# Introduction

At the time of our first conversation about her illness, Rita was thirty-eight years old and married with five children. On that day in April 2007, she described her illness with the following words: "I have difficulties breathing in . . . When I am ridden by shortness of breath, I am not able to sleep . . . My throat rattles . . . I will faint from shortness of breath." Her health status had deteriorated over many years and finally reached its nadir. In the same colloquy, Rita dated the onset of her respiratory illness (*bɨbɨ tivi*; literally: "short breath") to "some time after 1996."

When I later studied her clinic card, I discovered that Rita had employed biomedical care for respiratory problems at a much earlier point than the point she had marked as the onset of her illness. Her clinic card showed that she had complained about a cough in twelve of her twenty-one visits to biomedical institutions in 1987 and 1988. Another twenty visits in which she described symptoms ranging from a cough to a productive cough (including a cough that produced white sputum and blood and a cough associated with restlessness at night), shortness of breath, and chest pain followed until the end of 1995. Altogether, between 3 July 1987 and 20 May 2009, Rita made 162 visits to biomedical institutions; in sixty-seven of these visits, she addressed her respiratory problems.

Throughout the years of 1987 to 1995, Rita took a variety of biomedical drugs—cough linctuses, Procillin (procaine penicillin), chloramphenicol, and amoxicillin. Apart from the medications prescribed by health workers, Rita drew on a local herbal remedy to treat her cough. She drank the extraction of a thick leaf called *kamfarkhem*. She also bought a liquid made from tree bark from two Giri women (at least that is what she thought was the ingredient). Rita assumed that her illness was a physical disorder that would respond to biomedical drugs and herbal remedies.

What happened in 1996 that changed Rita's view of her complaints and made her determine that year as the starting point of her respiratory illness? Norma, an older woman from Giri 1 who was related to Rita through her husband, told Rita's husband, Tim, that Rita had been ensorcelled in 1996. Norma elucidated that a man had followed Rita on her way to a pond in the swamps and stolen her underpants while Rita bathed and did her laundry. Norma even named the man. Tim passed on the information to his wife, and Rita reminisced about the respective day. She had noted that

her underpants were missing when she got dressed after the bath. Rita was alarmed because she knew that her *fava ŋan* was absorbed into the fabric of her underwear.

The concept of *fava ŋan*—body substance adhering to one's skin—refers to female sexual secretions; but other bodily substances, such as sweat (*zoruk*), urine (*sɨk*), sperm (*nzip*), and saliva (*hui-in*), are also designated as *fava ŋan*. The Giri believe that their *fava ŋan* is attached to items that have been in contact with their body and thus absorbed their bodily fluids; for example, areca nut husks, cigarette butts, or clothes. The same applies to excretable parts of the body; for instance, fingernails or hair. From anthropological literature, we are familiar with the sorcerer's utilization of personal leavings, such as food remains, excreta, or hair clippings (Eves 1995: 218; Fortune [1932] 1989: 150; Hogbin 1935/36: 20; Lindenbaum 1979: 65; Patterson 1974: 141; Stephen 1996: 87, 93).

That Rita's underpants were nowhere to be found was one of the two reasons Rita accorded credibility to Norma's story. Second, Norma's kinship ties to Rita and her husband rendered her believable. Having heard Norma's report, Rita perceived her health status to be deteriorating, and she began to categorize her illness as local in nature—caused by poison sorcery and thus not receptive to biomedical cures.

I consulted Rita's clinic card again. Would the data support Norma's claim of ensorcellment? Did Rita's health status worsen in 1996 or later? On Rita's clinic card, no data were available for 1996, and only five visits—just two of them for her respiratory illness—were registered in 1997. But if we look at the three-year period from 1995 to 1998, it stands out that this was a phase in which the health care personnel shifted her treatment from cough to asthma medication. In 1995, Rita was given, for the first time, amoxicillin and Septrine (antibiotics)—not exclusively to treat her respiratory complaints but also for urinary tract infections.

