Meeting Moses came as an enormous relief. It was our first day on Nuakata, when everything around us seemed strange. Until Moses arrived at Hapela’awa‘awa, the hamlet where we had slept our first night, we were given a polite yet wide berth by the people around us. Clearly bemused by our presence, they were struggling to understand why we had come to Nuakata. Why Nuakata in particular? As I was feeling alien, dislocated, it was perhaps not surprising that the constellation of questions—on gender, person, women’s health—that brought me to Nuakata seemed misplaced. Removed from the safety of the text (i.e., the formal research proposal) and thrust into the everyday flux of hamlet life, my questions and the anonymous medicoscientific and ethnographic facts that inspired them seemed irrelevant, foreign, contrived. Most preposterous of all, however, was the assumption that my research might “assist” the people of Nuakata. No longer imaginary figures, these living people, variously perplexed, amused by, or indifferent to my research intentions, caused me to reflect again on my imposition. To this end, a dimly recalled comment by Fabian proved salutary:

We will always be liable to be seen (correctly) as old colonizers in a new guise as long as we understand critical, emancipatory anthropology as doing our critique to help them—be they the Third World, the working classes, the disinherited, women. . . . Who are we to “help” them? We need critique (exposure of imperialist lies, of the working of capitalism, of the misguided ideas of scientism, and all the rest) to help ourselves. The catch is, of course, that “ourselves” ought to be them as well as us. (1991, 264, emphasis in original)
Fluent in English and able to understand Alina Nu’ata, Moses negotiated my unease with the polite self-assurance of a diplomat, fostering conversation that restored a sense of equilibrium. Twenty-two years old, and formerly from the islands of Gawa and Kiriwina to the north, he had nearly three years of experience behind him as the sole community health worker (CHW) on the island. Anthropologists were not an unknown species to him, for he had vague childhood memories of Nancy Munn’s time on Gawa—memories reinforced by stories told about her by his kin.² As I attempted to explain my proposed research, my interest in women’s health, Moses became increasingly animated, even excited. Trained for two years in Western medical practices and clearly convinced of their worth, he was critical of local customs surrounding sickness and health. Community resistance to his involvement during pregnancy and childbirth frustrated him. He nominated maternal health as one of the most important health issues on Nuakata, along with malaria and diarrheal diseases.

Oblivious to it at the time, we later realized that Moses’ role with us on that day reflected his place in the community as a highly respected outsider, a Papuan familiar with the ways of dimdim. Regarded, in part, dova dimdim (like a white person), because of his education and knowledge of dimdim medicine, Moses was considered the obvious person on Nuakata to discern and interpret our concerns. He, in turn, subsequently perceived and represented me to the community as an ally in his struggle to improve the health of women on the island.

Talking with me several weeks later, Moses insisted that as a woman and a dimdim I was better placed than he, a young, single Papuan male, to acquire the respect and confidence of Nuakatan women. Perhaps I could persuade local women of the superiority of Western medical practices in relation to pregnancy and birth. However, in positioning me this way Moses evoked my ambivalent faith in Western medicine. In resisting the certainty of his convictions, I was alerted to my nostalgic hankering to uncover and (dare I say) preserve traditional Nuakatan knowledge and practices relating to pregnancy and birth—practices surviving from an idealized, and to that degree fictive, precolonial past.

Nostalgia of this kind not only assumes the existence of an imagined past, it also pretends that preservation of “culture” is possible and, more to the point, unequivocally desirable—surely nonsense on both counts. As Rosaldo explains, “mourning the passing of traditional society” and the “salvage ethnography” it has inspired have a long genealogy in...
anthropology (1989, 81). Spawned by the recognition of “the destructive intrusions of imperialism and its colonial regimes” in non-Western, non-industrialized societies, such a salvage ethnography is also intended as an implicit critique of “modern [and postmodern] industrial society” (1989, 82). It was from this ideological wellspring that my own nostalgia flowed. And it was a hybrid feminist inflection of this anthropological tradition that was present in my initial approach to fieldwork.

At one level I wanted to believe that Melanesian childbirth practices were more authentic and wholesome experiences for Nuakatan mothers than those of their Western counterparts. I was not a pioneer in this pursuit. As Dureau (1993) observes, writers such as Mead (1949) and A. Weiner (1976) have attempted to retrieve and represent a romanticized vision of Melanesian motherhood in implicit contradistinction to the inauthentic and defiled vision of Western maternity (see also Ginsburg and Rapp 1991; Jolly 1998b; Ram 1998).

As heir to second-wave feminist critiques of Western medicine’s increasing appropriation and colonization of pregnancy and birth, I was familiar with the vast literature attesting its progressive attempts to objectify and assume control over women’s bodies. A burgeoning literature detailing the negative impact of new reproductive technologies (NRT) on women’s experience of pregnancy and birth is also emerging. Accordingly, I feared the consequences of Western biomedicine’s continued infiltration of Nuakatan sociality. I feared Nuakatan women would be displaced from their central role in maternity, their knowledge and expertise would be devalued and lost, and they would come to imagine pregnancy and birth as a physical event, rather than a multifaceted phenomenal experience that expresses historical relationships between people. An awareness of diverse historical precedents in Pacific and, more specifically, Massim contexts reinforced these fears (Denoon 1989a, 1989b; Jolly 1991, 1992a; Young 1989b).

During the late nineteenth and twentieth centuries, British concerns about depopulation and infant mortality surfaced in its colonies among colonial administrators and missionaries. As a result Pacific mothers and mothering practices were subject to increased surveillance and modification by missionaries and colonial government personnel. Environmental issues (sanitation, housing, water quality) were identified as significant factors precipitating decreases in local populations. However, explanations that focused on indigenous mothering practices—specifically, the ignorance, licentiousness, or insouciance of native moth-
ers—received more sustained attention and responses from administrators and missionaries across the Pacific.

British colonial responses to depopulation were by no means uniform across the region (see Jolly 1998a, 1998b). In Papua New Guinea colonial medical administrators were initially preoccupied with the health of expatriates and the indigenous male labor force and only turned their attention to indigenous women’s maternal health in the 1930s (Denoon 1989a, 1989b). However, during the late nineteenth and early twentieth centuries Anglican and Methodist missionaries, like the Bromilows in the Massim, actively sought to transform indigenous women’s maternal practices. Reed (1998, 68–69) suggests that the depopulation debates further legitimated their efforts to discourage sexual promiscuity and “raise” or “lift” the way of life of Papuan women and, through them, the village communities to which they belonged (see Bromilow 1929). Massim missionaries believed that by channeling what they considered the promiscuous sexual energies of Massim girls and women into mothercraft, domestic hygiene, alternative gardening, and health-care practices, they might arrest depopulation and win native bodies and souls for Christ (Eves 1996a; Macintyre 1989a; Reed 1998; Young 1989b).

But my nostalgic hankerings to recover Nuakatan maternity practices cannot be fully explained by my ambivalent response to Western medicine’s appropriation of the maternal body. For this nostalgia was coupled with an unashamed and defiant romanticism—a romanticism that critically valorized women’s experiences of maternity (Dinnerstein 1977; Rich 1976) without deeming them constitutive of the category “woman,” or a defining point of “the feminine.” Long fascinated by the miracle, the mystery, the sheer wonder of birth, I was drawn to the feminist literature of the 1980s that suggests that women’s diverse experiences of maternity and motherhood enact and evoke distinct ways of thinking and understanding (Mortimer 1990; Ruddick 1980, 1989; Wilshire 1989)—ways that counter the dominance of reason in the Western world. Phenomenological renderings of pregnancy and birth in Western contexts challenge the notion of the autonomous subject founded on unsustainable oppositional relationships such as mind/body, inner/outer, subject/object, individual/society, nature/culture (Kristeva 1980, 1986; I. M. Young 1990). Accordingly, “pregnancy challenges the integration of my body experience by rendering fluid the boundary between what is within, myself, and what is outside, separate. I experience my insides as the space of another, yet my own body” (I. M. Young 1990, 161–63). Encouraged by Young’s work, I
sought to elicit Nuakatan women’s embodied experiences of pregnancy and birth as a means of reflecting on local notions of the self and person. I was also drawn to, touched by, yet unable to embrace, the writings of the French theorists (Cixous 1981a, 1981b; see also Grosz 1989, 119–26; Irigaray 1985a, 1985b) and the coterie of Anglo-American theorists that joined their celebration of the poetics of the female body through “writing the body” (l’écriture féminine) (Mallett 1995). Wary of the mystical, essentialist proclivities implicit within their work, and the ethnocentric vision of the female bodies this has promoted, I was nevertheless inspired by their poetic reclamation of the maternal body from the clutches of phallocentrism.9

My romanticism was tempered by other ideas and voices. A disquieting suspicion lurked in my thoughts that my fear (of Western medical intrusions) as much as my romanticization (of the potential meanings and significance) of Nuakatan women’s experience of maternity reflected a form of contemporary white female maternalism—a maternalistic (neo)colonialism.10 It was the form of colonialism appealed to and valorized by Moses when he suggested that, as a woman and a dimdim, I might be able to convince local women to adopt Western medical practices. This suspicion was fueled by two sources: my reading of the writings of women of color (see hooks 1982, 1984, 1991; Moraga and Anzaldúa 1983; Stack 1974) and the ethnographic writings of several anthropologists, Dureau (1993) and Scheper-Hughes (1985) in particular.

