Social Science & Medicine 193 (2017) 51–58

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Pastoral power in HIV prevention: Converging rationalities of care in Christian and medical practices in Papua New Guinea

P. Shih [a, b, *], H. Worth [b], J. Travaglia [c], A. Kelly-Hanku [d, e]

[a] Australian Institute of Health Innovation, Macquarie University, Australia
[b] School of Public Health and Community Medicine, UNSW Sydney, Australia
[c] Faculty of Health, University of Technology Sydney, Australia
[d] Sexual & Reproductive Health Unit, Papua New Guinea Institute of Medical Research, Goroka, Papua New Guinea
[e] The Kirby Institute for Infection and Immunity in Society, UNSW Sydney, Australia

ARTICLE INFO

Article history:
Received 3 May 2017
Received in revised form
25 September 2017
Accepted 28 September 2017
Available online 29 September 2017

Keywords:
Papua New Guinea
HIV prevention intervention
Pastoral power
Religion and health
Individual agency
Structural determinants
Individual responsibility
Michel Foucault

ABSTRACT

In his conceptualisation of pastoral power, Michel Foucault argues that modern healthcare practices derive a specific power technique from pastors of the early Christian church. As experts in a position of authority, pastors practise the care of others through implicitly guiding them towards thoughts and actions that effect self-care, and towards a predefined realm of acceptable conduct, thus having a regulatory effect. This qualitative study of healthcare workers from two Christian faith-based organisations in Papua New Guinea examines the pastoral rationalities of HIV prevention practices which draw together globally circulated modern medical knowledge and Christian teachings in sexual morality for implicit social regulation. Community-based HIV awareness education, voluntary counselling and testing services, mobile outreach, and economic empowerment programs are standardised by promoting behavioural choice and individual responsibility for health. Through pastoral rationalities of care, healthcare practices become part of the social production of negative differences, and condemn those who become ill due to perceived immorality. This emphasis assumes that all individuals are equal in their ability to make behavioural choices, and downplays social inequality and structural drivers of HIV risk that are outside individual control. Given healthcare workers' recognition of the structural drivers of HIV, yet the lack of language and practical strategies to address these issues, political commitment is needed to enhance structural competency among HIV prevention programs and healthcare workers.

1. Introduction

On World AIDS Day 2011, following a candlelit vigil to remember those who had died from AIDS related conditions, a church mission station in a remote Southern Highlands village in Papua New Guinea showed a film titled *Em Rong Blo Mi Yet* (Gahane et al., 2007) or 'It's my own fault' in English. It is the story of a promising young woman who moves from her rural village to the city for schooling. She has a brief affair with a wealthy, philandering man who lavished her with luxuries. After being tested positive for HIV at a voluntary counselling and testing service, she is forced to return home and accepts her fate of being sent by her father to live in the remote bush. The film ends with her dying alone in the wilderness, much to her family's anguish and regret.

Part of the appeal of *Em Rong Blo Mi Yet* is the social backdrop of the HIV epidemic that is only too familiar to Papua New Guinean audiences: the large-scale migration to urban areas to access better education and employment opportunities, and the unprecedented monetary and material wealth for some due to a resource boom. For many, economic development and progress has been at the expense of traditional customary values and familial relationships, leading to the widespread decline in moral discipline and social order, which is the root cause of the HIV epidemic (Eves, 2008; Luker and Dinnen, 2010; Shih et al., 2017; Wardlow, 2008). Thus despite the sympathetic stance against stigma of people living with HIV, and the urge for compassion and love for those infected, the title of the film 'It's my own fault' sends a strong message about the consequences of poor moral decisions.

Approximately 40,000 people live with HIV in Papua New Guinea in 2015 (UNAIDS, 2017). After the first diagnosis of HIV in

* Corresponding author. Level 6, 75 Talavera Road, Macquarie University 2109 NSW, Australia.
E-mail address: patti.shih@mq.edu.au (P. Shih).

https://doi.org/10.1016/j.socscimed.2017.09.049
0277-9536/

1987, the scale of the epidemic was apparent by the mid-2000s, with the declaration of a generalised epidemic in 2004 (UNAIDS, 2012, p. 23), and an estimated 64,000 people living with HIV by 2005 (AUSAID, 2006, p. 14). The urgency to respond to the growing epidemic mobilised large-scale public health campaigns, supported by international humanitarian aid programs. The understanding of HIV as a moral *and* a medical problem was further pronounced with revised data in 2007 which suggests that the epidemic is concentrated among key affected populations - female sex workers and men who have sex with men (Papua New Guinea National Department of Health, 2007), who are highly stigmatised in the predominantly Christian country.

In Papua New Guinea, the role of Christianity in the HIV epidemic is important and complex. Churches and faith-based organisations provide approximately half of the country's healthcare services, including HIV programs. The capacity and effectiveness of faith-based healthcare services is lauded by government and international donors, with churches spearheading the national HIV response praised for demonstrating a positive theology of love and compassion in healthcare provision (Kelly, 2009). However, the association of HIV infection with sexual immorality is often used to urge compliance with church teachings about moral vigilance (Eves, 2008; Kelly et al., 2010; Kelly-Hanku et al., 2014; Wardlow, 2008), which contributes to a negative and stigmatising perspective of HIV, incompatible with public health efforts (Benton, 2008).

