Situating Serodiscordance: Living in Relationships with Mixed HIV Status in Different Local, Historical and Biomedical Realities

Angela Kelly-Hanku

Introduction

> We don't think about it. We forget about it. We are normal and live our life, except when I must remember to check my review date and go to the clinic (Soso, HIV-positive woman in a HIV-serodiscordant couple, Goroka, Papua New Guinea).

In the Australian winter of 1981, the year I began primary school, an epidemic of unknown cause or origin officially began with reported cases of *Pneumocystis carinii* pneumonia in gay men in the USA. Soon after, Australians—mostly gay men and individuals with haemophilia—began to face the epidemic, forced to live with and respond to a new illness that affected not only them, but also their partners, family, friends, and communities. As no members of my family were infected or affected by this new mysterious illness, I remained oblivious to the virus for many years. It would not be for another decade and a half that I would find myself personally affected by HIV, and part of a "key population", as serodiscordant couples are now termed. But this was not how we viewed ourselves, nor how "HIV experts" classified us at that time. This was, in part, because at that historical moment HIV treatment was minimal and the current culture of biomedical prevention was still far in the future.

HIV is most frequently transmitted during "intimate acts in private relationships", making it a "disease rooted in relationships" (Kalichman 2000:175). As Persson (2011, 2013) has underscored in her body of work on serodiscordant relationships in Australia, it is critical to understand how serodiscordance operates relationally. This means enquiring into how HIV impacts upon the social and embodied

---

A. Kelly-Hanku (✉)
Sexual and Reproductive Health Unit, Port Moresby, Papua New Guinea

Institute of Medical Research & Kirby Institute, UNSW Australia, Sydney, Australia
e-mail: a.kelly@unsw.edu.au

A. Persson, S.D. Hughes (eds.), *Cross-Cultural Perspectives on Couples with Mixed HIV Status: Beyond Positive/Negative*, Social Aspects of HIV 2,
DOI 10.1007/978-3-319-42725-6_6

sense of self for both HIV-positive and HIV-negative partners, as well as the diverse ways this shapes how serodiscordance, and risk, is lived in different local realities. At the core of serodiscordance is the issue of intersubjectivity because individuals, as Merleau-Ponty (1973) said, rarely act in isolation from others. Similarly according to Schutz (1973:55), the social world "is from the outset an intersubjective world". Thus, although HIV is a virus physically confined to the body of the HIV infected individual, both the person with HIV and their partner (and others) experience HIV affectively and socio-culturally. In short, lived experiences of HIV are intersubjective, profoundly mediated by both social and biomedical contexts. Such an emphasis on the relationality and intersubjectivity of serodiscordance (within sexual and other familial relationships) has been at the heart of my own work on HIV, particularly as it relates to AIDS dementia (Kelly 2008a, b, c, 2010).

Seeing serodiscordance from this perspective destabilises any effort to essentialise what living in a serodiscordant relationship means. In this chapter specifically, by exploring serodiscordance in different local, historical and biomedical settings, I attempt to unsettle popular discourses of and the meanings ascribed to serodiscordance by illustrating how they are neither universal nor consistent across time or place. I provide historical insights into the "emergence" of serodiscordant couples by drawing on my own story as an HIV-negative woman in a heterosexual serodiscordant relationship in Australia. I also chronicle my experience of the emergence of HIV serodiscordant couples in the national response in Papua New Guinea (PNG), first as an imagined biomedical anomaly and subsequently as a normalized phenomenon of living with HIV. In doing so, I make visible snippets of the realities of couples' lives, bringing to the fore personal stories of HIV and serodiscordance. I thus consider the private lives behind a global health concern, offering an analysis of the effects of biomedicine and living in relationships with mixed HIV status. But first I examine the politics of representation of living with HIV and its impacts on understandings and representations of couples with mixed HIV status.

The Space for Serodiscordant Couples

Long marginalised to the edges of the epidemic (e.g. Kelly 2006; Roman 1997; Van der Straten et al. 1998), HIV-negative partners are now more visible than at any other time in the history of the epidemic, if for no other reason than their role in clinical research on Treatment-as-Prevention (TasP). Results from the high-profile HIV Prevention Trials Network trial have shown that early treatment of HIV reduces HIV transmission in serodiscordant couples by 96 %, as compared with delayed treatment (Cohen et al. 2011). As a result, TasP has become a key biomedical intervention in the HIV landscape, with a very specific goal; to reduce HIV incidence globally.