Countering romantic visions of non-Western maternity, Dureau asserts that women living in the western Solomon island of Simbo consider motherhood and maternity a “profoundly ambivalent state and relationship” (1993). Some Simbo women complain of the work load, the physical demands young babies place upon them, their diminished capacity to fully participate in community events. Others speak of fatigue and ill-health associated with pregnancy and birth. In so doing, some among them idealize Western maternity. Following Moore (1988), Dureau questions any “globalizing tendency” present in understandings of maternity, strongly suggesting “that the particular cultural evaluations, experiences and significance of maternity must be established for each ethnographic case” (1993, 31; 1998). Dureau’s thoughts are supported by Merrett-Balkos (1998) who reveals that for Anganen women in the Southern Highlands of Papua New Guinea birth is not an experience that is easily romanticized, for it is potentially fraught with spiritual danger. Similarly in rural Bangladesh birth and birthing women are considered potentially
polluting and therefore dangerous. Accordingly, Rozario (1998) cautions against romanticized accounts of traditional childbirth, rightly pointing out that they often overlook the difficult contexts surrounding births and the life-threatening dangers posed to mothers and their children. These themes are further elaborated by Scheper-Hughes (1985; 1992, 340–445).

Through her writing on the experience of mother love and infant death for women living in a northeast Brazilian shantytown, Scheper-Hughes challenges poetic theories of motherhood. She claims that poetic theories “do violence to the different experiences and sensibilities of poor and Third World women whose moral visions may not conform to the feminist paradigm” (1992, 341). The poetic theories to which she refers are those “proposing essential, or universal, womanly scripts” (1992, 341), in particular “Sara Ruddick’s (1989) ‘maternal thinking,’ Nancy Chodorow’s (1978) ‘feminine personality,’ and Carol Gilligan’s (1982) ‘womanly ethos’” (Scheper-Hughes 1992, 401). She argues that these and other theories of “maternal sentiment” are a by-product of a particular sociohistorical, economic, and political context. As such, they represent “an ideological, symbolic representation grounded in the basic material conditions that define women’s reproductive lives” (1992, 401). For these writers, empathy, intuition, and even pacifism are celebrated as inevitable, even natural consequences of maternity—assumptions and values about maternal nature that Scheper-Hughes asserts derive from the modern Western, bourgeois family. Challenging this, she contends that the experience of maternity and motherhood may “just as ‘naturally’ reproduce maternal sentiments of distance and estrangement as of attachment and empathy” (1992, 403).

Scheper-Hughes posits a pragmatics rather than a poetics of motherhood (1992, 341–402)—one that attempts to understand the complex factors that constitute women’s diverse experiences of maternity and motherhood, even when these understandings pose a fundamental challenge to the (feminist) anthropologist’s belief about what is normal, ethical, and, I might add, desirable, even universal.

Although critical of Western medical knowledge and intervention in relation to pregnancy and birth, I—like Moses—was fearful of its absence in remote and isolated communities like Nuakata and worried by the consequences of diminished choices—itsself a notion based on a culturally conceived expectation about the fundamental rights of the autonomous individual (Ginsburg and Rapp 1991, 314–15; Gordon 1976, 314–15; M. Strathern 1992). While mindful that infant and maternal mor-
tality rates have long been used in many contexts to justify radical and often dubious transformations of maternal behavior (see Kaufert and O’Neil 1993, 537; Oakley 1980, 128; 1984, 129), I could not ignore the basic fact that many more mothers and infants die as a result of preventable medical conditions arising during childbirth in Papua New Guinea than in so-called developed countries (Gordon 1990). My concerns about the absence of Western-style maternal health care were only intensified by my knowledge of the ever-diminishing national Papua New Guinea health budget (Mola 1991, 275; Thomason and Newbrander 1991, 629) and the gap between the theoretical goals and practical realizations of maternal and child health care in rural Papua New Guinea (Edwards 1992, 1994).

Feeling a great sense of indebtedness to Moses for all his efforts on our behalf and grateful too that he understood something of my research, I did little in those early days and weeks to dissuade him from his view of my role. After all, who would not wish to be an ally in the struggle to improve people’s health and well-being? While mindful that an alliance, or even a perceived alliance, with Moses might influence the course of my research, I remained confident that I could overcome any misperceptions that might arise. Like Moses, but possibly for different reasons, I assumed that because I am a woman, opportunities would soon arise with women to explain my broader interests in their customary knowledges and practices. In those early days and weeks I gave little thought and no credence to the adage that actions speak louder than words, that my actions rather than my faltering words might be construed in ways I had not anticipated.

**Because I Am a Woman**

But what did I mean by “because I am a woman”? How did I intend to act because I am a woman? How did I imagine people, men and women, would respond to me? What impact, if any, would my being a woman have on my research?

At one level, both in spite of and because of my theoretical ideas about these matters, I—like Moses—assumed that the partially visible form of my sexed body (e.g., breasts, body shape) together with the other implied yet invisible sexed parts and their secretions would represent and constitute me as (a) woman, and not (a) man, to the women of Nuakata. Women’s early responses to me—in inviting me rather than Roger to attend
the Women’s Fellowship meeting, urging me to bathe in their presence—ennobled this assumption. I imagined that, despite potentially different cultural discourses and practices associated with or elaborated within, upon, or by sexed bodies, I would share fundamental experiences and knowledge in common with the women of Nuakata associated with our shared bodily form and praxis—among them, knowledge of our potential to bear children. In this sense, the specters of maternity and heterosexuality infused my notion of woman (Butler 1990, 1993; Wittig 1981). Further, I assumed that these shared forms and potentialities would provide us with a basis to speak and build relationships with one another, which in turn would facilitate my research. To this end I would do as Nuakatan women do: tend gardens, prepare meals, wash clothes, attend Women’s Fellowship meetings, and so on. Overlooked, however, was the reality that as both researcher and outsider I would do much that local women do not do and vice versa, and that this, too, would be interpreted by local people.

While I believed that my sexed body would constitute and position me as similar to the women of Nuakata, paradoxically I hoped that this difference would not significantly impact on my research with men. With men I wished to be positioned as an androgynous subject, with women I wished to be positioned as a female subject. In same-sex relations I wanted sexual difference to count, to render us similar; in cross-sex relationships I did not. In short, I wanted things both ways. Perhaps more accurately, I wanted my relationships with people to go all my own way, even if those ways were patently contradictory! In what might be described as magical thinking, I assumed that my relationships with men could somehow transcend sex and gender, except in specific situations where I did not wish this to occur. With women I hoped that the form of my body would count more than my actions, while with men I hoped the reverse would be true. Although I cringe at the thought, these latter working assumptions partly reflect the idea that sex/gender belongs to woman/women. Sex/gender is pivotal to women’s subjectivity. It is largely irrelevant to the subjectivity of men, or relevant only as an insignificant absence or elision. I therefore vacillated between an understanding of “I”—of subject/self—as substantive, gendered, and an understanding of “I” as insubstantive, processual, and enacting. However, in living/enacting these vacillating positions, I demonstrated a consistent embodied understanding/expression of “I” as contingent, multiple. As
such I demonstrated that the speaking/acting context influenced both how I spoke/thought about concepts of the gendered self/"I" and how I enacted self/"I."

The most obvious difficulty associated with my ideas was that they anticipated what was yet to be investigated—namely, gender, gendered identity, the gendered person/self, gender relations, sexual difference (see Moore 1994c). In casting myself as sexed, I unwittingly sought to cast Nuakatan women in my own image and form, believing that whatever the differences between us, in sharing same-sexed bodies we were more similar than different. Not only did this thinking assume the primacy of the visible form of the body to both the gendered self and gendered identity, it also posited sexual difference as a universally significant distinction, reducible to mutually exclusive binary categories (male and female) that ground all other identities and selves (see Moore 1994c). I acted and proposed to act as if the sexed body precedes and grounds subsequent lived experience, which is itself informed by sociocultural and historical discourses. As such, the body is ontologically sexed, but this does not constitute some form of prescriptive essence. Rather, it provides one’s context, position, or particular vantage point—which, by definition, is also a constraint or limitation—with/in the world. The form of the body informs without strictly causing one to act. Accordingly, sex and gender (female/woman, male/man) converge and conflate around the form of the body and diverge where and when this form is elaborated and “woman” becomes a partially stable, universal category founded on the female form/substance of her embodiment.

Having lived without scrutiny or reflection while on Nuakata, my fieldwork assumptions recall Braidotti’s theoretical elaboration of Rich’s (1976) notion of feminine corpor(e)ality, mixed with a dash of Foucault’s (1978) discourses about sex and a sprinkle of feminist standpoint theory (Harding 1987a, 1987b; Harstock 1987). Before going to the field, I had been attracted to Braidotti’s (1991) vision of embodied subjectivity—founded on the idea that the (sexed) form of the body (in)forms experience—however, I remained only partially persuaded by her broader argument. Most appealing to me was her notion of the body, cogently summarized by Moore as “an interface, a threshold between the material and the symbolic” (1994c, 18). Braidotti’s “body” is neither a prescriptive essence that determines an essential subjectivity nor a blank slate upon which sex/gender is inscribed; rather, the body—in its very specificity and
materiality—locates and embodies subjectivity/subjectivities (Braidotti 1989, 101). Thought of as a threshold, the body both locates and is located by its sociohistorical contexts, transforming as it is transformed by them.