In the same year, she began taking salbutamol tablets—medication given to treat bronchospasms (a symptom of, for example asthma or obstructive pulmonary disease). In 1998, she received her first inhaler for asthma treatment. The first entry of the word "asthma" on her clinic card was also made in 1998. She was diagnosed with "chronic asthma," though a question mark was placed after the diagnosis. It appears from Rita's clinic card that her visits to the health center in 1998 were almost exclusively for respiratory problems—thirteen out of fourteen visits.

The same entry from 1998, which mentions chronic asthma, is accompanied by a remark: "[She] went to see an herbal officer at Nubia in 1996; ever since then she kept on going on and off." Her encounter with the herbal specialist—surprisingly referred to as the "herbal officer," here, a term I had never heard that gives it an oddly formal touch—took place before she

had received Norma's information. Rita later explained to me that herbalists would not be able to help her if she had been ensorcelled, as they do not have any power against sorcery. At the time of her journey to Nubia, Rita was in search of an alternative to the health center's cough medication and the *kamfarkhem* extraction.

This section of a vignette that is more thoroughly presented in chapter 3 illustrates how biomedicine is embraced in a local Giri context and how the version of biomedicine practiced in the area and local concepts, relationships, and practices are entangled in a single medical system. In chapter 3, we see that Rita felt it necessary to find out whether she suffered from a local or a foreign illness. Moreover, we learn that Rita utilized a biomedical technology (the X-ray) as a means to disclose whether she was suffering from a local or foreign illness.

Other case studies in the book reveal similarly complex entanglements of Giri ways of being, personhood, and social relationships with biomedicine. The fundamental question that guided my work was How do the Giri reinterpret and construct biomedicine against the backdrop of local conceptualizations of the person in health and illness? The structure of the introduction is derived from the two major themes inherent in this question; I start with a review of anthropological inquiry into biomedicine and then turn to anthropological investigations of (particularly Melanesian) personhood.

## Anthropological Inquiry into Biomedicine

Recently, biomedicine in its cultural contexts has come under wide anthropological gaze. In the preface to their *Encyclopedia of Medical Anthropology*, Ember and Ember provide a succinct definition of the term:

> The professional medicine of Western cultures has been called "biomedicine," because it mostly deals with the biology of the human body. But biomedicine, like the medicine of other cultures, is also influenced by conditions and beliefs in the culture, and therefore reflects the value and norms of its creators. So, if biomedicine is socially constructed and not just based on science, its beliefs and practices may partly derive from assumptions and biases in the culture. (2004b: xiii)

However, at the outset, it was not biomedicine that attracted anthropologists' attention but indigenous medical systems. Even after medical anthropology evolved into a specialized field in the 1970s, inquiry remained focused on indigenous medicine. Van der Geest surmised that the lack of anthropological research interest in biomedicine at that time was related to "too little exotic attraction for the ethnographer" (1984: 60). What is more, it seems that the self-perceived scientific objectivity of biomedicine kept anthropologists from

turning their attention to the examination of biomedicine as a sociocultural system for quite a long time. In Western societies, participants commonly think of biomedicine as factual knowledge (Amarasingham Rhodes 1996: 166–67) and illness as a natural occurrence (Hahn & Kleinman 1983: 313).

Western biomedicine is founded on the philosopher/mathematician René Descartes's (1596–1650) argument that mind, "a pure thinking entity" (Risse 1993: 14–15), and body, "ruled by universal laws of matter and motion" (14), can be separated. Descartes's conceptual framework, culminating in the Enlightenment, has promoted a mechanical approach to the human body: "The body was conceived of as a vast hydraulic network of hollow pipes, moving blood and nervous fluid in the circulatory and nervous systems under the influences of the mind" (15). The Cartesian mind-body dichotomy holds that "diseases . . . are physical entities occurring in specific locations within the body" (Amarasingham Rhodes 1996: 167); as part of the natural realm, the body is "knowable and treatable in isolation" (Hahn & Kleinman 1983: 313). Hence, in Western societies, biomedicine and the body have been conceived of as independent entities, not sociocultural artifacts.