This new concern with serodiscordant couples, however, has almost exclusively been focused on quantitative understandings of HIV transmission/acquisition risk rather than the intimate practices and daily realities of couples' lives. Their bodies have become a primary focus of the biomedical gaze in large-scale trials. Whether they engage in same-sex or opposite-sex intimate relationships, and whether located in African, North-American or other countries and regions, serodiscordant partners have become central to understanding HIV transmission risk from a clinical and epidemiological viewpoint. But this perspective is only partial and reflects little of living with serodiscordance. It has also meant that serodiscordant relationships have overwhelmingly been framed as sites of HIV risk, as if these couples in all their variances were the same across both time and space. Hence, with the transformation of the biomedical landscape, the recent attention to serodiscordant couples is welcomed, but comes with a level of caution as to the genuine interest above and beyond "risk" and the potential biomedicalisation of these relationships.

People new to HIV could be forgiven however for believing that serodiscordant relationships are a recent phenomenon, a late addition to the HIV epidemic and to "living with HIV". But, of course, intimate serodiscordant partnerships have always been a characteristic of the epidemic; they simply have not been given the attention they now incite, whether biomedical, political or social. This was the reason I referred to the politics of representation in an earlier article where I explored, using visual images, my partner's life and subsequent death from AIDS dementia, a feared and deeply stigmatised AIDS-related condition, arguing that my shadowed face in one particular image at an AIDS Candlelight Memorial was symbolic of my invisible serostatus position as an HIV-negative partner of a person living with HIV (see Kelly and Kerner 2004).

Situated Knowledge

To explore the issues outlined for this chapter I draw on a number of different sets of "data" (knowledge). Along with insights gained through my work as a social researcher on HIV in PNG, my life, like that of many people, has also been intimately impacted by the virus. Jossie and Soso, two women employed in my home to care for my children, live with HIV; both of them have married HIV-negative men in the five to ten years we have known each other. Reaching further into the past, my connection to serodiscordance grows more intimate still. My partner Andrew died from AIDS-related dementia in early 1999, 8 days before my 23rd birthday. Thus my embodied experience of serodiscordance is situated at a very different historical moment than Jossie's and Soso's. I have permission and the blessing of family members, friends, and research participants to draw on all of the stories presented in this chapter. My commentary here should be recognised as, in part, auto-ethnographic, in the midst of an ongoing HIV journey that is both professional and personal, across highly diverse cultural, linguistic and temporal settings. In this way, I work in the "borderland between passion and intellect, analysis and subjectivity, ethnography and autobiography, art and life" (Behar 1996:174). This perspective offers a unique window onto changes in the biomedical landscape over time—changes which I argue are critical to the (re)framing of serodiscordant relationships in PNG, and likely in other contexts as well.

Intimate Understanding

I met Andrew in my late teens. The night of the day we met I dreamed of our wedding; needless to say I was deeply taken by him. I had never met someone who had intrigued me as much nor whom I shared so much in common with. Diagnosed with HIV in December 1984, Andrew had already lived with HIV for many years before I met him; his resilience, passion and humour were infectious not only to me, but also to all those who met him. I was not intentionally entering into a relationship with "a person with HIV." I was experiencing my first great love. It was a love that would teach me much about the value of life, but also of living with HIV; lessons I continue to benefit from long after his death.

Our relationship posed immediate challenges; in the mid-1990s in Australia, effective HIV treatment was lacking and much fear and discrimination prevailed. Andrew's family carried a hereditary bleeding disorder and was deeply affected by HIV early on in ways most families were not. Andrew was 11 years old when he was infected and 14 years old when diagnosed with HIV. His maternal uncle, who also had haemophilia, was diagnosed in his early thirties. This uncle, who died the year before I met Andrew, left behind an HIV-negative wife and young daughter, born within a year of his diagnosis.

AZT was the only HIV treatment available at the time Andrew and I met. Many people suffered from its toxicity, hence his decision not to risk premature death from treatment side effects. Treatments advanced considerably during our 4-year relationship, though treatment as we know it today simply did not exist. In particular, there were severely limited options for people like Andrew, who had been diagnosed with HIV-related dementia some 18 months into our relationship. At one point, he was granted, on compassionate grounds, permission to commence treatment on a trial drug believed to cross the blood brain barrier.