But my greatest difficulty with Braidotti’s argument stemmed from the very aspect of her theory that I found attractive, namely, the ascription of primary ontological status to binary (either/or, male/female) sexual difference, and specifically, the argument that the (either/or) sexed form of the body informs all other forms of difference; that form, rather than some other phenomenon, say action or relations, constitutes the most significant similarity or difference between people. That the sexed form of the body is somehow temporally prior to and therefore more significant in locational terms than other embodied forms of difference (e.g., ethnicity, disability, class) is open to dispute on a number of levels. For example, following Foucault (1978), a string of feminist authors, including Butler (1990), Haraway (1991), and Yanagisako and Collier (1987), have noted that sex is a discursive phenomenon. It is constructed in and by discourse. Accordingly, sex does not exist independently of these discourses, and without such discourses bodies cannot be sexed. It also follows that across the world multiple discourses on sex (may) exist. As anthropological and other studies testify, both the categories of sex and the features which constitute them differ from discourse to discourse, culture to culture (see, for example, Herdt 1994; Jackson 1997; Morris 1994). As Moore (1994c, 20) observes, only in theory is it possible to distinguish and prioritize discourses on sex and their effect on, in, and through bodies from those of class, ethnicity, sexuality, cosmology, and so on.

Despite these prefield criticisms of the notion of the ontologically sexed subject, this idea provided me with both a reassuring and a strategic premise for establishing relationships between myself and Nuakatan women. At the same time I also subscribed, at least in theory, to the contradictory view espoused by M. Strathern that “it remains a matter of ethnographic identification whether or not ‘being a man’ or ‘being a woman’ occupies an organizing—representational, systematizing—place in the classification of behavior” (1988, 61). Indeed, it remains a matter of ethnographic identification who and what the terms man, woman, and I designate, and whether or not they are considered static categories (nouns), fluid processes and relations (verbs), or some combination of the two.
My contradictory assumptions were soon challenged, and in ways that were relevant to my consideration of how gender, person, and agency were expressed and/or understood on Nuakata. After living on Nuakata for several weeks I learned that the causal statement “because I am a woman” cannot be spoken, as there is no abstract verb “to be” in Alina Nu’ata. Although the locative verb miya, meaning “to sit, stay, remain, dwell,” passes for the English verb “to be,” in certain contexts it is not applicable to the translation of the statement “because I am a woman.” In both English and German, the verb “to be” formerly meant “to dwell,” however this definition has arguably fallen silent in these languages (see Heidegger 1975). In contemporary usage the English verb “to be” often implies a fixed independent state (of mind, personhood) or form of existence. Accordingly, “being” is objectified as a state of the subject (e.g., I am a woman; I am happy; I am hungry); a state that can be defined and known; a state separable from the contexts integral to “its” enactment. In contrast, staying or dwelling in Alina Nu’ata is conceived as an active pastime. Place and bounded spaces are integral to staying or dwelling (see chap. 4). Unlike the English verb “to be,” which functions to extract and abstract existence from the conditions that characterize it, in Alina Nu’ata the verb “to stay” assumes, rather than denotes, existence. For example, in conversation on Nuakata, the verb “to stay, to dwell” (miya) is often used in contradistinction to the verb “to go, to do” (lau). People conventionally mark their departures from one another by detailing what each of them will be doing and in what context, when they leave each other. Typically, someone may say yamiyamiya na ʻowa ʻulau (I staying and you, you go) or ʻumiymiya na yau, mata yalau yagu dalava (you staying and I will go to my hamlet). Whether one stays, goes, or does something else does not call into question or negate one’s existence. But where, when, and with whom one acts transforms the speaking/acting “I.” As such, existence is inextricable from the activities, relations, and spaces that define it. This is further reinforced by the way the language is written: personal pronouns and the verbs that follow them are written as one word rather than (as in English) two words—for example, yavahili (I read), and not ya vahili.

The closest possible expression for “because I am a woman” in Alina Nu’ata is wuwuna waihiu, yau (because woman, I), or wuwuna yau waihiu (because I woman), however I never once heard this expression used.
In conversation, it was rare for the category “woman” or “man” to be explicitly invoked as a cause of behavior, even though women’s and men’s work and other habitual activities on Nuakata often differed. An analysis of the terms provides some insight into this. Yau is an absolute pronoun, meaning I, me, and mine. It is one of the three pronominal forms in Alina Nu’ata, ya, yau, yabom, which denote the English “I.” Often used alone or in expressions incorporating the personal pronoun ya (I)—which can only be used in conjunction with a verb, e.g., yalau (I go)—the absolute pronoun yau (I) denotes and is used in conversation to draw attention to the unified, singular and particular “I.” It is the “I” that by its specific staying, actions, belongings (to people, things, places) is particularized or unified; for example, yau, Melbin ‘ainaena (I, from/of Melbourne), yau, yapaihowa (I, I work). Similarly the plural absolute pronouns denote singular collectives (groups)—collectives that are unified and particularized by specific act(s), places, relations, or feature(s) shared; for example, ‘aiwaiwaitiu Nuakataena (we women from Nuakata). As with the plural absolute pronouns that denote groups collectively constituted as one, the singular absolute pronoun yau may be thought of as a coalescence of activities and/or relations, unitarily embodied. This embodiment is necessarily spatial; it is located. As such, this discursive “I” (or “we”) is contingent, dependent. The “I” is identified as a unity (based on, for example, sex/gender, age, place, family relationship, clan, activity, etc.) according to the speaking/acting context. It is discursively constituted in relation to “you.” Yau, waibiu beibi ya’avalai (I, woman baby I carry it), or waibiu, yau beibi ya’avalai (woman, I baby I carry it), then, is not spoken or thought as a particular ontological state of “being.” “Woman” (waibiu) and “I” (yau) together here suggest or imply a unitary position or embodied context for speaking and acting in relation to specific others. This does not negate other possible unitary speaking/acting positions or dimensions of “I.”

Several related points emerge from this discussion. The absolute pronoun yau for “I” and the contingent “I,” referred to earlier when I reflected on my own enactment of “I,” have much in common. In both examples the speaking/acting context is assumed to influence, if not determine, the unifying characteristic(s) of the “I” (woman, from a particular place, etc.). Multiple, alternative ways of characterizing/enacting this “I” are eclipsed in these contexts. It cannot be assumed, however, that this unitary, contingent “I” invoked in speech (i.e., the pronominal “I”) and other forms of action is, or is thought to be, a manifestation of
an underlying constant and coherent entity or state of being known as “self/person.” The relevance, meaning and/or expression of such concepts on Nuakata remains to be established or refuted. The unitary “I,” referred to here, provides the context for, and affects social action, agency, without necessarily causing a given action.

This analysis of the contingent “I” resonates with Rumsey’s persuasive discussion in “Agency, Personhood and the ‘I’ of Discourse in the Pacific and Beyond” (2000). By referring to regional and cross-regional examples of (“direct indexical” and “anaphoric”) pronominal usage, Rumsey challenges the view espoused by M. Strathern (1988), Sahlins (1981, 1985), and Mosko (1992) that there are distinctive regional modes of social action or agency. Sahlins argues that chiefly action in Polynesia is premised on a notion of “encompassment.” Accordingly, chiefs use the singular personal pronoun “I” to encompass the actions of many people as their own, “summing up in their own person the lives of many” (Rumsey 2000, 102). In contrast, M. Strathern (1988) posits a uniquely Melanesian form of social action, premised on the notion of the partible person. As such, persons are understood as a composite of multiple relationships, of male and female parts that are both the “source and outcome of action” (1988, 14). While the person is composite, that person’s acts are singular. It is only under the condition of unity that these “acts appear as a composite of social relations. Unity in turn hinges on agency: the agent reveals the unity for . . . it is acts which unify” (1988, 275). Thus for someone to act he or she must eclipse without denying the composite parts of him- or herself. The same is true for collective action. For example, a group of women who work collectively to raise funds for the United Church must appear to act as “one woman.” While fund-raising, their cross-sex kinship ties to multiple others beyond the collectivity are necessarily eclipsed.

