

# 1 Birth in the Age of AIDS

THIS IS A BOOK ABOUT HIV/AIDS AND CHILDBIRTH—two phenomena that may seem incongruous. One conjures up illness and loss; the other life and hope. Yet of the 2 million children living with HIV worldwide, 90% have acquired the virus from an HIV-positive mother during pregnancy, birth, or breastfeeding (UNAIDS 2008: 33–37). We often read about such demographic statistics generated by organizations such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), or the Centers for Disease Control and Prevention (CDC). But what do we know about the experiences of these women? What is it like to go through pregnancy knowing that you are an HIV-positive woman? How do you decide whether to give birth to a baby if you are HIV-positive? Is the birth event itself different for an HIV-positive woman? And how does being HIV-positive affect the experience of feeding your newborn? In short, does being HIV-positive transform the experience of becoming a mother? If so, how? The answers to these questions are as numerous and varied as the number of women involved and are influenced by the contexts of their lives, such as their nationality, class, ethnicity, race, religion, sexual orientation, kinship arrangements, and the year in which they are pregnant.

In this book I explore the lived experiences of pregnancy, childbirth, and motherhood in the age of AIDS among low-income and lower caste women living in the South Indian state of Tamil Nadu in the early twenty-first century (see Map 1). My focus is on the impact of the Prevention of Parent to Child Transmission (PPTCT) of HIV program on women's lives in India. This program, jointly organized by UNICEF and the Government of India, provides free HIV counseling and testing to pregnant women in government mater-



**Map 1** India, with the state of Tamil Nadu shaded.

nity hospitals and provides free single-dose antiretroviral therapy to pregnant mothers who test HIV-positive and their newborns. The program was piloted in 2000 and formally inaugurated in Tamil Nadu in September 2002. Women may come to learn of their HIV-positive status before, during, or after their pregnancy (or not at all). Because I am particularly interested in the impact of this PPTCT program, in this book I foreground the experiences of those women who learned of their HIV-positive status during pregnancy.

The adult HIV prevalence rate in India is low—currently reported to be 0.34% (UNAIDS 2009)<sup>1</sup>—but because of India’s large population (more than 1 billion people),<sup>2</sup> the country ranks third worldwide in actual number of people living with HIV/AIDS—2.4 million—behind South Africa and Nigeria (UNAIDS 2008). Of those 2.4 million people, only 50% were thought to be aware of their HIV status in 2008–2009, thus making the population vulnerable to a potentially dramatic spike in the number of HIV-positive people (NACO 2009: 15). However, reported HIV prevalence rates for India have fluctuated wildly<sup>3</sup> and have been hotly contested. Regardless of statistical disputes or irregularities, as the country with the highest number of HIV-positive people in all of Asia, India is clearly confronting a daunting epidemic, and global health organizations and governments around the world are responding.

The HIV/AIDS epidemic is more challenging to manage for cultural and political reasons than for biology reasons alone. As a medical anthropologist, I draw my attention to these sociocultural dynamics of HIV/AIDS. As an anthropologist interested in the impact of global and national policies and programs on local communities and individual lives, I recognize that although a program such as the PPTCT program makes good public health sense, its social effect transcends the health arena. In this particular case, in which low-income mothers are the targets of this health policy, structures of gender, socioeconomic class and caste, and global economic and political inequalities among nations influence both how the program is implemented and the repercussions that it has on women’s bodies and lives—within their families, in interactions with medical practitioners, and with organizations providing care and support for people living with HIV/AIDS. As Didier Fassin has so aptly stated in his poignant ethnography of HIV/AIDS in South Africa, the experiences of people living with HIV/AIDS in places around the globe that may seem remote from any given standpoint should not be viewed as foreign but rather as part of a shared humanity that we must think about “less in terms of difference than inequality, less a matter of culture than history” (Fassin 2007: xv). Describing the experiences of those women in India whose lives have been

touched by HIV/AIDS and by this global health program to prevent the transmission of HIV from mother to child is thus also a way to portray the local embodiment of world history.