Soon after Andrew started this trial treatment, however, he stopped. The side effects were unmanageable and intolerable, and ongoing cognitive deterioration suggested that the regimen was not adequately treating HIV in his brain. He wanted desperately to live but not at the cost of being severely impaired by dementia. Andrew and I were never to benefit from the medical advances that were yet to come in the ways many of our friends did and continue to do. With his ongoing cognitive deterioration, the hope for HIV treatments to halt or reverse the damage of HIV to his brain became a hope for death, suggesting the complex and temporal dimensions of hope, treatments and HIV (Kelly 2007).

Situating HIV in PNG

In the almost 30 years since HIV was first diagnosed in PNG in 1987, epidemiological, socio-cultural and political understandings of the epidemic have undergone momentous change. As the country with the largest number of people living with HIV in the Pacific (National AIDS Council Secretariat [NACS] 2010, 2013) and with a rapid increase in diagnoses in the early years, the epidemic in PNG was previously predicted to follow the path witnessed in sub-Saharan Africa (Australian Agency for International Development 2006; NACS 2013).

That said, there is increasing recognition that not all people in PNG are equally at risk of infection, nor is the epidemic evenly felt across the country (Kelly-Hanku et al. 2014a, b; Maibani et al. 2011; NACS 2013). The current epidemic is complex; mixed rather than concentrated or generalized (Kelly-Hanku et al. 2014a, b), and not readily classified into HIV estimate models or epidemiological categories. When I first began working in PNG at the turn of the century, HIV treatments were not yet available. A few years later, they were integrated in a pilot project at the country's largest HIV clinic in the nation's capital. Thus, HIV treatments were late to be incorporated into PNG's response to the epidemic, particularly considering the grim sub-Saharan analogies that were drawn at the time. Fast-forward to the present day and treatments are available throughout the country.

In the past 10 years, a wealth of research (social, cultural, laboratory and epidemiological) has enhanced our understandings of HIV in PNG. This includes my own research studies, such as *The ART of Living*, the first study on living with HIV and treatment in the country (Kelly et al. 2009a), as well as the first study to bring attention to the core issue of this edited volume: couples with mixed HIV status (Kelly et al. 2011). In this study, of participants living with HIV who were sexually active and in a regular heterosexual relationship, 21 % reported being in a serodiscordant relationship; a further 14.3 % did not know their partner's status (Kelly et al. 2011). There was no significant difference in condom use between couples with mixed HIV status, couples with the same HIV status or those where the status of the partner was unknown. In qualitative interviews from the same study, people living with HIV described their HIV-negative partners as playing an important role in their lives in terms of treatment adherence, keeping HIV a secret, nutritional support and a sense of normality through sexual intimacy and care (Kelly et al. 2009a; 2011).

More recent qualitative research on prevention of parent-to-child transmission (PPTCT) programs shows that, with the rapid roll out of antiretroviral treatment (ART), HIV-positive women and their negative husbands are fulfilling reproductive desires, with increasing numbers of couples knowingly entering into a serodiscordant relationship (Kelly et al. 2013). Marriage, pregnancy and parenthood are significant cultural practices and expectations in PNG, and understanding this makes plain how transformative biomedicine can be. It allows people with HIV, and serodiscordant couples, to re-enter society from the margins of contagion and pollution, enabling their claims of reproductive citizenship (Kelly 2012b).

Notwithstanding severely limited second-line treatment and numerous treatment stock outs, the treatment and management of HIV in PNG has progressed significantly in the past few years. Portable point-of-care CD4 machines are now readily and widely available in most treatment centers. But access to viral load testing—critical to determining treatment failure—is non-existent. The absence of viral load testing influences the clinical management of HIV as well as discourses of HIV risk. Excluding the few HIV activists who attend regional meetings, nowhere have I heard people with HIV or their HIV-negative spouses talk about "non-infectiousness", undetectable viral loads or TasP, as found in other studies of serodiscordant couples. Rather, people talk about treatment as putting the virus to sleep or putting a fence around it and enabling them to have "normal" babies free from HIV. While it is not clear if this encodes the same understanding that lies behind more scientific discourses, its expression is certainly different in PNG. As viral load testing becomes available in the future, it will be important to map how this new technology might alter narratives of HIV risk and how the knowledge of viral load might be incorporated into the sexual and reproductive practices of couples with mixed HIV status.