Rumsey argues, contrary to Mosko (1992), that these seemingly distinct forms of Melanesian and Polynesian agency are potentially compatible and allow for “moments of both encompassment and partibility” (Rumsey 2000, 101). Moreover, he claims that moments of encompassment and partibility are both “inherent in the nature of language” and the nature of agency in general, most obviously discursive agency (111). It is the latter, universalist aspect of his argument that is most relevant to this discussion of both my own and Nuakatan experience of discursive forms of social agency. Drawing on his own earlier work (Merlan and Rumsey 1991; Rumsey 1989) and linguists Benveniste’s (1966 (1956), 1971) and
Urban’s (1989) discussions of the meaning and use of personal pronouns, Rumsey asserts that we cannot assume that “each situated use of the personal pronoun ‘I’ ‘indexes’ or invokes a constant self.” Rather, following Benveniste’s dialogic and relational view of personhood, he claims that the use of “I” in discourse constitutes the speaker as a transcendent, if not “expansive,” encompassing, subject in relation to “you.” While this human subject is not essentially transcendent, unitary, or centered, there is a “momentary effect”—which is an inherent feature of language—whereby the act of speaking establishes the “current center in relation to which the values of all the other deictic terms (‘here,’ ‘there,’ ‘this,’ ‘that’) are fixed . . . and in relation to which ‘subjectivity’ and performativity” are possible (Rumsey 2000, 110–11). By invoking the “I” in discourse, people, whatever their cultural context or language, posit themselves as unitary agents—unitary agents of speaking. This is true even when in any given speech they move between an encompassing or composite understanding of the “I”; that is, between multiple discursive positions (“projected selves” or identities). As Rumsey suggests, the transcendent, discursive “I” provides a powerful model for the construction of unitary action or social agency in general. It allows us to consider specific manifestations of encompassment and/or partibility and how they “interact with each other” in the “ongoing construction of social identity and agency” in any given sociopolitical and historical context. Most important of all in the context of this discussion of Nuakatan personhood and agency, it “enables us to consider ‘encompassment’, ‘partibility’ and ‘personhood’ as aspects of ongoing social interaction” rather than abstract cultural and/or metaphysical categories unique to Melanesia or Polynesia (Rumsey 2000, 113).

But this discussion of the discursive “I” and the Nuakatan yau tells us little about the relationship between yau and waihiu on Nuakata. It does not address what it means to speak as a woman on Nuakata. For this we need to know what the category waihiu denotes and how it is used. In Alina Nu’ata the noun waihiu, or its plural equivalent waiwaihiu, was used to refer to an individual (woman) or group of people (women) aged roughly between twenty and forty-five. On Nuakata this corresponds to the period of (a woman’s) life when she may marry and actively bear, feed, and care for children and/or older kin. In practice, then, married, pregnant, widowed, and divorced women less than approximately forty-five years old were addressed as waihiu. Someone who was in this age group and whose bodily form suggested a capacity to bear children and
garden produce, yet was unable to do so due to circumstances of ill health, inadvertent sterility, witchcraft, and so on, was still considered a woman—albeit a lonely woman for whom we should feel sorrow, a woman diminished by circumstance. In this sense, potential rather than actual bearing capacity was a crucial, implicit dimension of the category “woman.” However, it was not its only distinguishing feature, nor was it necessarily the aspect most often appealed to when identifying or referring to someone by this term. This was contingent on the speaker and speaking context.

Used as an adjective *waihiuna* means literally “its womanliness.” The adjective *waihiuna* is also placed after some common nouns (typically animals) to designate what I might term female/sex, suggesting that in Alina Nu’ata, womanliness and female are conflated. In this sense, perhaps, women’s bodies are understood on Nuakata as contexts rather than essences. What women can and cannot do is contingent. To be named a woman is to be recognized as a female within a loosely defined age span or period of life, distinct from a prepubescent female child (*gamabine*), a young, unmarried female (*vahala*), an older respected woman/female (*‘aihale*), and a very old woman/female (*‘a‘a‘ihale*). To be named a woman is also to be recognized as distinct from a man—*loheya* and *loheyana* (its manliness, male), *gama* (a prepubescent male child), *hevali* (a young male), *taubada* (an older, respected man/male), and *tautaubada* (a very old man/male).

This bald description says nothing of the way these terms were used in conversation. And they cannot be understood except in conversation and the associated activities to which conversations refer, for they are relational terms. For example, the “gendered” terms used to designate older people, be they man or woman, were used as direct, respectful terms of address. However, in practice, people often respectfully addressed older, familiar others without employing these formal terms. They observed respect without giving it a gender. People rarely drew attention to the sex/gender of children, particularly young, small children, be they related to the speaker or not. And certainly I observed little or no apparent difference in the expectations of, or responses to, young children, boys or girls. They, like older, bigger children, were generally spoken of or addressed as *hedaheda* (children), *hed* (child), *natugu* (my child), or by name. It was their status as children rather than their sex/gender that was most significant to adult speakers.

While I could perceive no apparent differences in the activities
younger, smaller children engaged in—typically, they trailed behind or were carried by their older siblings, played with flotsam and jetsam in the sand, ran about their hamlets or through the encroaching bush, splashed around in shallow water with other children, and so on—the same was not quite true for older, bigger children (i.e., from approximately age seven to puberty). As with the younger children, there did not seem to be significant differences in the nature of their play. Boys and girls alike played with one another in the water; created things in the sand; made grass darts, pandanus windmills, and boats; paddled their canoes around the various small bays around Nuakata; climbed coconut palms; attended to their smaller siblings; searched for seasonal food like mangoes, shellfish, prawns, and nuts; and drifted between hamlets throughout the course of any given day. What differences there were in the play of older boys and girls seemed idiosyncratic rather than gender/sex-related. Girls and boys alike were encouraged to attend preschool and primary school. If they had the ability, they were also actively encouraged and, where possible, supported to pursue secondary and postsecondary education. However, when it came to work it was clear that the adult expectations of girl children were different from those of boys. For example, I both observed and was told that from the age of seven or eight girls begin to garden with their mothers, establishing and tending their own plots with their mothers’ assistance and supervision. They begin to carry increasingly weighty boha (bags) on or suspended from their heads. They are also expected to help their mothers scrub pots, sweep hamlets, and wash clothes and dishes. Occasionally boys volunteered or were asked to do these activities, but they were clearly not expected to perform them routinely. Daily expectations of boys were few. Their fathers or maternal uncles often enlisted them to fetch things (including firewood), climb palm trees, or fish with them; however, girls also performed these tasks.

When asked, adults invoked sex/gender as the reason for their differing expectations of older children’s and teenagers’ behavior. When it came to gardening and carrying garden produce, mothers explained the need to teach their daughters to do as they do. Young girls accepted that they needed to develop strength if they were to carry heavy loads on their head and neck like their mothers. The activities of teenagers were more consistently and markedly differentiated along gender lines than those of younger boys and girls. Most young people left school upon completion of their primary education, when they were thirteen or fourteen years
old. While both teenage boys and girls participated in sporting and church youth group activities, girls routinely assisted their mothers with garden work, food preparation, and other domestic activities. In contrast, teenage boys spent much of their time wandering around the island with their friends; playing games; looking for betel nut, flying fox, or shellfish; fishing; and so forth. While sex/gender was invoked as the reason for differing expectations of boys and girls, boys were not considered constitutionally incapable of doing work expected of girls, or vice versa. Nor were they considered silly or inferior if they engaged in these activities. Tending and weeding gardens, cooking and food preparation, were considered optional activities for boys and men, but necessary ones for women. Of course, why this gendered division of labor existed on Nuakata remains to be explained (see chaps. 3 and 5).

In language, then, if not wider practice, sex and gender are neither distinct nor static categories on Nuakata. Multiple features or dimensions, including age, period of life, status within the community, position within a given generation, and—to a degree—someone’s bodily form and condition (growing, not growing, sick, capable of bearing children, etc.) coalesced in the terms waihiu (woman) and, equally, towaho (man) and other sex/gender categories. Just as the categories themselves become meaningful in relation to one another, so, too, the embodiment of these categories is relational. The relational, conversational context determined which aspect of these terms was emphasized—which embodied dimensions were made explicit and which remained implicit (see DeVereaux 1986, 69). When someone is identified as a man or woman, it seems that the respective changing bodily form is assumed to inform, without determining, his or her embodied acts. Accordingly, bodies are implicitly understood on Nuakata as enacting forms rather than static entities. They are enacting forms that enact and inform as they are enacted and informed by their historical, cultural, and relational contexts. Butler’s reflections on embodiment and performance resonate with these ideas.

One is not simply a body, but in some very key sense, one does one’s body. . . . It is, however, clearly unfortunate grammar to claim that there is a “we” or an “I” that does its body, as if a disembodied agency preceded and directed an embodied exterior. . . . The “I” that is its body is, of necessity, a mode of embodying, and the what it embodies is possibilities. . . . [T]he possibilities that are embodied are not funda-
mentally exterior or antecedent to the process of embodying itself.

As an intentionally organized materiality, the body is always an embodying of possibilities conditioned and circumscribed by historical convention. (1988, 521)

My contact with people during those early weeks on Nuakata posed an immediate and, at times, indecipherable challenge to my assumptions about the impact of my sex/gender on my research. Nuakatan women neither used the expression “because I am a woman” nor spontaneously invoked the category “woman” or “man” as a cause of behavior. Moreover, I was never simply recognized as a woman on Nuakata, not by women, not by men, and certainly not by children. Much to my chagrin, adults of all ages initially addressed me as sinebada. Used during colonial times as a subservient way of addressing dimdim women (Macintyre 1993, 52), older, respected women were occasionally addressed this way during our time on Nuakata. Its continued use in relation to dimdim attested to the reality that “colonial times”—colonial relationships—have not yet passed for adult generations on Nuakata (or, at the very least, Roger and I enlivened their memory). Older children simply called us dimdim, suggesting that skin color rather than sex/gender or any other feature rendered us different from themselves. Infants and very small children initially addressed both Roger and me with recoiling bodies and screams. Much to their parents’ embarrassment and extreme discomfort, we embodied their nameless and unnameable fear and terror.