To foreground inequality is not, however, to deny the significance of cultural variation. Medical anthropologists view illness and disease as a window into understanding social life and cultural forms. We can learn much about societies' belief systems, including our own, by observing responses to disease. Likewise, a deep look into what causes illness, why certain people get sick, why certain people die, and how diseases travel reveals a great deal about human social organization and value systems. HIV/AIDS is arguably one of the most salient diseases to think about anthropologically precisely because it evokes intense moral responses that both reinforce and challenge cultural norms and because it reveals so blatantly the gross inequalities of our world. As Arthur Kleinman and Paul Farmer wrote in the early years of the HIV/AIDS pandemic, "All illnesses are metaphors. They absorb and radiate the personalities and social conditions of those who experience symptoms and treatments. . . . The way in which a person, family, or a community responds to AIDS may reveal a great deal about core cultural values" (Farmer and Kleinman 2001: 353–56).

Anthropologists and other social scientists have found that in India AIDS is interpreted predominantly through the lens of the morality of sex. The prevailing view is that HIV/AIDS comes about as a result of premarital and extramarital sexual relationships, both of which fall outside the prescribed norm in India. Recent studies have revealed that sexual practice does not always conform to the stated ideals (Puri 1999; Verma et al. 2004). Nevertheless, the norms prevail. Thus, to be HIV-positive is to be marked with a grave social transgression, and the disease is intensely stigmatized. Media reports of HIV-positive people being ostracized in all arenas of social life in India—the family, the workplace, medical settings, and the community—are commonplace. Such discrimination fosters a culture of secrecy in which HIV-positive people avoid disclosing their status as a coping strategy. It also can lead to high rates of depression and even suicide among this population (Chandra et al. 1998; Steward et al. 2008). As a result, the government, nongovernmental organizations (NGOs), and community-based organizations (CBOs), which are known as networks run by and for people living with HIV/AIDS in India, are not only engaged in HIV prevention and treatment but also waging a campaign to prevent the stigma and discrimination that plagues those affected by the disease. In this book I draw from Erving Goffman's seminal theoretical discussion on stigma (Goff-

man 1963), but I do so in the same vein as Richard Parker and Peter Aggleton, who argue that stigma must be viewed not simply as an individual psychological process but as a key component of social power and as “central to the constitution of the social order” (Parker and Aggleton 2003: 17).

Anthropologists who study reproductive health similarly argue that the management of and beliefs about the processes of reproduction both reflect and transform sociocultural systems and get to the heart of ideas about the body, life, gender, family, and, increasingly, technology. As Faye Ginsburg and Rayna Rapp wrote in the introduction to their edited volume, *Conceiving the New World Order: The Politics of Reproduction*, “Regardless of its popular associations with notions of continuity, reproduction also provides a terrain for imagining new cultural futures and transformations” (Ginsburg and Rapp 1995: 2). In this book I thus explore how responses to HIV/AIDS in the context of birth and motherhood both reflect and transform social relations and cultural value systems. For example, although the stigma experienced by HIV-positive people, particularly women living with HIV/AIDS, serves to reproduce and enforce Indian and Tamil cultural norms of sexual morality, the presence of HIV/AIDS and its spread to rural areas and to individuals who are not associated with high-risk groups, as has become increasingly evident through widespread prenatal testing, also reveals the cracks between imagined cultural ideals and actual practice, leading to increased self-reflection about the unstable and changing nature of cultural identity. Furthermore, although HIV-related stigma may serve to bolster preexisting forms of gender-based discrimination, such as taboos against widow remarriage and denial of inheritance rights of women, HIV-positive women who become affiliated with feminist, human rights-based organizations to combat discrimination against HIV-positive women are publicly pushing back against both of these social conventions; in doing so, they may help to open up the social space to combat these forms of gender discrimination not only for HIV-positive women but also for women in Tamil Nadu or in India more broadly.