Sero-Silence and Diversity

The current PNG National HIV Strategy (NACS 2010) is the first to mention serodiscordance, and does so only twice. This occurred only because my supporters and I were so intent on breaking the silence that surrounded such couples and, in particular, ensuring their access to Post Exposure Prophylaxis (PEP). The policy on PEP provision at the time the Strategy was drafted named only victims of sexual violence and occupational exposure. I knew that unless serodiscordance was explicitly included, the policy would be left to interpretation, and possibly discriminatory application. To appropriate and re-apply a phrase coined by Persson (2008), our work in those meetings (where the strategy and policies were designed) was to ensure there was no "sero-silence". Another expression of sero-silence is the way global public health discourses frequently frame serodiscordance as homogenous. This muzzling of diversity in mixed-status couples, historically and across different socio-cultural (and biomedical) landscapes, is an ongoing limitation of the extant literature. Here I offer just a few examples of the diversity I have come across in my work and personal experience.

Many marriages throughout PNG, but particularly in the Highlands Region, are polygamous. I encountered a serodiscordant polygamous marriage in early 2008 while in Mendi, the provincial capital of the Southern Highlands, for the ART of Living study. The diagnosed HIV-positive woman, one of two wives, had been enrolled in the PPTCT program, after having tested positive for HIV at her first antenatal visit. She had only given birth within the last 24 h prior to me meeting her. As we talked, her co-wife shared that she too wanted a baby but that she did not know her HIV status. Nor, it turned out, did the husband of these women. He had recently been released from prison for a brutal act of domestic violence. Wanting to know their status, the co-wife and their husband attended the Catholic HIV Center a few days later. Both tested negative for the virus.

Though only a snippet, this family's story has stayed with me, offering a variant narrative to the dominant construction of serodiscordance perpetuated by national and international policy and rhetoric. In prevailing HIV discourse, polygamous unions are erased, despite polygamy being a type of marriage endorsed and codified culturally, religiously and often legally in many parts of the world. In countries such as PNG, serodiscordant polygamous unions are not a socio-cultural (or biomedical) anomaly. Yet such relationships are rarely acknowledged in the literature on serodiscordance more broadly, let alone in the clinical drug trials that have brought biomedical attention to serodiscordance. Polygamous unions with mixed HIV status stretch and challenge our common understanding of serodiscordant "couples". But if we look beyond intimate partnerships, serodiscordance begins to stretch and diversify even further.

At another point during my time in Mendi, a local priest brought a group of people living with HIV from his diocese for their HIV medical review at the local Catholic HIV treatment and care centre. There were two young brothers amongst them. As people waited for their reviews, we all played a game of basketball, laughing and sharing stories. A story of the boys was relayed to me be by another member of the group. Both boys had been infected perinatally, though their middle brother was born without the virus. Their parents, however, had died from AIDS. This chain of infection and death was forged before ART was introduced in PNG; had the family lived elsewhere where treatment was already available, this chain of infection and loss of life may have been prevented.

This story of mixed HIV status between family members is not unique to this family or to PNG. In Australia, prior to the development of more advanced HIV treatments, I knew of families in which parents and children were serodiscordant, or siblings were of mixed-status—including a family with identical twins where one was HIV-positive and the other negative. This kind of serodiscordance also characterized my late partner's family: Andrew's uncle was infected but his wife and daughter were negative. Though not often discussed, intra-familial serodiscordance has only become *more* common as HIV treatment and prevention have evolved. Indeed, because PPTCT programs are designed to ensure that children of HIV-positive mothers are born without HIV, and that HIV-positive men do not infect their spouse and therefore their child, such programs increase rather than decrease mixed-status relationships. Creating serodiscordance within families is the explicit global biomedical aim of PPTCT.

Treatment and the (Re)framing of Serodiscordance

I grasp the concern about the emphasis placed on biomedical technologies to control and manage HIV (e.g., Knight et al. 2014), what some criticize as a "remedicalization of HIV" (Nguyen et al. 2011) at the expense of other socio-cultural and structural interventions. And yet, as someone whose serodiscordant relationship came to a tragic end because existing treatments were incapable of extending my partner's life, I am also compelled to acknowledge the exhilaration and hope that contemporary treatments afford those living with the virus. But rather than debate the promises or limitations of treatment, I want to explore the potential re-framing of serodiscordance in the context of treatment. I note that Persson (2015) uses a similar term—re-imagining—in relation to TasP among serodiscordant couples in Australia. The similarity is both coincidental and speaks of the extent to which biomedicine is affecting the re-framing/re-imagining of serodiscordance across vastly different epidemiological and cultural landscapes.