Going on a Health Patrol

Several weeks after we arrived on Nuakata Moses invited me to accompany him on his monthly health patrol of the island. I jumped at the opportunity to observe his work and so begin my exploration of the relationship between Western and local medical knowledge and practices. On this journey we met with two pregnant women in different hamlets, one pregnant with her fifth child, the other pregnant with her eighth. Speaking in halting English, Moses asked them both, “Are you feeling well? Have you been taking your chloroquine [malaria prophylaxis]? Have you been eating vegetables, protein—fish, shellfish? Have you talked with your husband about where you will have the baby? Why didn’t you attend the last maternal and child health clinic?”

Shy, embarrassed, and reticent in our presence, they looked down as
they mumbled their “yes” replies to these questions, one indicating that she had been too sick to attend the prenatal clinic, the other reporting that she had no one to care for her small children on the clinic day. Moses replied with an unnerving silence, commenting to me as we walked to the next hamlet that the women do not come to the aid post for the clinics, or to give birth, because their husbands will not let them. He added that, like the health patrols, the maternal and child health clinics were held on a monthly basis on Nuakata. On these occasions clinic sisters trained in maternal and child health come from the mainland to immunize children under five. They also conduct physical examinations of pregnant women (measuring fundal height, listening for fetal heartbeat, determining position of the fetus in utero), identifying those at risk of birth complications. Pregnant women at risk are advised to deliver at Alotau Hospital on the mainland.

The questions posed to these women, indeed even the order and manner in which they were spoken, expressed Moses’ understanding at that time of the primary issues associated with pregnancy on Nuakata. He viewed pregnancy and childbirth as health issues. Believing himself responsible for the health needs of the community, he indicated that it was his role, first, to prevent “illness” and, second, to treat illnesses as they arose. According to Moses, illness is caused by physical factors alone. This personal view of his role and its primacy extended to pregnancy and birth. His understanding of maternity, birth, and breast-feeding and his role with pregnant women was filtered through his community health worker training and the clear expectations of his employer, the Alotau district division of the Milne Bay Health Department. Reduction of maternal and child mortality, malnutrition, malaria, and diarrheal diseases had been identified as a priority for all preventive and curative health strategies locally implemented by community health workers throughout Milne Bay Province.

Aware that local women lose their acquired immunity to malaria during pregnancy, thereby placing them at risk of anemia, postpartum hemorrhage, inadvertent miscarriage, and stillbirth (Edwards 1987; Gillett 1990; Mola and Aitken 1984; Taufa 1978), Moses routinely supplied them with prophylactic doses of chloroquine. According to Moses, some women, particularly young educated women, have been persuaded by his preventive health talks and have followed his advice to take prophylactic doses of chloroquine. Some simply forget or refuse to take the tablets, complaining of their bitter taste. Moses experienced this refusal as “resis-
tance” and recalcitrance, attributing it to women’s lack of education and inadequate understanding of their bodies and the way the fetus develops in utero.16

Apart from malaria he stated that “the major health problems with pregnant and breast-feeding women is [poor] diet,” compounded by a heavy and unequal work load compared to men.

When [ladies] are preparing meals they give the best to the man and they have what is left. That is why their health is not really good. . . . I think on this island ladies do most of the work. [For example:] Men only clear the garden; . . . ladies dig it, plant it, weed it, and when the time comes for harvesting, they do that too. Only those responsible men help their wives in the garden, others are very slack and lazy. They expect the ladies to do the work.

Moses indicated that, unlike his advice about malaria, both his dietary recommendations and his provision of weekly “blood [iron] tablets to increase the blood system” have been generally well received by pregnant women. Critical of men’s lack of understanding of the health issues associated with pregnancy and birth, Moses stated that he had attempted, with minimal success, to involve men in preventive education sessions about maternal health, nutrition, and family planning held at the aid post.

Later that day we came to Emma’s hamlet. At Emma’s invitation we clambered inside her house where she and her week-old baby daughter Reni were ensconced by a fire. First, Moses made his inquiries: Had her bleeding stopped? Yes. Was she having difficulty with breast-feeding? No. Was she eating vegetables? Yes. How was the baby’s umbilicus? With this, Emma fiddled with Reni’s clothing revealing a completely healed navel. Moses simply nodded, issued her with a child vaccination book, and told her to come to the maternal and child health clinic the following week.

Then it was my turn. Taking my notebook out and pausing for her replies, I asked, “Where did you give birth to Reni? Who was present at the time? Why are you staying inside the house? What food are you eating? What did you do with the placenta?” Although slightly embarrassed and amused by this barrage of questions, Emma answered my inquiries patiently and in turn, as might a teacher, one moment speaking from her own experience, the next offering brief explanations of custom. As she
spoke she scanned Moses’ face carefully, monitoring his responses. Watching her watching him, I made a mental note of her caution, suspecting she was reluctant to speak openly about customary practices in his presence.

She had given birth in her hamlet while being watched over and cared for by her mother and several other maternal relatives. Following the birth she and the baby were washed in warm water before settling down by a fire prepared inside the house. She stated, “After birth, it is our custom for mother with her baby to stay by the fire inside the house for twenty days.” During this time “their mothers will care for them both.” In the days that followed Reni’s birth she repeatedly warmed her hands by the fire, then placed them on the tied umbilical cord. This dried it out, so that within four days it had fallen off. Emma’s kin buried it in her garden to ensure that Reni “may grow to be a good gardener.” For the first five or six days after Reni’s birth, Emma had eaten only the boiled young leaves of pumpkins. In accordance with custom, neither she nor those caring for her had eaten fish while she was still bleeding. She commented that the smell alone could make her sick, causing her bleeding to continue. Reni’s placenta was placed in a bag and hung from a tree, so that she might grow to be active and a good climber.

Before we left, Moses reiterated his instructions to her to attend the forthcoming maternal and child health clinic to immunize Reni, adding, “It is your responsibility to breast-feed when your baby needs it. Don’t wait.” Emma smiled. Later Moses repeated the same questions and instructions almost word for word to Emma’s sister, Roda, who had given birth to a daughter one month earlier. One week later both women arrived at the aid post, as directed, for the maternal and child health clinic, apparently unperturbed by Moses’ assertive, instructive style.

In his conversations with Emma and Roda, Moses’ silences, as much as his questions, were revealing, reflecting strong disapproval of their decision to deliver in the village and his broader frustration about his limited obstetric role on Nuakata. With the exception of emergencies, he was only invited to visit mothers and their new babies a day or so after the birth. Moses knew from his training that the risk of death through bleeding diminished for women whose deliveries were supervised by trained health workers, and those who died of infection following birth had received much less prenatal care than other mothers (Edwards 1992; Mola and Aitken 1984).

During a wide-ranging discussion several weeks after the patrol,
Moses revealed that he had been deeply disturbed by the first village births he attended on the island.

The first two mothers that I attended, I found out that they delivered on the bare ground like dogs, and that really shocked me. One mother had a retained placenta. . . . I managed to deliver the whole thing out, except a membrane got stuck. I was going to do a manual removal, but I am not allowed to because I did not have proper, sterile things with me. If I was only at the aid post I would do something to remove it out. . . . At another birth . . . the baby’s cord wasn’t tied properly . . . and it was bleeding. As soon as I got there I [tied] the cord and the bleeding stopped. [Equally disturbing was the discovery that although] the mothers of women [in labor] are present during birth, they do not help. They do not help! They just stand there or sit [some distance] away . . . and wait to receive the newborn baby. I haven’t asked them why it is relating to their customs.

These experiences confirmed some of Moses’ worst fears about the health risks posed to mother and child during village births, reinforcing his conviction that women should deliver at the aid post. Consistent with national findings, Moses nominated puerperal sepsis, postpartum hemorrhage, and obstructed birth as the most significant risks to women giving birth on Nuakata—risks that he claimed could be averted by allowing him to supervise and assist deliveries in the cleaner, more sterile environment of the aid post (Gillett 1990; Health 1991, 242). Although totally convinced that women should deliver at the aid post, he understood their reluctance to give birth there. He commented, “One reason is that they feel shy to come because I am a male single worker. They are shy because of the sexes, I mean making themselves public to me. If I was married it would be slightly different.” Moses was acutely aware that, as in other places across Papua New Guinea, it was considered improper for local postpubescent girls/women to display the lower half of their bodies (below the navel and above the knee) to men with whom they have no sexual relationship and especially young single males such as himself. Public displays of this kind would be considered sexually provocative and a source of malicious gossip. If such views were not originally instituted by the early Christian missionaries in the Massim, then it was certainly reinforced by their efforts to discipline local women’s bodies (see
Eves 1996b; Reed 1998). While respecting this custom, Moses contended that health matters, particularly maternal health matters, provided sufficient cause and the necessary context for such customs to be flouted and overturned. Committed to his work, he felt great frustration that on Nuakata, like most other rural places in Papua New Guinea, women remain reluctant to utilize maternal health services at aid posts staffed only by male health workers. He knew that the husbands of pregnant and birthing women often discouraged, or even prevented, their wives from receiving maternal health care from him.