Eventually, anthropological investigation into biomedicine was ignited in the early 1980s by two seminal articles (Hahn & Kleinman 1983; Young 1982) and a special issue of *Culture, Medicine and Psychiatry,* edited by Gaines and Hahn (1982). These works called researchers to treat and explore (European and North American) biomedicine as a sociocultural system and, as such, one medical tradition[1]—one ethnomedicine—among others.[2] This approach has strongly stimulated comparative studies of biomedicine and other medical systems (Gaines & Davis-Floyd 2004: 96). Biomedicine, rooted in Western industrialized countries, is not practiced and consumed uniformly throughout the world.

It is multiple: "*not one, but many medicines*" (Hahn & Kleinman 1983: 315). When transplanted, it takes new forms (see, e.g., Gaines & Davis-Floyd 2004: 104; Kleinman 1995: 24–25; Lock & Nguyen 2010: 5–6; Saillant & Genest 2007: xxii–xxiii). A quote from DelVecchio Good aptly captures this view: "Although biomedicine is fostered through an international political economy of biotechnology and by an international community of medical educators and bioscientists, it is taught, practiced, organized and consumed in local contexts" (1995: 461). Furthermore, we must add another dimension: today, biomedical knowledge is produced and technologically innovated not only in Western countries but also elsewhere (Kleinman 1995: 25).

My major objective was to study biomedicine in its local entanglements. This book explores how Giri consume biomedicine, both inside and outside of biomedical institutions. A substantial amount of research was carried out at the local health center (Bunapas Health Center) and the provincial hospital (Modilon General Hospital). Therewith, this work forms part of a growing

body of anthropological research that studies the domain of biomedicine by way of investigating biomedical institutions. What is more, this book is at once the ethnography of a rural health center in Papua New Guinea (Bunapas Health Center) and a medical ethnography of contemporary Giri. Anthropologists have only recently begun to carry out ethnographic studies in Papua New Guinea biomedical settings, and academic literature in this field is just beginning to emerge (Keck 2005; Street 2009, 2011, 2012, 2014; van Amstel & van der Geest 2004).

The paucity of ethnographic studies in medical settings is characteristic of not only the Papua New Guinea context but also the non-Western world more generally (van der Geest & Finkler 2004). Even anthropologists working in Western countries have only recently turned toward description and interpretation of hospital cultures, having only gained greater access to Western clinical settings since the mid-1970s (Young 1982: 258). Yet, anthropologists and other social scientists have predominantly centered their studies on physician-patient relationships and other microscopic settings (Baer et al. 1997: 223). Hospitals, as such, have not been the focus of much anthropological research; though, as van der Geest and Finkler suggested, hospitals are "premier institution[s] of biomedicine" (2004: 1995).

Highlighting this relative scarcity of ethnographic studies situated in hospitals, van der Geest and Finkler (2004) called for more ethnographic studies in biomedical settings in a "Hospital Ethnography" issue of *Social Science & Medicine*. Perhaps, they surmised, a major reason for the prevailing absence of hospital ethnographies may be related to the fact that hospitals have, for a long time, been regarded as "identical clones of a global biomedical model" (2004: 1996) and "places where established universal principles of biomedicine were practised uniformly" (1995). Their central concern was to show that hospital life reflects the features of its society. Therewith, they turned against the idea that the hospital is a culture set apart from life outside the hospital—a view that was prominent among sociologists, who had begun to scrutinize hospitals in the late 1950s.

Sociological description and analysis of life in hospitals (e.g., Caudill 1958; Fox 1959; Laub Coser 1962; Roth 1963; Stanton & Schwartz 1954) were concerned with exploring what G. Sykes called "a society within a society" (1958: xii). Instead of treating the hospital ward as a "tight little island," a "world unto itself" (Laub Coser 1962: 3), van der Geest and Finkler took the view that the hospital is "an important part . . . of the 'mainland'" (2004: 1998). As such, hospital ethnographies "open . . . a window to the society and culture in which the hospital is situated" (2004: 1998). A particular strength of their edition is that it embeds wards and hospitals in the wider sociocultural context. The authors disclosed how values, rules, and notions of the outside world pervade biomedical institutions.