This article argues that healthcare practices are deeply implicated in the understanding of morality in relation to health, and exercise a political rationality that has social regulatory effects, beyond the purpose of ensuring wellbeing. Drawing from the work of Michel Foucault, we argue that HIV prevention healthcare aims to affect the actions of individuals and communities through the practice of care, which we refer to as *rationalities of care*. We examine how healthcare workers from two faith-based healthcare services in Papua New Guinea draw together Christian and medical knowledge and rationales in their HIV prevention practices by implicitly defining the behaviours which people should enact to maintain their own health and, in effect, reproduce cultural knowledge about the cause and responsibility for illness.

Our analysis of the link between Christian and medical rationalities of care is underpinned by 'pastoral power', an underanalysed concept developed by Foucault (Foucault, 1981, 1982; Foucault et al., 2009). Through the practices of healthcare professionals, Foucault suggests that the regulatory functions of modern medicine mirror the ways that religious leaders in the early Christian church guided their followers towards self-care. This study in Papua New Guinea shows that the connection between modern medical and Christian care practices intensifies the way in which HIV prevention produces regulatory effects. We detail how local cultural, social and economic realities that contextualise HIV spread complicates the practice and impact of pastoral rationalities of care, and thus highlight the limitations of current HIV prevention practices.

1.1. Pastoral power: Techniques and proliferation

Foucault argues that religious leaders in the early Christian church exercised their duty of care over their followers through 'pastoral power'. This power ensures that each of their followers gained spiritual salvation after death by maintaining good conduct throughout their lives (Foucault, 1981, 1982; Foucault et al., 2009). Four key elements characterise pastoral power. Firstly, it is a *benevolent* type of power that is oriented towards achieving wellbeing and eventual salvation for those under pastoral care, rather than causing duress or harm. Secondly, it is exercised *implicitly* through subtle guidance. This distinguishes it from the 'sovereign power' exercised by the King [*sic*] or other law enforcers, who command authority in explicit and coercive ways. Thirdly, it is *individualising*, as pastors guide and equip each person with knowledge and capacity to take care of themselves. Through their expertise, pastors set the direction of right conduct, and encouraged individuals to follow pastoral advice to achieve salvation. Individuals become the *subjects* of this implicit manifestation of power, as they internalise the knowledge and guided course of actions set by pastors. Fourthly, through practices such as confession that allow more intensified and specific guidance, each individual is encouraged to self-examine and reflect on their moral conduct by revealing their true thoughts (Foucault, 1982, pp. 783–784). These functional elements of pastoral power together ensure an effective regime of governance, as individuals learn to self-regulate within realms of expected norms.

By the eighteenth century, European non-ecclesial institutions such as medicine and psychiatry began to adopt the technical functions of pastoral power, as it "spread out into the whole social body" (Foucault, 1982, p. 784). The aim of these modern institutions is more about the salvation of the body and wellbeing in *this world*, rather than the soul in the *next world*, and thus the "old" power technique originating from Christian institutions has been taken up in a "new political shape" (Foucault, 1982, p. 782).

Demonstrating the uptake of pastoral power in non-Christian institutions, people are increasingly subjected to the guidance of experts in modern life (Burchardt, 2009, pp. 337–338). A number of studies highlight the increase in motivational coaching and self-help under the guidance of professionalised trainers, and the growing importance of people's self-management of health conditions, from chronic diseases (Galvin, 2002) to diet and obesity (Warin, 2011). These studies suggest that the growing emphasis of individualism in medicine and healthcare reflects the increased pervasiveness of neoliberalism in both political and personal realms (Brijnath and Antoniades, 2016; Crawshaw, 2012; Petersen, 1996).

However, the attention on individualism in the analysis of pastoral power can under-theorise the link between the regulation of individuals and the regulation of society (Waring and Martin, 2016). Indeed, pastoral power is aimed at the salvation of not just one, but *each and all* of the pastor's followers (Foucault, 1981). As an extension of Foucault's work, Waring and Martin (2016) highlight how pastoral power enmeshes individual and collective regulation in their study of quality assurance in the English National Health Service by network leaderships. For example, pastoral practices *construct* governing rationalities more effectively by interpolating them into pre-existing locally relevant knowledge systems of a community. Through *inscriptive* practices, such as developing a personal ownership of expert constructed values, individuals internalise and normalise their adherence to pastoral guidance. Expert-constructed values are projected and reinforced as shared norms as they are practised in group settings as *collective* practices; and through the surveillance of individuals *and* communities by inspection, ongoing compliance of behavioural expectations is maintained (see also Waring and Latif, 2017; Waring et al., 2016). In healthcare quality assurance, these different pastoral practices are required to manage the growing complexity and regulatory needs of the health system, by supplementing self-regulation at the individual and social level with broader governing schemes (Waring and Martin, 2016).

Waring and Martin (2016)'s work is a timely reminder of Foucault's depiction of power as pervasive and dispersive throughout the social body, as different institutional realms facilitate the movement of power. Studies in the global circulation of healthcare practices also suggest that power technologies are highly *mobile* through increasing flows of communication (Briggs, 2005; Ong,