Moses’ attempts to persuade women to deliver at the aid post reflected his strongly held belief that both the place of birth and the expertise of the birth attendants may influence the outcome of birth. The significance of place to the process of birth, the newborn, and its bearer was conceived by Moses in very specific ways—ways that did not accord with understandings of the integral relationship between birthplace and identity reported by anthropologists in many places across the Massim and Papua New Guinea (see, for example, Merrett-Balkos 1998; A. Weiner 1976). In his view it was not essential to literally establish continuity between the place of one’s birth and the place where one grows, lives, dies—the place where one’s ancestors may also have been born, lived, and died. Rather, for Moses, place of birth—in this instance, the aid post—was considered significant only as it potentially facilitated the health of the woman and child during and immediately after labor. Moses described the aid post as cleaner and more sterile than the village or village houses. He regarded cleanliness as essential to the health of the laboring woman and her unborn child; it was associated with Western-style buildings. Women could deliver inside on mats on the concrete floor, rather than outside on the ground or in their houses. In Moses’ view, dogs and pigs give birth outside on the bare ground; women should not. Therefore, not only did he suggest that the aid post was a cleaner place for birth, but he also implied that it was a more dignified, if not more civilized, place. During birth, this place, rather than the village, was believed to render the pregnant woman and her unborn or newborn child more fully human.

But for Moses, birthplace issues were secondary to those about birth attendants. Who assisted the laboring woman and her child and by what means was considered most significant. Certain that Western-style medical practices and practitioners offered childbearing women and their infants
the greatest chance of survival, Moses was convinced that alternative prac-
tices and practitioners exposed mother and baby to avoidable health risks.
He discounted their knowledge of birth, derived from their experience as
mothers and midwives, as inadequate, if not dangerous. For Moses the
presence or absence of onlooking kin was believed to be irrelevant to the
process of labor and birth and the health of the laboring woman and child.
Only people trained in Western-style medical practices were considered
appropriate birth attendants, for they could actively support and assist,
rather than passively observe, the laboring woman during birth.

Moses also implied that trained birth attendants required proper
equipment to adequately assist the laboring woman. “If necessary I’ve
got proper equipment that I can use, like clean things to use—like gauze,
cord, clamps. It’s a bit sterile.” Accordingly, proper ways of giving birth
were facilitated by appropriate equipment, by the proper person in the
proper place. Without these proper people, places, and things to assist
childbearing women, labor presented a significant health risk to
Nuakatan mothers and infants. At the same time, he ruefully noted that
if difficulties were encountered during or after labor, there was only a
limited array of Western medicine available at the aid post. Unlike a few
community health workers working in other provinces, he had no drugs
to treat postpartum hemorrhage (Edwards 1992, 79). Committed to
national and regional preventive health plans and policies that empha-
sized the need to train local women as village birth attendants (1992),
Moses remained pessimistic about the implementation of such policies on
Nuakata. His previous efforts to attract local volunteers to provide
basic health care for people living on parts of the island distant from the
aid post had met with no response. Moreover, the Milne Bay Provincial
Health Department had no available funds to develop a provincwide vil-
lage birth attendants training program.

One Week Later: A Maternal and Child Health Clinic

A week after the health patrol the maternal and child health clinic was
conducted at the aid post. Fifteen women attended, carrying their young
children. Made of fibro cement on a concrete slab, the aid post was one
of three Western-style buildings on the island. Small and poorly venti-
lated, the aid post comprised four barely furnished rooms—a consulting
room with a single bench for patients and a desk and stool cobbled
together from scrap wood for Moses, a completely empty room where people could stay for inpatient care, another room with a wooden slat bed, and a storeroom where basic medical supplies and equipment were kept. It had neither lighting nor functioning kerosene burners to sterilize what few medical instruments (two pairs of tweezers, a pair of scissors, and clamps) Moses possessed.

At one point in its history the aid post had a two-way radio powered by a solar panel. Several years ago the radio broke and was taken to Alotau for repairs. It was never returned. Since then the community has been without the ability to communicate directly with the mainland. With the radio gone, the solar panel was later stolen by a local youth who used it to power his cassette recorder. Despite persistent community efforts to secure its return, it too remained lost to the aid post.

Although a day had been set aside for the clinic, it did not begin until midafternoon, when all the women known to be coming had arrived. Until then Moses remained outside, close to his house, variously talking with me and relaxing with some of his friends. Withdrawing to the aid post, he systematically worked through an alphabetical list of names, seeing each woman together with her child(ren) in turn. As on the patrol, he spoke with people in English, relying at times upon several women, Emma among them, to act as interpreters. Waiting together outside the aid post for their names to be called, those assembled talked and laughed with one another. Yet much to my dismay, on the occasions when I ventured outside to sit among them, their eyes fell to ground and the talking dwindled away. Conversation inside the aid post between Moses and each of the women was similarly sparse, even strained. Women who outside had been confident, animated, became deferential and embarrassed as Moses fired yes/no questions at them to determine why they had come. At Moses’ request they pointed to the problem, sometimes naming it in Alina Nu’ata—for example, cough or hot body —then waited for his response. Most striking in these exchanges were the things left unsaid, the things unable to be said.

Most who attended the clinic that day sought treatment for their children—be it immunizations or treatment for illnesses such as malaria, scabies, diarrhea, coughs, and failure to thrive. As Moses had anticipated, the two pregnant women we had seen on patrol did not arrive. Nor did the East Cape nurses. Their attendance was totally dependent upon the availability of local boats and suitable weather conditions. Aid post
records reveal that during 1992 the nurses attended six times; however, during the nine months Roger and I spent on Nuakata in 1993 they did not attend once.

Moses distributed medicine and advice in more or less equal quantities. Antibiotics for infections, camaquine to treat young children with malaria, dressings and antiseptic for infected sores. But the dominant refrain repeated to each of these women, particularly the breast-feeding mothers, related to diet and nutrition. “When you follow custom children start losing weight. They will not feel well or grow. I want to see change next month.”

In discussions with pregnant and breast-feeding women, Moses spoke of food as something that sustains the pregnant woman while also feeding the developing fetus/baby. Specifically, food was described and represented as a source of nutrition. The power of a particular food type (yams, fish, green vegetables) to sustain people was said to derive from its unique constellation of invisible yet loosely quantifiable constituent parts (vitamins, minerals, protein, carbohydrates, and sugars) known to disseminate throughout the body in the blood. These vital nutritional components were also said to pass between mother and child through breast-milk. Breast-milk was therefore significant as a necessary source of nutrition. Moses repeatedly urged women, irrespective of their physical or social circumstances, to eat a variety of foods—fish for protein, vegetables for vitamins and minerals, and so on—to satisfy their nutritional needs.

Confined to nutrition, Moses’ advice about food took little account of the social relations associated with growing, preparing, providing, and distributing food. He contended that if uncontaminated by germs or bacteria, the various food types give rise to predictable physiological effects in healthy bodies. Food’s capacity to support, strengthen, and grow healthy, living bodies was described as integral to the food itself. Accordingly, who labors how to produce food, with what intent, is deemed irrelevant to the health of the consumer. So, too, is the context in which the food is consumed. In other words, food is represented as an object detachable from its production and its producer.

Reconceiving Pregnancy and Birth on Nuakata

Climbing the hill between Yalasi and Bwauli on my way back from the aid post that day, I was preoccupied by a number of thoughts and questions. Uppermost among them were, Why were the women still so shy
and reserved in my presence? Was I equally shy, or reluctant to foist myself upon them? Would this ever change? If so, when? How? Pushing these thoughts aside, I reflected on the day’s activities and the health patrol a week earlier. First I was struck by the high attendance at the clinic, given the long and strenuous journey with small children that some of the women had to make. Moses’ conscientious attitude to the work and his provision of health care was clearly respected by the women. Even so, no pregnant women attended the clinic and, with the exception of one breast-feeding woman, no women sought medical treatment or advice for themselves. Moses indicated that some pregnant women attend for prenatal care when the female nurses from East Cape were in attendance. This attendance pattern reflects a broader national trend, particularly in rural areas. Across the country, mothers attend maternal and child health clinics primarily for curative care for their children (Health 1991, 222–23).

I was struck too by the ritualized form of the clinic, the distinctive and familiar performances of its participants, of Western medical knowledge and expertise enacted. In crossing the threshold into the aid post, Moses’ casual demeanor changed. Once inside and at work, he became serious, efficient, organized. Time, which until then had stretched on seamlessly, was suddenly demarcated by everyone’s knowledge of an alphabetical list of successive appointments squeezed into diminishing daylight hours. Moses presided over the space and its occupants with authority, directing women where to sit with their children while he moved about the rooms freely, writing brief notes at his desk, collecting supplies from the store-room, confidently examining, weighing, or treating children in spite of their protests. Whereas outside his conversations had meandered across many territories with no clear destination, inside they were brief, concise, and directed to a clear end point—diagnosis of illness based on a clear description of physical symptoms. Discussion was strictly confined to matters of health, precluding any sense of familiarity between the women and Moses. Women’s opinion and experience was not solicited. They in turn did not question his explanations or advice, but meekly deferred to his expertise. In this intimate and confined space, both the conversational style and physical examinations themselves maximized the distance and distinction between patient and health worker. Moses’ medical expertise, authority, and power seemed to converge within the aid post, where it was fully dramatized amid his equipment and supplies.

