researchers appear concerned about the continuing effects of institutionalized racism and occupational stratification, of environmental degradation and the disruption of family life owing to shrinking or absent employment opportunities,[25, p. 48] of *planned, purposeful* shrinkages of housing and social services during the nightmare years of the Reagan-Bush era.[26] A truly enormous literature has amassed that implicates "black female sexuality," on the other hand, in various non-monogamous, "promiscuous" sexual behaviors that heighten their risks of HIV transmission and, worse, transmission risks to "the general population," a conceptual misnomer that by definition excludes and vilifies them. They are frequently implied or stated outright to reach puberty too early, as if that were actually and necessarily up to them. They are alleged to *initiate* sexual activity too early with too many "partners," as if sexual molestation and predation were not facing them squarely in the face, as if all sexual contacts were necessarily "partners." They are criticized for sexual precocity and for having too little thought of the future, as if the mere hedonistic pursuit of pleasure were all there were to it, as if there necessarily *are* futures in grinding poverty, institutionalized racism, and ubiquitous male violence and sexual predation. Is this any less true in Papua New Guinea or Fiji, in the F.S.M. or Hawai'i?

Relatively few researchers explicitly explore the risks of love, intimacy, affection, trust, and above all, monogamy to these women and girls.[27-28,29] Infinitely more heterosexual women than men practice "monogamy," and infinitely more females have sexual intercourse enacted on them and in them than they themselves initiate it.[30] Thus, "just say 'no'" is a conceptually flawed message not just detrimental to the public health, but actually dangerous for women. The point is not to deny women their own agency when they exhibit it, certainly not to decry the sexual and other pleasures that can be achieved thereby, but neither must we exaggerate, reify, normalize, and promote that which does not very often exist.

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Dis-ease in the public health

The middle-range of structured behaviors and structuring forces, this dynamic nexus between the over-arching structures of domination that are difficult to change (e.g. capitalist relations of production and deforestation) and the micro-specific sexual and other intimate behaviors that are difficult even to see (e.g. condom negotiation), is where we need to concentrate more effort. When we begin to incorporate these larger levels in our clinical practices, theoretical hypotheses, case reports, ethnographic research, and policy planning sessions, our notions of disease and illness will begin to change shape, and our conceptual models of "causation" will begin to follow suit. Have we yet fully discussed the effect of political corruption and financial mismanagement upon the supply of health resources or upon personnel turnovers? Did we listen to warnings about the foreordained likelihood of increasingly antibiotic-resistant strains of bacteria and protozoa? "Health resource constraints" were the most overtly political of the four factors that Candy Lombange mentioned in her 1984 assessment of STD treatment and control issues in Papua New Guinea.[31] Declining staff morale, infrequency of in-service training opportunities, and segregation of services are three more good examples she mentioned of such "middle-range," structuring forces that have negative im-

pacts upon health care delivery. So are imbalanced gender ratios in hospitals, university classrooms, laboratories, and other health care settings; each has demonstrable impacts upon client presentation and regimen "compliance" in clinics. Dr. Bellamy noticed in the nineteen oughts and teens in the Trobriand islands that there was great difficulty in general with hospital patients absconding from treatment, but even greater difficulties getting women to attend in the first place.[32] Over the longer term, that has remained a significant obstacle throughout the Pacific to the stemming of epidemics and has become a significant promoter of the extension of pathogens into new populations.

The social structural forces I am speaking of particularly are sexual violence and sexual harassment, pure and simple. I saw this process unfold graphically on Daru island, as for instance, when I listened to the myriad reasons why women simply and consistently refused to attend clinics out of fear and foreboding of the stigmas that would likely attach to them, or of the sexual come-ons they would experience from male health workers. Think of what effect sexual harassment has upon female students in training to become doctors and nurses, too; this is no less true for U.S. women surgeons as for female students at the University of Papua New Guinea. Think of the number of untreated female STD patients who will slip through the cracks, forever infected, infectious, and suffering. Think of what kind of message is *really* being sent when the acting police chief in a certain province warns actual and potential rapists of the possible harm to *themselves* if the woman they pack-rape happens to have AIDS: "Some of these [rape] victims live in the villages and you never know if the woman or one of your friends [that is, co-rapists, "going in line"] is infected. All those who are involved in these pack rapes expose themselves to the risk of catching this killer disease" (http://www.wr.com.au/national/980415a3.htm). What about the killer disease of pack-rape?