Four years later, another special issue on hospital ethnography (with van der Geest among the editors) appeared—this time in *Anthropology & Medicine*—though with a different focus. The editors (Long et al. 2008: 73) noted in their introductory article that only scant ethnographic research had been directed toward relationships other than those at patient-clinician interfaces. They advocated the inclusion of a multiplicity of stakeholders, such as nurses, health managers, allied health personnel, relatives, friends, advocates, and support groups. Among the few pieces of work that have dealt with this variety of actors is Zaman's (2005) ethnography of an orthopedic ward in a Bangladeshi hospital that considers—aside from patients and doctors—relatives, ward boys, cleaners, gatekeepers, and nurses. Most recently, ethnographies of two African hospitals, one in Kenya (Mulemi 2008, 2010) and one in Tanzania (Sullivan 2011, 2012), have appeared, adding to the growing body of literature on non-Western hospitals and responding to the calls of the 2004 and 2008 hospital ethnography special issues.

A principal objective of this book is to contribute to the qualitative literature of medical settings in non-Western countries. This work was written with the objective of illuminating how Giri actors give local character to two establishments in which biomedicine is practiced. Yet, my work stands apart from the contemporary hospital ethnographies by Zaman, Mulemi, and Sullivan, in that my point of departure is not so much the medical institution itself as my Giri interlocutors, whom I followed in their quest for diagnosis and medical treatment.

My study was primarily focused on Bunapas Health Center (BHC), which is the sole health center of the Giri region and beyond. Eventually, my interlocutors also led me to the provincial hospital, Modilon General Hospital (MGH). My intention was not to write a comprehensive ethnography of each medical institution—especially MGH, with patients and a workforce that come from across the province and even beyond. Instead, I explored both the local health center and the provincial hospital, with a focus on Giri stakeholders: Giri patients, medical personnel, and caretakers.

## Anthropological Inquiry into Conceptions of Personhood

This book analyzes Giri ideas of personhood and details the bearing of these local conceptions of the person on biomedical services. How do Giri people reinterpret and appropriate biomedical services against the backdrop of their conceptualizations of the person? The Giri person is, as theorized by the New Melanesian Ethnographers (most prominently Marilyn Strathern [1988] and Roy Wagner [1991]),[3] essentially a social being, constituted relationally through interactions with others. In the cultural logic of the Giri, social relations have a significant bearing on individual health and illness. I support

Keck's argument that "no adequate investigation of health and illness . . . would be possible without an understanding of the concept of the person" (2005: 53). This book discusses at length the relationship of health and illness with concepts of the person.

Mauss's ([1938] 1985) lecture on the person sparked much debate over personhood in anthropology. His argument that understandings of personhood are culturally and historically produced has been advanced in subsequent literature. Battaglia (1983: 291) demonstrated that Sabarl (Southern Massim) personhood is represented by both Mauss's "personnage" and the autonomous individual, which are, she suggested, in a dialectical relationship. Various anthropologists studying personhood have found it useful to differentiate between the individual, the self, and the person.

Harris (1989) and Morris (1994), for example, considered the concepts of individual, self, and person—when clearly defined—useful analytical tools. However, as A. Strathern and P. Stewart (1998c: 172) argued, to come to a clearer understanding of personhood it is necessary to examine personhood from the perspective of indigenous ontology. By taking the Melpa-speaking Hageners' (Western Highlands Province) concept of "noman" as an example, A. Strathern and P. Stewart (1998c: 175–77, 2000: 64–66) showed the artificiality of the categories of individual, self, and person.

"Noman" can be translated as "mind, intention, will, agency, social conscience, desire, or personality" (A. Strathern & P. Stewart 1998c: 175). It includes individual and social aspects of personhood. One may say, then, in general terms, that "*noman* signals the domain of 'personhood'" (177). Von Poser's (2013: 9) exploration of Bosmun personhood may be cited here as a further, and topical, example. She found that aspects of individual, self, and person (approximating the concepts described by Harris [1989]) are conflated in Bosmun constructions of personhood. Wagner (1991) is a third Melanesianist who gave preference to local ideas.[4] His approach is discussed below. Self and person are not isolated from one another but are interrelated and overlapping.