The absence of treatment played a critical role in how Andrew's and my relationship and lives unfolded, including how our experiences of discordance differed in very important ways from the couple I quoted at the start of this chapter. Life was rarely ever "normal" for us. Our daily lives were constant reminders of HIV, of illness and demise. His disease consumed his life, my own and that of his family. In addition, parenthood was something Andrew and I wanted to experience together. But unlike many mixed-status couples today, even in a low-income country such as PNG, we had no safe means of making a family in Australia in the mid to late 1990s. At the time, it posed significant risks (particularly for me as the female, HIV-negative partner) or required highly intrusive (and expensive) biomedical interventions (e.g., sperm washing). In comparison, PPTCT makes reproduction for couples with mixed HIV status seem almost mundane. Because of advances in treatment and increased global access, those currently living in resource-limited settings are able to achieve something that was not possible earlier in the epidemic for Andrew and me, even in a resource-rich context: they not only survive, they thrive.

Until fairly recently in PNG, particularly when treatments were new and today's sense of living with HIV was not yet evident, considerable stigma and moralisation surrounded sexuality in the context of HIV. However, through both my research and my personal involvement in the lives of people with HIV, I have witnessed the emergence of new sexual relationships that defy earlier HIV narratives of sorcery, demise and discrimination (Kelly 2012a, b; Kelly et al. 2009a, b). With access to antiretroviral therapies now widespread, such narratives have diminished considerably, as evidenced by the stories of two women living with HIV: close friends Jossie and Soso were both supported in their marriages to HIV-negative men by their health care workers. Moreover, Jossie was supported to have four children, all of whom are negative as a result of ART and her determination to adhere to breastfeeding advice.

Serodiscordant relationships in PNG now appear largely accepted by health professionals and, to varying degrees, within families and communities. This does not diminish the difficulties of disclosure, of positive-negative sexuality, of treatment adherence or reproduction. However, with treatment, the quest for relationships and parenthood is not limited to those who can afford expensive interventions or those who live in high-income countries; it is now in the grasp of most mixed-status couples in PNG. The mixed-status couples I know in PNG live a sense of normality far removed from my and Andrew's experience.

God, Risk, and Being Normal

Biomedical discourses homogenize HIV risk amongst serodiscordant couples, failing to account for variances across settings and sexual practices that affect risk. They also tend to overlook the culturally specific dynamics that shape and inform how relationships of mixed HIV status (be they monogamous, polygamous or heterosexual, homosexual or both) are lived in local, historical and biomedical realities. In the context of PNG, one key cultural dynamic to consider is the role of religion. Several Christian churches play an important role in the national response to HIV (particularly treatment and care) (Kelly 2009), and Christianity more generally has a profound impact upon the diverse and sometimes conflicting ways that people perceive HIV treatment and HIV risk (Eves 2012; Kelly-Hanku et al. 2014a). But more than that, Christianity offers those living with HIV an important and prevailing framework for understanding health and personal infection, sometimes alongside or in stark contrast to biomedical models (Kelly-Hanku et al. 2014a; Kelly 2012a). And it is Christianity, as opposed to TasP, or even condoms, which is perceived by those without HIV to provide the greatest protection against infection (Eves 2012; Kelly et al. 2009b), including HIV-negative people in serodisordant couples. Sophie, a participant in the *Art of Living* Study (2008) highlighted this dimension to HIV in PNG when she shared the following comment by her HIV-negative husband: “He told me, ‘I love you and we live together; so according to my own faith, your sickness will not infect me’” (Kelly et al. 2009a).

Soso told a similar story, one that highlights the increasing normalization of serodiscordance in PNG in the biomedical age, but also the powerful influence of Christianity on local risk perceptions. Soso and her husband had both been diagnosed with HIV when she was 1 month pregnant. Immediately starting on ART, she gave birth to a little girl free of HIV. Her husband, sadly, passed away and a short time afterward she commenced working in my house to support herself and her three children. Not long after I came to know Soso, Michael, a friend and *wantok* (person from the same village) of her late husband, asked Soso to marry him. Michael knew that Soso was HIV-positive and that his friend had died of the disease. As a church man, Michael believed in several things: that he should be married; that Soso did not create the “sin” of HIV in her body, and; that God would protect him from HIV because he, like Soso, was innocent, for neither of them caused the disease. During a conversation about this book chapter, Soso shared with me what her new husband had said to her at the time of his marriage proposal:

> My belief in God is that I can marry you and not get this disease. I am an innocent man. You are a mother. And your husband is responsible for giving you this disease so I won’t get this disease. I believe in God the Father.