For a moment my thoughts drifted back to the mainland, where a
month earlier I had attended a prenatal clinic at Alotau Hospital. It, too, began in the midafternoon after a sizable crowd of pregnant women had amassed on the wooden benches outside in the waiting area. As each woman’s name was called, each was directed to follow the waiting nurse. Trailing behind her, she was ushered into a curtained cubicle, told to lie down on a bed before being externally examined by nurses and nursing students, female and male. No attempt was made to engage the woman in general conversation. In this confined space the nurses maintained an efficient, almost officious, economy of words and actions. With stethoscope, medical notes, and prenatal booklet at the ready, they hovered over the named but effectively anonymous pregnant woman, silently scanning her exposed pregnant body and scrutinizing her eyes for visible signs of anemia. Fundal height measurements were taken to assess fetal growth, development, and gestation, and her swollen stomach was gently prodded and poked to determine the fetal position in utero. Many of these rituals were performed without explanation, their purpose and intent only revealed through the authoritative pronouncements that followed: “The baby is growing; you are not eating enough vegetables; you have three months before you will give birth; the baby is in the wrong position; you must give birth in the hospital;” and so on.

As the women came from varying language groups, the nurses spoke to them in a staccato English. What sense the pregnant women made of the procedures, the questions, or their parting instructions is difficult to tell, but easy to speculate upon. Without exception they did not talk except to make barely audible responses to direct questions. They simply lay there, passive, blushing, their gaze averted. Their feeling of overwhelming embarrassment was obvious for all to see. And then when final directives were issued they clambered off the bed; their slow, deliberate movements belying both their evident relief that the examination was complete and their sure wish to be gone.

Most striking about these recollections was the sense that, although distinctive, Moses’ enactment or orchestration of the maternal and child health clinic on Nuakata was, in many ways, mimetic. The Nuakatan maternal and child health clinic was not unlike the Alotau clinic, which in form, organization, relational tone, even medical procedure and setting, was not unlike general outpatient hospital clinics I had attended in Melbourne. There were obvious ways in which these clinics differed, not the least being disparities in the number and training of medical personnel, clinic facilities, and the array of medicines and medical equipment.
But arguably it was the remote setting and staffing by a single male community health worker that constituted the most significant difference between the Nuakata clinic and the Alotau and Melbourne ones.

However, there were obvious structural ways in which the Nuakata and Alotau clinics were alike—the organization of time, the alphabetical listing of appointments, the arrangement of furniture, equipment, and medicines within the clinic, the constraints on movement of patients within the clinical space. But most striking of all were the similar, if not habituated, ways in which the Alotau nurses and Moses occupied and moved within their respective clinical environments. Eye contact was avoided with the person examined, except when advice was given or specific information solicited. Moses and the nurses stood over supine patients, probing, surveying, inspecting the surface of their still bodies as one might inspect and assume authority and control of an inert, dysfunctional object. When patients were present the health workers kept their bodies erect, their eyes focused, and their movements definite, efficient, contained. Their faces remained impassive, their speech uniformly modulated in pitch and tone. Their field of interest seemed bounded by the maternal body surfaces under their gaze. When pregnant women were absent from the consulting room they were uniformly referred to as “villagers” or “village women.” In the same breath their lack of understanding or Western education was noted. To the observer these postures created a sense of difference and distance between health worker and patient. While the health workers enacted knowledge of the body, the pregnant women became passive recipients of this reified surface view. By the health workers’ hands, through their clinical handling and comments, these women were rendered as passive, maternal bodies at risk. In categorizing them as “uneducated villagers” in need of medical care and advice, there was a sense in which the health workers infantilized these women, construed them as underdeveloped, if not slightly primitive.

In noting these similarities I do not imply that Moses, or the Alotau nurses, either unconsciously or intentionally conformed to a set of conventional ideas or protocols detailing the embodiment of Western medical knowledge and practice in these clinical spaces. Taken to their extreme, the former suggests a structuralist vision of social action that allows little or no room for personal agency and innovative social change, while the latter assumes an individual subject-agent who acts by consciously discerning and initiating behavior that may or may not be appropriate to the social setting. Both views are potentially at odds with
my earlier discussion of (discursive) subjectivity agency, gender, and embodiment, to which I shall return shortly. Rather, following Bourdieu (1977, 1990a, 1990b) in particular, but also Merleau-Ponty (1962), Heidegger (1977), Mauss (1973), and Dewey (1958), and those such as Jackson (1989) who have applied their work, I suggest that the mimetic actions of Moses during the clinic can be better understood as habitual practices invoked—as they themselves had been—by the setting (buildings, furnishings, equipment), the patients, and Western medical knowledge. In other words, Moses’ bodily actions or dispositions within the aid post were informed by habits instilled within clinical environments. Such habitual forms of body use are necessarily relational or interactional. They arise in shared spaces or environments of people, objects, places, knowledges—what Bourdieu terms the habitus.

Bourdieu defines habitus as the “durable and transposable systems of schemata of perception, appreciation and action” arising from “the institution [or embodiment] of the social in the body” (Bourdieu and Wacquant 1992, 127; see also Bourdieu 1977, 72, 214). Through his notion of habitus he articulates a theory of practice intended to escape “both the objectivism of action understood as a mechanical reaction ‘without an agent’ and the subjectivism which portrays action as the deliberate pursuit of a conscious [rational] intention. . . . [It is an attempt to] escape from the philosophy of the subject without doing away with the agent” (Bourdieu and Wacquant 1992, 121). Accordingly, “to speak of habitus is to assert that the individual, and even the personal, the subjective, is social, collective. Habitus is a socialized subjectivity” (1992, 126). Bourdieu’s subject and/or agent cannot be meaningfully understood as separate or distinct from the material conditions, the socially and symbolically structured spaces integral to its existence (Moore 1994c, 80). Cultural meanings and values “inform” the organization of any socially structured space, but “they are not inherent in the organization of that space” (76). It is the behavior of social actors within that environment that elicits these meanings and values. By their actions, these actors necessarily interpret and/or reinterpret the cultural meanings that inform the given space. Human action is therefore understood as historical, temporal. “It is not an instantaneous reaction to immediate stimuli . . . [for] the slightest ‘reaction’ of an individual to another, is pregnant with the whole history of these persons . . . , their relationship” and the historical structuring of relationships within these shared social spaces (Bourdieu and Wacquant 1992, 124).
While Bourdieu claims that the habitus predisposes or inclines the actor to habituated patterns of body use, he indicates that actors can potentially subvert these patterns by engaging in alternative activities/interpretations within that shared environment. Through their bodily praxis, people are both “informed by and give form to a habitus” (Jackson 1989, 136). Or as Dreyfus and Rabinow cogently state, “our socially inculcated dispositions to act make the world solicit action, and our actions are a response to this solicitation” (1993, 38). But this is not to suggest that these actions are intentional, formulated, and able to be articulated. For Bourdieu’s theory of praxis is also a materialist theory of knowledge that owes much to Marx and Wittengenstein, but also Merleau-Ponty and Heidegger. It situates understanding in practices (Taylor 1993, 50).

Following the program suggested by Marx in the Theses on Feuerbach, it aims at making possible a materialist theory of knowledge, that does not abandon to idealism the notion that all knowledge, be it mundane or scholarly, presupposes a work of construction. But it emphasizes that this work has nothing in common with intellectual work, that it consists of an activity of practical construction, even of practical reflection, that ordinary notions of thought, consciousness, knowledge prevent us from adequately thinking. (Bourdieu and Wacquant 1992, 121)

It is a materialist theory of knowledge that is perhaps more clearly articulated by Jackson, who, when commenting on the body practices associated with Kuranko initiation, notes that

what is done with the body is the ground of what is thought and said. From an existential point of view we could say that the bodily practices mediate a personal realization of social values, an immediate grasp of general precepts as sensible truths. (1989, 131–32)

Absent from the foregoing discussion is consideration of how actors’ social positions/locations influence their practices and their practical understanding. Crucial to Bourdieu’s theory of praxis, this is also relevant to my reflection on Moses’ clinical practices and my broader exploration of gendered subjectivity/personhood on Nuakata and beyond. Bourdieu insists that actors’ practices are necessarily influenced, if not
determined, by their social position in relation to pivotal cultural discourses and social relations, notably discourses of class and gender (see Moore 1994c, 77). Actors are located by and locate sociocultural distinctions and structural inequalities through their embodied practices.