Giri consider a strict separation of person, self, and individual inapt. Like other cultural groups of Melanesia and beyond, Giri give tremendous importance to the person and not, as seen in Western cultures, to the self (Fajans 1985; Keck & Wassmann 2010: 185–86). In other words, Giri are predominantly "person oriented" (Fajans 1985: 383). But I do not claim that Giri think in analytical categories of person, self, and individual. As Fajans said in her analysis of the Baining (East New Britain) person, "My analysis, while not an indigenous model (the Baining are not explicit about these matters), is in keeping with the Baining emphasis on external behaviors and relationships, and their lack of interior, emotional, subjective explanation" (1985: 371). She supplied numerous examples to support her argument.

According to Fajans (1985: 367, 371, 383), the Baining are reluctant to speak about their own and others' subjective motivations and feelings; instead, they provide descriptions in terms of "aspects of social roles, interpersonal interaction, and the nature of social behavior and action" (371). The idea (widespread in Oceania but also found elsewhere [see Danziger 2006, 2010; Wassmann et al. 2013]) that it is virtually impossible for one to know the thoughts and feelings of others has recently become known as "the doctrine of 'the opacity of other minds'" (Robbins & Rumsey 2008: 408). I shall give a brief example of Giri people's reluctance to speculate about others' inner motives, an instance that Fajans (1985: 383), herself, described.

Early on in my fieldwork, I talked to a young Giri man about the different pathways that Giri schoolchildren habitually take to the schools located in the Giri 1 and 2 main villages. My conversational partner described two commonly used paths—one leading along the gravel road, on which one is exposed to the hot sun, and the other a shorter, shady bush track. He then mentioned a schoolboy who usually took the hot and longer gravel road. When I asked him why this boy did not walk along the apparently more pleasant bush track, he answered, "Mi no inap long save" (I cannot know).[5] When I inquired further, he simply replied, "Em i les" (He does not want to). My repeated inquiry as to why he did not want to take the bush track was answered again with "Em i les tasol" (He just does not want to).

The works of two Melanesian scholars, Marilyn Strathern (1988) and Roy Wagner (1991), were particularly influential in spurring the shift of focus from Western notions of the autonomous individual to the relational person. M. Strathern (1988) made the case that the Melanesian person is—in distinction to Western notions of personhood—primarily constituted by relations with a multiplicity of other persons. In keeping with the example of Melanesian leadership, M. Strathern (1988: 156–59) replaced the idea of the (Hagen) big-man as an autonomous, self-contained, "entrepreneurial" (Rio & Smedal 2008: 240) individual, with the image of a relational person. In the words of Rio and Smedal, "More than being the generator of social relations he is a visible manifestation of the social relationships that he encompasses—he is their outcome, their effect. The big-man is an image that sociality produces" (2008: 240). Theorizing on the person as a set of relations with others led M. Strathern (1988: 13) to formulate the concept of Melanesian persons as composites, or "dividuals," rather than persons marked by individuality.

Wagner reconceptualized the role of Hagen big-manship along the same lines, setting out to "develop . . . Marilyn Strathern's concept of the person who is neither singular nor plural" (1991: 162). According to Wagner, Melanesian individuals are not discrete, self-contained entities. Rather, the individual and group mutually construct and imply one another. He called this "the fractal person," which is "never a unit standing in relation to an aggregate, or

an aggregate standing in relation to a unit, but always an entity with relationship integrally implied" (163).

M. Strathern's and Wagner's approaches have been immensely influential, and other Melanesianists have taken up and amplified their claim that Melanesians "do not think about social life in terms of the individual versus the society" (Hess 2009: 42). Their works have been augmented, scrutinized, and challenged by subsequent works and have fostered a perpetual debate about Melanesian personhood.[6,7] LiPuma (1998) and A. Strathern and P. Stewart (2000: chap. 4) have expanded on M. Strathern's theory. They have claimed that both relational (or dividual) *and* individual modalities mark Melanesian personhood, wherefore A. Strathern and P. Stewart spoke of the "relational-individual" (2000: 2, 63).