Over the years Michael had shared similar comments with me that reinforced the normality of their marriage and the notion that God would decide if he became sick or not.

I asked Soso one morning, as we shared breakfast, about when her next HIV medical review would be; I was worried because she had not said she would be late to work for some time because she needed to first attend clinic in the morning. She dismissed my concern, saying, “Don’t worry, sometimes when I am busy here with the children, I send Michael and they give him my medicine”. When I asked her if there were many other husbands like Michael who were negative and go to the clinic, Soso replied; “When I was diagnosed there weren’t couples like my husband and I. Now there are lots of couples where the man or woman has HIV and their partner doesn’t; it’s normal”. Taking the idea of normal further, she said:

> We don’t think about it. We forget about it. We are normal and live our life, except when I must remember to check my review date and go to the clinic, but the rest of the time we don’t, we just act normal. I don’t think too much about it, I forget about it. We just stay normal and live life. And my daughter [exposed to HIV in pregnancy] is normal. I will see my children get older and have children of their own. I am fit and healthy.

This notion of normal intrigued me, as did the belief in God’s ability to protect a person from HIV; I would never have used such concepts to describe my relationship with Andrew. I clearly saw signs of HIV’s presence in Andrew’s body in ways Michael does not see in Soso. And so we could never forget about HIV in the way Michael and Soso described. Moreover, I was scared of becoming infected in a way Michael does not appear to be. Although raised in the Roman Catholic tradition, I did not believe in or trust that a spiritual figure would ensure my safety from infection. My fear increased when HIV viral load testing came into use, and I was not alone. Andrew and I heard stories of people committing suicide in response to receiving their viral load results. There was, at that time, limited social understanding of their meaning, but the numbers used to express viral load—in the thousands and millions—were enormous. This was in stark contrast to CD4 test results, which were, depending on your stage of disease progression, in the double or, if you were lucky, triple figures. Beyond the figures themselves, there was no biomedical, let alone popular discourse of non-infectivity or undetectable viral load back then. In short, our serodiscordant experience could not have been more different than Soso and Michael’s. Christianity, normality and biomedicine were not frameworks for understanding HIV in my Australian context all those years ago.

Conclusion

As HIV treatments have been re-applied to prevent the transmission of HIV, couples with mixed HIV status have been brought into the biomedical, public health and clinical gaze, most markedly with TasP. But this gaze has almost exclusively been focused on quantitative understandings of risk. Narratives of the daily lives, feelings and practices of couples and individuals in these relationships have not been afforded the same priority as clinical and epidemiological understandings. In this chapter, I have tried to address this imbalance by providing vignettes of actual practices, intimate events and feelings among mixed-status couples, both through my own story and those of others. In doing so I have sought to show that, though the biomedical model makes no space for such a perspective, serodiscordance is an intersubjective experience, an intensely relational and diverse phenomenon.

Despite the existence of diverse serodiscordant relationships from the outset of the epidemic, our understanding of serodiscordance has been narrow. This, I suggest, is in large part because the concept of serodiscordance has been used to understand transmission risk rather than people's lived realities. This has resulted in a systematic erasure of differences in local realities—polygamous unions are a good example. Further, by limiting the concept of serodiscordance to "risk" in couples, we fail to understand the complex and dynamic ways that HIV is experienced and lived in social relationships, above and beyond those of a sexual nature, encompassing broader family relations and community contexts. In places such as PNG, where family and familial relationships are central to identity, these connections are paramount and worth further consideration as we refine and deepen our understandings of serodiscordance.

I have drawn here on my long-term understanding of HIV, ranging from having been in a serodiscordant relationship in Australia early in the epidemic to now living and working with serodiscordant couples in PNG. I have shown that, while living in a mixed-status relationship goes well beyond sex and reproduction, it is nonetheless within these domains that we can most easily observe some of the many changes and new possibilities brought about by HIV treatment. Welcome biomedical advances in the global response to HIV mean that mixed-status couples (and families) in PNG and Australia can now identify as "normal", rather than as a "key population" as global HIV discourses currently in circulation would have them classified. My own early experience of being part of a mixed-status couple in a resource-rich setting like Australia contrasts markedly with the realities of mixed HIV status couples today and the normalisation of serodiscordance that is emerging in PNG and other settings in what is now a very different biomedical landscape.