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When we begin finally to push past what we say on the "macro-" level of seroprevalence within and serosurveillance of and upon nation-states, which large-scale, structuring bureaucracies help to promote, we will arrive at a more grounded model of sexually transmitted *dis-ease*. Given a renewed commitment to understanding health problems that affect us all, by applying qualitative methods, meanings will begin to take their rightful precedence alongside, if not over numbers. For instance, what kind of understanding, all too common in the literature, will the following statements promote: "[t]he prevalence of current sexual practice is 26% females and 39% males. Table 4 shows 21% have sex more than several times a year. Of all students, 16% have had sex with more than one partner?"[33, p. 27] Each and every of these terms and percentages employed could be conceptually debated and unpacked for weeks before they could be rendered meaningful to researchers across time, place, study, method, and discipline. For the same reason, a recent pronouncement from former PNG Member for Parliament, Peter Barter, makes as little sense: "We know that most of these [931 reported cases of HIV antibody seropositivity, up until December 21, 1997] were through heterosexual contact and that men and women were equally affected" (quoted at <http://www.wr.com.au/national/980415a3.htm>).

I am therefore against the presumptions entailed in promotions of "rapid ethnographic assessment." I trust "baseline data" the least, for the same reason, and would suggest that K.A.P.-type survey instruments be used, if at all, at the *end* of research, not the start. Qualitative methodology proponents uncover inherently different realities than do those of quantitative ones. Unfortunately, there are too few such proponents of qualitative methodologies who have sufficient power to help enable *persons* to emerge out from behind putative, patterned *cases*. Sexuality, sexual intercourse, and other forms of sexual expression, willing and not so, coerced and negotiated, is simply far too complicated to be counted, categorized, and surveilled upon — it is no different for "HIV seroprevalence," "AIDS cases," and "prostitutes," either. Real, workable, effective solutions have to begin to be sought on more close-in, social levels, instead of on technical, statistical, and diplomatic ones.

We can perhaps begin to practice a fresh approach by paying a different kind of attention to *our own behaviors* and how we approach them analytically. We need to acknowledge loudly and publicly the enormous risks involved in just being "normal," of just being heterosexual in a world that is compulsorily so. Aiming for monogamy in heterosexual relationships that are physically and psychologically dangerous thereby needs to be debated, not accepted. "Trusting" in love, faith, and intimacy in ways that are contra-indicated is something that deserves public discussion, not bland presumption and bureaucratic rubber-stamping. Thinking that a virus, all by itself, is completely responsible for the worst pandemic of our time is simply wrong-headed. This new kind of discussion needs to reflect and be reflected in perhaps a different kind of health education materials.[34] Health workers themselves, perhaps particularly female ones, will thereby begin to rethink their own and their

clients' "risk" assessments and perhaps construct their relationship to "the general population" a bit differently. Indeed, for several interesting ways, health workers are frequently subject to risks that *other* members of "the general population" aren't, and they don't stop at the sexual.

We can begin right now to define and operationalize units of analysis better. Throughout the past 15 years or so, "HIV" (antibody) and "AIDS" (incidence and prevalence) have been for the most part *quantitatively estimated, mapped, and projected,* not qualitatively understood. Seroprevalence figures are, first, produced, and then often compared by employing wildly conflated "estimates" and "patterns," as in the hegemonic constructions, "Pattern I," "Pattern II," and "Pattern III" "countries." *Before "comparing" two or more "things," that is, we should come to know one of them.* Even worse, "HIV" (antibody) and "AIDS" (incidence and prevalence) are, many thousands of times a day, dubbed as being synonymous: "HIV/AIDS." They are conceived of as existing on the level of and understood within the scope of nation-states, thus facilitating the conceptual doubly-whammy of international and intra-national surveillance and quantitative reification.[35] Unfortunately transmission dynamics, medical technologies, medical products, medical techniques, and movements of both human populations and microbes do not hold to those nation-state boundaries. Surely everyone can appreciate that the kinds of "structural adjustments" demanded and macroeconomic measures suggested to facilitate the concentration of capital and state, particularly by organizations such as the International Monetary Fund and the World Bank, "may have created conditions favoring the spread of HIV infection"[36, p. 539]

Given a renewed commitment to understanding health problems that affect us all, by applying qualitative methods, meanings will begin to take their rightful precedence alongside, if not over numbers.

Conclusions

There are probably many researchers trying not to compromise their qualitative principles regarding a or several pandemics that are increasingly monitored, "understood," and surveilled upon by quantitative means. These researchers are pinpointing practicable, workable, effective solutions to some of the issues I have raised in this essay. These researchers are underfunded and relatively powerless. They have often had rather uneasy relationships with more powerful, better connected people and agencies, including other well-intentioned NGOs. They consistently point to the methodological, discursive, public health, and even moral difficulties encountered when one or one's organization adheres to the kinds of quantitative approaches that 1) accept the non-permeability of political borders, and 2) accept too willingly analytic units such as "risk groups," for instance, "homosexual men," "truck drivers," and "CSWs" (commercial sex workers).