Critique was leveled at M. Strathern for comparing Melanesian notions of personhood to the ideology of the fully individual Western person, and not to reality (LiPuma 1998). LiPuma (2000: 131) suggested that most aspects of Melanesian personhood can be found in Western societies; Western persons are also "interdependent, defined in relation to others, depend on others for knowledge about themselves, grasp power as the ability to do and act, grow as the beneficiary of others' actions, and so forth" (LiPuma 1998: 60).

If we follow A. Strathern and P. Stewart, and LiPuma, aspects of individuality have always been present, at least to some extent, in Melanesian conceptions of personhood. However, concepts of personhood are not static. LiPuma (1998: 64, 2000: 128–29) suggested that individual aspects of Melanesian personhood have gained importance with modernity.[8] Counterexamples exist, however. Lipset, for example, demonstrated, by means of courtship stories told by young men from the Murik Lakes (East Sepik Province) region, that precolonial courtship and marriage practices have "remained somewhat enclaved" (2004: 211) from encompassment by modernity and individualism.

Giri people act, for the most part, relationally, but they also strive for individuality. The medical context provides evidence of this duality. For example, Giri staff at BHC expressed that they sometimes felt overwhelmed by their kin's requests for medical treatment outside of regular consultation hours and for accommodation in staff housing during phases of health center closure (see chaps. 2 and 4 on closures). Health workers complained that their kin did not respect the fact that they acted in their roles as health professionals. In the health workers' opinion, they should be enabled to "transcend their relational identities" (Wardlow 2006: 20) in the professional context, and relatives should refrain from approaching them with extra requests. However, there is also evidence of health workers giving special attention to their kin, seizing the opportunity that unfolds in such situations to strengthen their bonds with kin by aiding them (see chap. 4 for extensive discussion).

## The Chapters

This book is organized into five chapters. Chapters 1 and 2 give the relevant background information for chapters 3 to 5. I open chapter 1 by situating myself in the ethnographic setting of the study, placing myself in the web of social relations within which I became embedded in the research site, thus providing an introduction to key interlocutors. The second section of the chapter provides an ethnographic sketch of the Giri focused on village settlement and social organization. The latter portion of the chapter describes this book as ethnography in terms of the doing and writing up of fieldwork. Particular emphasis is laid upon fieldwork as a process of mutual knowledge production between researcher and interlocutors.

Chapter 2 starts with a historical glimpse of biomedical services in Giri. The main thrust of the chapter is the delineation of various perspectives on the local health center, BHC, as it is today. Beginning with an overview of the different health center services, I then look at understandings of BHC from the viewpoints of those who administer and receive health care. Through this, I offer first impressions of local manifestations of biomedicine and, thus, lay the foundation for the issues addressed in the subsequent three chapters. The objective of these chapters is to explore the appropriation of biomedical practices, technologies, and knowledge. All three chapters address the question of how Giri, who have their own medical traditions, respond to incoming medical ideas and aid. Furthermore, chapters 3 to 5 show that Giri people's encounters with biomedicine are not limited to the services offered in the Giri area, as Giri patients actively seek biomedical care at other biomedical institutions, particularly at the provincial hospital in Madang.

In chapter 3, I elaborate on terminological and technological innovations. To be precise, I demonstrate, through two case studies, how these novelties have impacted the established medical system. By inflection, I elucidate how the introduced theories and diagnostic and therapeutic strategies have become localized—bearing in mind that biomedicine is not a homogenous entity but instead shaped by the local setting and its actors. In regards to biomedical technologies, I argue that they are recontextualized according to indigenous knowledge of the body, health, and illness. My basic argument is that the Giri notion of the person as a predominantly relational being governs the appropriation of biomedicine, through which biomedical artifacts and procedures become invested with social meaning. This argument is pursued through the following two chapters.

Chapter 4 exposes the strategies through which biomedical space is transformed into Giri place. Focusing on the social relations of therapy management, the chapter explores how the complex webs of relationships in which patients and health workers are suspended pervade the local health center

and the provincial hospital. Among other topics, I detail the significance of giving and sharing local food as a strategy employed by caring family members to comfort and strengthen patients and to actualize social relationships. Moreover, I outline the important roles that Giri medical and paramedical personnel play as part of Giri patients' support groups at MGH, particularly as mediators between patients and hospital services but also as food providers and hosts to patients and their family members. I suggest that provision of care and support is grounded on the principle of reciprocity. The chapter concludes with a discussion highlighting my understanding of reciprocity as a principle that Giri people have applied to the health center and hospital.