Focusing on HIV/AIDS and birth compels me to draw from the anthropology of reproduction and the anthropology of AIDS, both robust subfields within medical anthropology. This project is the first of its kind to deeply explore the intersections of reproduction and HIV/AIDS from an ethnographic perspective, bringing forth the voices of women from one part of the world as they struggle and strive to make sense of the effect that HIV/AIDS and programs that have emerged in response to this disease have had on their reproductive lives.

## Global Health Policy: Local Reality

Both reproductive health and HIV/AIDS have been major foci of global health organizations involved in what has broadly been called international development. The international development agencies, which first emerged in the post-World War II era, were and continue to be an important factor in the processes of globalization, with new international organizations, such as UNAIDS and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, coming into play and new foundations, such as the U.S.-based Bill and Melinda Gates Foundation, the Clinton Foundation, and the Gere Foundation, supplementing earlier household names, such as the Ford Foundation and the MacArthur Foundation. Programs designed within the arenas of such international development organizations to combat HIV/AIDS and maternal and infant mortality and morbidity are implemented globally and attempt to both work within and transform local practices and systems of knowledge to improve health outcomes. The proliferation of such organizations working in health-related fields in India along with the rise in local NGOs has been a direct result of the neoliberal turn in India and the government's retrenchment from the provision of health services (Finn and Sarangi 2008). Anthropologists have been keenly interested in examining the relationships between such global initiatives and discourses and their local manifestations. In the introduction to their 2000 edited volume *Global Health Policy, Local Realities: The Fallacy of the Level Playing Field*, Linda Whiteford and Lenore Manderson argue that "too often international health planners design programs based on the assumption that 'all else is equal' and that each recipient nation shares the same 'level playing field.' The assumption of uniformity may be necessary to the process of planning global health programs but also may create needless barriers to their effective execution" (Whiteford and Manderson 2000: 1–2). These writers call for more studies of the localization of international health policies and programs, and my work is a contribution to that end. Understanding how global health policies and discourses about HIV/AIDS and reproduction intersect with local realities and inform everyday practices for poor women in Tamil Nadu is a primary goal of this book.

Global health policies are, of course, not developed in a vacuum. Typically these policies are rooted in local U.S.-based or European contexts or they emerge out of globalizing processes themselves, such as colonialism, postcolonial development projects, and currently the global spread of neoliberalism. In this sense these global health policies carry with them core cultural and political values and interests of those contexts. This book is a historically spe-

cific ethnographic study of the intersection of such global health policies, state policies, and local practices on the reproductive lives of HIV-positive women in Tamil Nadu, South India, at the beginning of the new millennium.

What I found is that there are unintended consequences of the PPTCT program. My research suggests that low-income pregnant women who are the targets of this program are given little choice over whether or not to get tested for HIV and how to proceed with the pregnancy once they receive an HIV-positive diagnosis. My research also demonstrates that as a result of this program, women are being diagnosed as HIV-positive before their husbands, and this can have negative repercussions on the status of women within the extended patrilocal, patrilineal family structure, because women are accused of being promiscuous and are blamed for bringing HIV/AIDS into the family, thereby exacerbating preexisting gender inequalities. As a result of their HIV-positive status, these women, like Saraswati, may be ostracized from their husband's family. Many become AIDS widows at a young age, and their HIV status becomes a justification for their husbands' families to force them out of the home. With little or no education, they face grave difficulties supporting themselves and their children. Even though women are tested for HIV in the interest of improving public health, their HIV-positive status often leads to stigma and discrimination within the medical arena itself, even when seeking basic obstetric care.

To make matters worse, during the first half of 2004, when I conducted most of my ethnographic interviews, although the government was providing antiretroviral medicine to prevent HIV transmission from mother to child, it was not providing antiretroviral treatments for the mothers themselves. Thus an HIV-positive diagnosis during pregnancy was sometimes experienced as both a social and a physical death sentence for these women. Since that time the government has established an antiretroviral therapy (ART) program for such women, and networks and governmental bodies have worked hard to overcome the public stigma associated with HIV/AIDS in India. This has led to some improvement in the quality of life of women who test positive through the PPTCT program, although at the tail end of my research in 2008 ART was still difficult for some to access and the stigma associated with HIV/AIDS was far from eradicated.