On a final note, the power of recent scientific discoveries and increased access to HIV treatment notwithstanding, the "end of AIDS" is not (yet) ensured. People still become infected and die from AIDS-related conditions, as my dear friend of almost 10 years Jossie did in late 2015, leaving her HIV-negative husband and children behind. Given that HIV medicine is a rapidly moving field, there is an ongoing need to understand treatment as situated within local meanings and practices, particularly in serodiscordant relationships. We must forego a-historical and de-contextualized conceptions and, instead, engage critically with diverse cultural, temporal, and biomedical realities to understand what living with serodiscordance means and may mean into the future.

Acknowledgment I am indebted to Asha Persson and Shana Hughes for their insights and careful editing of this chapter, as well as to the women and men who have shared their stories with me over the course of my involvement in the HIV epidemic.

Dedication This chapter is dedicated to my friend and sister Jossie who died from HIV and TB co-infection 17th November 2015 and to her husband and four children.

References

Australian Agency for International Development [AusAID]. (2006). *Impacts of HIV/AIDS 2005–2025 in Papua New Guinea, Indonesia and East Timor: Final report of HIV epidemiological modelling and impact study*. Canberra: AusAID.

Behar, R. (1996). *The vulnerable observer: Anthropology that breaks your heart*. Boston: Beacon.

Cohen, M. S., Chen, Y. Q., McCauley, M., Gamble, T., Hosseinipour, M. C., Kumarasamy, N., the HPTN 052 Study Team, et al. (2011). Prevention of HIV-1 infection with early antiretroviral therapy. *New England Journal of Medicine, 365*(6), 493–505.

Eves, R. (2012). Resisting global AIDS knowledges: Born-again Christian narratives of the epidemic from Papua New Guinea. *Medical Anthropology, 31*(1), 61–76.

Kalichman, S. C. (2000). Couples with HIV/AIDS. In K. B. Schmaling & T. G. Sher (Eds.), *The psychology of couples and illness: Theory, research and practice* (pp. 171–190). Washington, DC: American Psychological Association.

Kelly, A. (2006). *Changing minds, changing lives: The lived experiences of AIDS dementia.* Ph.D. thesis, La Trobe University.

Kelly, A. (2007). Hope is forked: Hope, loss, treatments, and AIDS dementia. *Qualitative Health Research, 17*(7), 866–872.

Kelly, A. (2008a). Forgetting and the memory of forgetting: The material and symbolic role of memory in the intersubjective lives of people with AIDS dementia. *Dementia: The International Journal of Social Research and Practice, 7*(4), 451–460.

Kelly, A. (2008b). The intentionality of insight: The meanings given to insight in the lived experiences of AIDS dementia. *Dementia: The International Journal of Social Research and Practice, 7*(4), 521–544.

Kelly, A. (2008c). Living loss: An exploration of the internal space of liminality. *Mortality, 13*(4), 335–350.

Kelly, A. (2009). The body of Christ has AIDS: The Catholic Church responding faithfully to HIV and AIDS in Papua New Guinea. *Journal of Religion and Health, 48*(1), 16–28.

Kelly, A. (2010). Lost the feel for the game: Meanings of onset and diagnosis of AIDS dementia for significant others. *Qualitative Health Research, 20*(4), 531–540.

Kelly, A. (2012a). *Faith, hope and healing: The importance of religious beliefs and practices in the treatment narratives of people living with HIV in Papua New Guinea*. Paper presented at Sexualities, Sexual Rights and HIV in Papua New Guinea and the Pacific. Canberra: Australia.

Kelly, A. (2012b). *Negotiating changing notions of sexual and reproductive contagion and rights amongst women living with HIV in Papua New Guinea*. Paper presented at the annual meeting of the American Anthropological Association, San Fransisco.

Kelly, A., & Kerner, A. (2004). The scent of positive lives: (Re)memoralizing our loved ones. *Qualitative Inquiry, 10*(5), 767–787.

Kelly, A., Frankland, A., Kupul, M., Kepa, B., Cangah, B., Nosi, S., et al. (2009a). *The art of living: The social experience of treatments for people living with HIV in Papua New Guinea*. Goroka: Papua New Guinea Institute of Medical Research. https://sphcm.med.unsw.edu.au/sites/default/files/sphcm/Centres_and_Units/Art_Living.pdf. Accessed 31 Jan 2016.