By his highly focused and restrained actions within the clinic space—be it at the aid post or during health consultations in the village—Moses attempted to convince local people, male and female alike, that in his social role/position as a health worker attending to pregnant women and those giving birth, his sex/gender, sexuality, and sexual desire were nullified or rendered irrelevant. Similarly, he attempted to convey to women that as a health worker he considered their bodies, particularly their genitalia, as divisible or partible from themselves, their sex/gender, sexuality, sexual desire. Within the clinic space Moses treated maternal or diseased women’s bodies as androgynous and partible—as bodies distinct from selves/persons, distinct from other bodies. While he always behaved respectfully to people outside the clinic space, he did not deliberately position himself as an androgynous subject or agent in these contexts. Ironically, then, when performing his work as a health worker, the presence of female patients caused him to act (pragmatically) as if sex/gender and sexuality were irrelevant to either his own actions and/or subject positions or the women in his care. Arguably this only heightened everyone’s awareness that both his and their actions and/or subject positions were informed by sex/gender and sexuality in these spaces. It is a point reinforced by pregnant/birthing women’s rejection of Moses’ medical care. They demonstrated that where cross-sex relations occur between known adults in intimate spaces, the sex/gender and sexuality of those involved necessarily inform their actions and/or subject positions. Although they may have worried over their own health and the health of the unborn or birthing child, they were more concerned to enact proper, respectful, if not ethical, relations between Moses and themselves.

Moses’ practices within the clinic space can be interpreted as strategic. By actively discouraging familiarity, especially sexual familiarity between himself and his women patients, he demonstrated a practically and theoretically informed understanding of respectful ethical relations between Western-style medical health practitioners and their patients. Typically, familiarity, especially sexual familiarity between health practitioner and patient, is actively discouraged. It is an ethical stance, which is more difficult to maintain in rural and isolated settings, where the practitioner
necessarily encounters people outside the clinical setting and must relate to them in other ways.

Moses not only treated maternal bodies as androgynous, he also considered and treated them as bodies at risk. Along with the East Cape nurses, he assumed responsibility to define, assess, predict, monitor, and, where possible, prevent and manage these potential physical risks. Local customary practices were treated and construed as pernicious, static conventions that should be replaced by the “proper” and ever-developing knowledge, practices, sites, and implements of Western medicine.

By making pregnant/breast-feeding women and their infants the target of preventive health strategies, Moses, as a Western medical representative of the provincial and national health authorities, constituted these women as a unified group—a group of women who, because of pregnancy, were at risk of illness and death. This simplistic conflation of physical/biological risk with pregnancy, arguably perpetuated by the collation of narrowly focused maternal mortality statistics, has reinforced the strategic development of equally narrow medical responses focused on the individual pregnant woman. Accordingly, maternal and child health clinics on Nuakata are conducted in the belief that the most effective and efficient way of averting illness and avoidable deaths during pregnancy and childbirth was to examine pregnant women alone and target educational talks to them as a group. While men were not excluded from these clinics, in practice it was rare for them to attend with or without their pregnant wives, small child(ren), or one of their female kin. Notice of forthcoming clinics was always directed at women, suggesting that individual women were held primarily responsible for their own health—imagined as a physical/biological condition—and that of their small children, particularly while they were pregnant or breast-feeding. Moses indicated that it was the husbands’ role to assist their wives, and, where possible, relieve and share their wives’ burden of care. This familial hierarchy of responsibility for maternal and child health seemed based on the contemporary Western nuclear family. It took little or no account of the responsibility for care and nurture shared by the wider paternal, and especially maternal, family or *susu* on Nuakata.

Although borne by Moses and made his own, this struggle to overturn customary practices and impose Western medical ideas and practices was by no means unique to him or Nuakata. Provincial preventive health policies and strategies, developed in conformity with the National Health
Plans, which were in turn influenced by primary health-care (PHC) policies generated and instituted by international health agencies (WHO and UNICEF) whose personnel were persuaded by current Western medical knowledge and practice in relation to pregnancy and birth, informed much of his thinking and practice. Established as the paradigm of choice at the combined WHO and UNICEF conference in 1978 at Alma Ata in the then Soviet Union, the PHC policy for the developing world encouraged the provision of preventive, curative, and rehabilitative care at the local village level. The PHC policy discouraged the provision of costly, and therefore unsustainable, technologically sophisticated Western medicine. Instead it sought participation of local people in the planning, implementation, and use of basic Western-style health services. Crucial to the implementation of this paradigm were community health workers, who would receive shorter and less detailed medical training than Western-style medical practitioners and nursing staff. Maternal and child health care was one of eight basic health initiatives promoted by the PHC initiative.

Once again, Bourdieu’s work provides some insight here, in particular his notion of field and the relationship between field and habitus. Although it teeters toward structuralism, Bourdieu’s concept of field offers a way of understanding Moses’ embodiment of the field of Western medical knowledge and practice and the subfield of basic primary health care (BPHC) that neither denies his agency nor precludes a systematic (rather than systemic) understanding of his actions and the knowledge they express. When Bourdieu speaks of “fields” (Bourdieu and Wacquant 1992), discussion focuses on relations and processes rather than things and states. According to Bourdieu, a field is

> a network, or a configuration, of objective relations between positions. These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation . . . in the structure of the distribution of species of power (or capital). . . . As a space of potential and active forces, the field is also a field of struggles aimed at preserving or transforming the configuration of these forces. (Bourdieu and Wacquant 1992, 97–101)

While a field may be understood as “a set of historical relations between positions anchored in certain forms of power” or capital, habi-
tus comprises “a set of historical relations ‘deposited’ within individual bodies in the form of mental and corporeal schemata of perception, appreciation and action” (Bourdieu and Wacquant 1992, 16). In other words, the field—in this instance basic primary health care as it relates to maternal health—conditions or “structures” the habitus. The habitus inflects the field, rendering it meaningful, as it is embodied by people who are themselves positioned in and by the field.

Each field, be it the artistic field or the field of Western medicine and its subfield of BPHC within developing countries, “prescribes its particular values and possesses its own regulative principles. These principles delimit a socially structured space” (Bourdieu and Wacquant 1992, 17). According to the position agents occupy in this space, they will work to either maintain, modify, or transform the field’s existing boundaries or form.

As delegate for the field of preventive Western medicine, Moses sought to eliminate both the threat and reality of maternal and child mortality on Nuakata. In so doing he not only challenged local beliefs and practices about the place and conditions of birth but also how women should deliver, who should be present, who should orchestrate the delivery, who should provide care in what forms immediately following the delivery. His advice was not simply confined to birth but extended to pregnancy, breast-feeding, and care of the infant.

As many have observed and detailed in other social and historical contexts, Western medical knowledges and practices in general, and those associated with maternity in particular, constitute neither an ahistorical nor a disinterested epistemology/praxis. In prescribing “the way to be born,” the “to be born” is also prescribed, as is the bearer. In prescribing the place of birth, the particular significance of place to birth is detailed. In declaring who should orchestrate birth, birth orchestrations are further defined. And by nominating who knows about birth, what is, can be, and should be known is specified.

During these initial efforts to explore Moses’ praxis with pregnant and breast-feeding women, I gave little concerted thought to how my own actions were experienced and interpreted by local people. I gave only selective credence to the adage that actions speak louder than (faltering) words. Focused on Moses’ praxis, I could barely reflect on my own. Thinking about it recently I realized that my actions and discussions during those first weeks on Nuakata must surely have reinforced the view that I was aligned with Moses’ health project. For example, during this
time I was confronted with people’s untreated weeping sores and cuts, and malarial fevers and headaches. Wanting to respond to their need, I assumed provision of basic medical care for the Yalasi and Bolime sides of the island. I placed my faith in the medicine I knew. In addition, my trips to Bwauli to see Moses, to participate in the health patrol and attend the maternal and child health clinic, constituted my only highly visible diversion from our language learning sessions with Wycliffe. With Moses I shared an apparent ease of conversation that, except for two other people who spoke English with me, I had with no other local person at the time.

Still holding to the belief that the sexed form of my body would count for more with local women than any other dimension of my embodiment or praxis, I was reluctant to acknowledge the significance of my white skin and my comparatively big body. There was a sense in which my whiteness and my size were invisible, neutral (Frankenberg 1993, 191–243). And so when women averted their gaze from me, blushed, or gave inaudible responses to my questions, I interpreted this as shyness, in much the same way as Moses had defined their reluctance to attend his clinic or use his medicines as resistance or recalcitrance. My interpretation focused on when the shyness would end rather than its causes. Aware, at one level, that local women’s shy, embarrassed demeanor embodied the deferential stance of the colonized, I was nevertheless reluctant to acknowledge that my body, my skin color evoked a history of colonial relations between white and Milne Bay women.

Whiteness changes over time and space and is in no way a transhistorical essence. Rather, . . . it is a complexly constructed product of local, regional, national, and global relations, past and present. Thus the range of possible ways of living whiteness, for an individual white woman in a particular time and place, is delimited by the relations of racism at that moment and in that place. And if whiteness varies spatially and temporally, it is also a relational category, one that is constructed with a range of other racial and cultural categories, with class and with gender. This construction is, however, fundamentally asymmetrical, for the term “whiteness” signals the production and reproduction of dominance rather than subordination, normativity rather than marginality, and privilege rather than disadvantage. (Frankenberg 1993, 236–37)
I understood, and yet was reluctant to acknowledge, that being a woman was not enough to render me the same as the women on Nuakata. In their eyes, initially at least, I appeared as White, Other, and powerful—more different than the same. So focused was I on reinforcing the similarities between us that I was unwilling to fully admit the differences, the socially, historically, and politically important differences that exist between a white woman from Australia and the women living on Nuakata.
Fig. 3. Moses Diawasi, community health worker

Fig. 4. Mari with her baby daughter