The choices of lower class and lower caste women are limited within the context of decisions about HIV testing during pregnancy and in relation to the experience of birth and infant feeding for HIV-positive women. These choices are highly influenced by structures of global health policies and by national and state public health policies and services, international and national poli-

cies concerning the manufacture and sales of pharmaceuticals, transnational human rights and feminist organizations and discourses, gender and kinship structures, and social class and caste. Nevertheless, although my work makes these structures apparent, I also highlight the ways in which women use their agency to navigate these structures in pragmatic and creative ways.

### Structure, Agency, and Gender

It is assumed in the United States (and elsewhere) that women in India are subjugated and have little or no control over their reproductive lives, the implication being that North American and European women have substantially more decision-making power and act as free individuals. Much has been written about the ways in which such “othering” discourses on “non-Western” or “third world women” primarily serve to create a sense of superiority in the “West” (Mohanty 1991; Abu-Lughod 1993). I recognize that the reproductive decisions of the women I met were constrained by social and cultural structures, including gender inequality. This is true of women everywhere. But, using Laura Ahearn’s definition of agency as “the culturally constrained capacity to act” (Ahearn 2001: 54), I draw attention to women’s agency as they frame their decisions in response to the previously mentioned set of factors.

Ever since Anthony Giddens’s theory of “structuration,” which in one social theory accounts for both the “strategic conduct” of agents that results in potentially transformative action and institutional structures that reproduce social systems (Giddens 1979: 95), anthropologists have sought to achieve this balance in their ethnographic analyses. Feminist anthropology since the 1990s has highlighted the ways in which women around the world exert their agency in the face of local and global structures of patriarchy in ways that can sometimes be described as “accommodating protest” (MacLeod 1991), because “resistance and compliance are not mutually exclusive” (Mankekar 1999: 29). Although agency may be expressed as resistance or may demonstrate the necessary foundations for resistance (Raheja and Gold 1996), it “may also involve complicity with, accommodation to, or reinforcement of the status quo” (Ahearn 2001: 55). Furthermore, “all too often, compliance is the most effective way to resist an oppressive power” (Seizer 2005: 325). My work contributes to these post-structural feminist understandings of agency and structure insofar as I examine many structures and agentive engagements with these structures that HIV-positive women demonstrate as they navigate the terrains of pregnancy, birth, and motherhood, sometimes reinforcing sociocultural norms but sometimes opening up spaces for the possibility of social change.



Feminist medical anthropologists and historians engaged in the study of reproduction, particularly the medicalization of reproduction, have similarly shifted their theoretical attention away from earlier feminist approaches, which foregrounded the links between medicalization, biopower, and the control of women's bodies (Martin 1987; Jordan 1993), toward an increasing emphasis on explaining and documenting how women actively engage with new forms of medical science and technology in complex, context-specific, and sometimes contradictory ways (Rapp 2000; Inhorn and Van Balen 2002; Van Hollen 2003a). As Margaret Lock and Patricia Kaufert wrote in the introduction to their 1998 edited volume, *Pragmatic Women and Body Politics*, women's responses to medicalization "may range from selective resistance to selective compliance, although women may also be indifferent" (Lock and Kaufert 1998: 2). Ultimately, they suggest that "ambivalence coupled with pragmatism may be the dominant mode of response to medicalization by women" (2). Given that the women in my research were engaging with the medicalization of their reproductive processes within the unique context of HIV testing and HIV-positive diagnoses, indifference was never a response that I encountered. However, ambivalence coupled with pragmatism perfectly characterizes the nature of these women's responses and decision-making processes. It is precisely this kind of ambivalence coupled with pragmatism that I hope to convey through this ethnography.