Kelly, A., Kupul, M., Kepa, B., Pirpir, L., Emori, R., Nosi, S., et al. (2009b). Christian discourses in young people's narratives of sex and HIV in the Eastern Highlands Province, Papua New Guinea. *Catalyst: Special Issue HIV/AIDS, 39*(2), 102–114.

Kelly, A., Kupul, M., Frankland, A., Worth, H., Nosi, S., Mek, A., et al. (2011). Living serodiscordantly in Papua New Guinea: Sexual practices of HIV-positive people on ART by serostatus of regular heterosexual partner. *AIDS Care, 23*(6), 734–740.

Kelly, A., Worth, H., Kupul, M., Fiya, V., Vallely, L., Neo, R., et al. (2013). *HIV, pregnancy and parenthood: A qualitative study of the prevention and treatment of HIV in pregnant women, parents and their infants in Papua New Guinea*. Sydney: Papua New Guinea Institute of Medical Research & University of New South Wales. https://sphcm.med.unsw.edu.au/sites/

default/files/sphcm/Centres_and_Units/HIV_Pregnancy_Parenthood.pdf. Accessed 4 Mar 2016.

Kelly-Hanku, A., Aggleton, P., & Shih, P. (2014a). "We call it a virus but I want to say it's the devil inside": Redemption, moral reform and relationships with God among people living with HIV in Papua New Guinea. *Social Science & Medicine, 119*, 106–113.

Kelly-Hanku, A., Rawstorne, P., Kupul, M., Worth, H., Shih, P., & Man, W. Y. (2014b). Anal sex, vaginal sex and HIV risk among female sex workers in Papua New Guinea. *AIDS and Behavior, 18*(3), 573–582.

Knight, R., Small, W., Pakula, B., Thomson, K., & Shoveller, J. (2014). A scoping study to identify opportunities to advance the ethical implementation and scale-up of HIV treatment as prevention: Priorities for empirical research. *BMC Medical Ethics, 15*(54), 2–13.

Maibani, G., Ryan, C., Lote, N., Edward, G., Ralai, A., Gare, J., et al. (2011). *Papua New Guinea – Australia sexual health improvement program (PASHIP). Report on the baseline survey*. Goroka: Papua New Guinea Institute of Medical Research.

Merleau-Ponty, M. (1973). Phenomenology and the sciences of man. In M. A. Natanson (Ed.), *Phenomenology and the social sciences* (Vol. 1, pp. 47–108). Evanston: Northwestern University Press.

National AIDS Council Secretariat [NACS]. (2010). *National HIV and AIDS Strategy 2011–2015*. Port Moresby: National AIDS Council Secretariat.

National AIDS Council Secretariat [NACS]. (2013). *Papua New Guinea HIV prevalence 2012 estimates*. Port Moresby: National AIDS Council Secretariat.

Nguyen, V. K., Bajos, N., Dubois-Arber, F., O'Malley, J., & Pirkle, C. M. (2011). Remedicalizing an epidemic: From HIV treatment as prevention to HIV treatment is prevention. *AIDS, 25*(3), 291–293.

Persson, A. (2008). Sero-silence and sero-sharing: Managing HIV in serodiscordant heterosexual relationships. *AIDS Care, 20*(4), 503–506.

Persson, A. (2011). HIV-negativity in serodiscordant relationships: The absence, enactment, and liminality of serostatus identity. *Medical Anthropology, 30*(6), 569–590.

Persson, A. (2013). Notes on the concepts of "serodiscordance" and "risk" in couples with mixed HIV status. *Global Public Health, 8*(2), 209–220.

Persson, A. (2015). "The world has changed": Pharmaceutical citizenship and the reimagining of serodiscordant sexuality among couples with mixed HIV status in Australia. *Sociology of Health & Illness, 38*(3), 380–395.

Roman, D. (1997). Negative identifications: HIV-negative gay men in representation and performance. In M. Deuberman (Ed.), *Queer representation: Reading lives, reading cultures* (pp. 162–176). New York/London: New York University Press.

Schutz, A. (1973). Concept and theory formation in the social sciences. In M. Natanson (Ed.), *Alfred Schutz: Collected papers I: The problem of social reality* (pp. 48–66). The Hague: Martinus Nijhoff.

van der Straten, A., Vernon, K. A., Knight, K. R., Gomez, C. A., & Padian, N. S. (1998). Managing HIV among serodiscordant heterosexual couples: Serostatus, stigma and sex. *AIDS Care, 10*(5), 533–548.