In chapter 5, I turn to reproductive health and deliver insights into Giri women's employment of the biomedical reproductive health services offered at the local health center and provincial hospital. I argue that Giri women are highly creative agents who dovetail biomedical health care (such as pharmaceuticals they receive throughout pregnancy, birth, and the postpartum period) with traditional practices connected with birth (such as postpartum seclusion). Women's ingenious strategies to reinterpret biomedical care allow them to draw on the former without having to counterpose the latter. However, a transformation of traditional practices comes with biomedicine gaining a foothold in the Giri medical system. Biomedicine, for example, challenges the relevance of placental burial—a practice that was, in the past, of utmost importance because it was said to anchor the Giri child in its web of social relations. At this point, I advance the argument that the Giri person is primarily relational. It will be made evident that, from conception onward, the child becomes through the contributions of others.

The conclusion picks up threads from the different chapters of the book and summarizes these into a discussion of the local entanglements of biomedicine and how Giri conceptions of the person bear on the form that biomedicine takes in Giri. Biomedical practices, technologies, and services are appropriated and imbued with social meaning. In Giri thought, social relations affect individual bodies and the way in which individuals experience their bodies in health and in illness. Giri decisions to draw on or dismiss certain biomedical services are informed by their relational understandings of the person. Eventually, the conclusion discusses implications for public health interventions in Giri, suggesting ways to bridge medical anthropology and public health. Also, I look at possibilities for further research.

## Notes

1. I use the term "tradition(al)" throughout this work to encompass all that is customary and conventional, referring to historically contingent values and practices of Giri culture. I do so with the knowledge that tradition is not static or rigid but characterized

by fluidity. Innovation is part of tradition. Importantly, tradition is contingent upon human agency, as recently emphasized by Otto: "Traditions appear highly changeable and their maintenance or adaptation involves the active involvement of human actors" (2007: 36).

2. Fabrega (1975) advocated the view that biomedicine is as much a cultural product as are other medical systems.
3. Josephides (1991) coined the term "New Melanesian Ethnography."
4. This was noted by A. Strathern and P. Stewart (1998c: 174).
5. It must be noted that Giri also often used this phrase to indicate that I had asked an inappropriate question—for example, a question touching upon knowledge that I or other people present must not know (cf. Goldman 1993: 283–84). In the latter case, interlocutors often got back to my unanswered questions in dialogue, pointing out that a particular person, who had been present during the initial conversation, must not know certain information.
6. Besides relationality, other central notions by which Oceanic personhood has been explored are partibility and permeability (see, e.g., Hess 2009; Mosko 2010; P. Stewart & A. Strathern 2000: 17–20; A. Strathern & P. Stewart 2000: 64).
7. Anthropologists working in various locations have picked up M. Strathern's work. One might remember that M. Strathern took the term "dividual" from Marriott's (1976: 111) reading of South Asian personhood and applied it to Melanesian notions of sociality. Not surprisingly, contemporary works for South Asian dealings with notions of dividual personhood often reintroduce M. Strathern's concept to the South Asian context (e.g., Aura 2008; Osella & Osella 2006).
8. Modernity is not a singular phenomenon but is plural; it is not solely a Western product but has complex and multiple origins; not only does it unfold within Western countries, but its processes and dynamics can be found outside the geography of the West. Countering Eurocentric accounts of modernity, cultural theorists have thus come to embrace the notion of alternative, multiple, or plural modernities that accommodate this very diverse and culturally specific manifestation of modernity (T. Mitchell 2000: xii). As for Papua New Guinea and anywhere else, local, regional, and global forces shape particular versions of modernity (Foster 2002). The works of Gewertz and Errington (2004; Errington & Gewertz 1996) examine the realization of Papua New Guinea modernity (also see Hirsch 2001).