As various researchers in different fields have pointed out, such designations as the above have become part of our vocabularies, consciousness, and health policies and programs, but without the careful, consistent scrutiny they deserve. These terms, *despite* local realities, *despite* the fact that they are contentious ones even in the cultures and countries from which they emanate, are too often sloppily mapped onto other cultures and countries. Members of these other cultures and countries are then implicitly or explicitly requested or expected to "flesh them out" and "dress them up" and then apply them to "solve" the problems that sponsoring agencies tell them they have - as if the latter always don't know, as if the former always do. This process only further instantiates these terms' ontological status, for instance, "C.D.C. case definitions of AIDS" that are inherently cultural constructions, or the existence of "HIV tests" when in fact 99.99% of the time the test in question is an HIV *antibody* test. Let's not just "rethink" this — let's undo it. If the phrases "the gay community," "homosexual men," and "prostitutes" are already greatly reified, inadvisable terms in the cultures from which they emanate in international health monitoring and surveillance, imagine the conceptual difficulties encountered for "local peoples" when they become part of the NGO or WHO package that "local" members/recipients must accept in order to qualify for aid and assistance. Perhaps surveillance is a regrettable, last resort, not a sound initial approach.

Therefore, ask yourselves which of the following terms, concepts, and phrases *really* can be operationalized and are empirically stable enough such that they should remain or become more important features of health policies and health programs: "heterosexual AIDS", "AIDS testing", "AIDS virus", "commercial sex workers", "homosexual men", "lesbian sex", "bisexual men", "AIDS transmission", "monogamous relationships", "faithful partners", "Pattern III Country", "largely via heterosexual transmission", "AIDS knowledge", "national estimates", "core transmitters", "pools of infection", "prostitutes", "husbands, who then bring it back home to innocent wives and children", "99.7% specificity", "promiscuous intercourse" and "sex".

Now, recall the point about multiple, shifting, conflicting identities. Doug Porter has argued perceptively in a recent essay, "*A Plague on the Borders*", with great relevance to those who work in the insular Pacific, that "the entry of agencies concerned with the HIV pandemic marks a new phase in efforts to impose borders and boundaries on this

contested region . . . [T]hese projects represent a new 'plague *of* borders' [my emphasis] through which externally derived identities and sexualities travel and add to the multiplicity of contests over terrain and identities that are already apparent."[3, p. 217] He argues persuasively that macro-level terms and concepts such as "epi-center", "frontiers", "margins", "prostitution", "borders", "home" versus "foreign," and so on, much less more micro-level terms and concepts such as "truckers", "heterosexual spread", and so on, dangerously simplify what is an infinitely more complex, shifting, and fluid situation. In fluid states/States, there aren't any "epi-centers" and "margins" but the conceptual, or at least one couldn't know otherwise until after the fact, after the kinds of methodologies have been deployed that produce data interpretable in no other way. "Sentinel sites" in other words, and "core transmitter groups," and "transmissive bridges" to "the general population," too, are simply and demonstrably flawed models *of* reality, though they be most effective models *for* reality; in other words, they certainly don't *de*scribe the ongoing situation so much as *in*scribe it.

Paul Farmer has argued alongside Porter that epidemiological units such as "nation-state" are useless and worse with respect to dengue virus, HIV, hepatitis B, and the form of gonorrhea that produces penicillin resistance. He, too, decries the kind of "avidity for numbers" noted by prominent international AIDS experts, and notes further that [such organisms have often ignored political boundaries, even though their presence may cause a certain degree of turbulence at national borders. The dynamics of emerging infections will not be captured in national analyses any more than the diseases are contained by national boundaries, which are themselves emerging entities — most of the world's nations are, after all, 20th century creations.[20, p. 100]

Farmer has therefore called for a "sociology of liminality," of the structurally determining forces and consequences of pathogenic, palliative, and transmissive boundary-crossing, by bodies, pathogens, and policies.

Are we ready to move conceptually and otherwise away from the comforts of thinking about transmissive "epi-centers" versus "margins," away from "risk group" theorizing about HIV transmission and overly individualizing models of transmission prevention? Can we learn how to avoid the naturalistic fallacies of assuming that, because women can *use*, say, new forms of contraception and microbicides, they are necessarily in *control* of them?[37,38] Are we ready to design microbicides that don't abrade genitalia, subvert the immuno-protective function of mucus membranes, or make only one gender responsible? Are we ready to face up to the fact that paradigmatic classification schemes may have "only limited usefulness today," that their "continued application obfuscates our ability to describe the distribution of HIV according to characteristics or behaviors that are alterable,"[39, p. 566] if by social structural means, not psychological? Are we ready?

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The language of the men of medicine is a fearful concoction of sesquipedalian words, numbered by their thousands.

Frederick Saunders (1807 - 1902)