### Women and HIV/AIDS

Social scientific studies on women and HIV/AIDS globally focus primarily on women's vulnerability and risk of contracting HIV, resulting in the feminization of the HIV/AIDS epidemic such that the number of HIV-positive women has now exceeded the number of HIV-positive men globally. Women now make up 52% of the infected population (UNAIDS 2010: 23). Scholars have shown how "structural violence" associated with gender discrimination increases women's vulnerability, with particular attention to commercial sex work, domestic and sexual violence, and women's lack of power to negotiate safe sex (Schoepf 1992; Farmer 1999; Epele 2002; Mill and Anarfi 2002). Studies on HIV/AIDS and women in India also emphasize women's vulnerability to HIV in a patriarchal social context (Ashraf and Godwin 1998; Majumdar 2004; Shanti 2004; Ghosh et al. 2009). These studies point out that lack of education, lack of decision-making power related to health care, and lack of access to information and health care services, combined with a taboo against speaking about sex or AIDS, make women more vulnerable to contracting HIV than men.

Conversely, some have pointed to the ways in which increased autonomy for women in India helps reduce their vulnerability to HIV (Bloom and Griffiths 2007). Many of those scholars conducting ethnographic research in India with the aim of improving HIV prevention efforts have sought to better understand sexual practices and awareness of sex and HIV/AIDS among various groups within the population, including women (Nag 1996; Verma et al. 2004) and adolescent girls (Bhan et al. 2004; Mahajan and Sharma 2005). Special attention has been given to the study of female commercial sex workers (Asthana and Oostvogels 1996; Guntupalli 2008), especially in relation to the empowerment of sex workers in the Sonagachi project in Kolkata (Pardasani 2005; Ghose et al. 2008; Swendenman et al. 2009) and also in relation to *devadasis*<sup>4</sup> (Orchard 2007) and the often hostile interaction between sex workers and the police (Biradavolu et al. 2009).

Another key topic of research on women and HIV/AIDS globally is the relationships between gender, stigma, and HIV/AIDS; studies suggest that HIV-positive women throughout the world face greater stigma and discrimination than do HIV-positive men (Bond et al. 2003; Ogden and Nyblade 2005). Research from India corroborates these more global findings, with reports of in-laws (with whom many women live) accusing women of infecting their sons. Women in India who become AIDS widows at a young age face added discrimination in a society in which not only AIDS but also widowhood itself is stigmatized (Bourdier 1997, 1998; CFAR and PWN+ 2003; Van Hollen 2010).

A third area of research on women and HIV/AIDS that is relevant to my own study addresses the issue of reproductive health. Social scientists exploring this topic have examined such things as HIV-positive women's experiences with sterilization to prevent pregnancy (Hopkins et al. 2005), how HIV contributes to infertility (Inhorn and Van Balen 2002), morbidity and mortality associated with pregnancy among women living with HIV/AIDS (Berer 1999), debates about infant feeding for low-income HIV-positive mothers (Blystad and Moland 2009; Desclaux and Alfieri 2009; Traoré et al. 2009), and ethical and political issues of providing ART to prevent mother-to-child transmission in the global south (Hankins 2000; Richey 2011).

Maria de Bruyn provided an important report on women's decision-making processes and difficulties in preventing pregnancy or dealing with wanted or unwanted pregnancies based on a broad review of the literature on HIV/AIDS and a comparison of interviews with women in four different countries (de Bruyn 2002). Others have addressed the same topic by focusing on one country (Kirshenbaum et al. 2004). To date, the most comprehen-

sive study of women, reproductive health, and HIV/AIDS in India is Patrice Cohen and Suniti Solomon's *AIDS and Maternity in India: From Public Health to Social Science Perspectives—Emerging Themes and Debates* (2004); this edited volume aims to bridge perspectives of the social and medical sciences on the topic of mother-to-child transmission of HIV in India. The book's contributors first contextualize women's reproductive concerns within broader sociocultural factors concerning gender inequality in India; these factors make women vulnerable to HIV infection and make HIV-infected women vulnerable to discrimination and to economic and social suffering (Geetha 2004; Shanti 2004). The contributors then move on to consider what work has been done on women's perspectives about HIV transmission during pregnancy, birth, and infant feeding. Finally, in the last chapters the contributors point to the need for more detailed studies examining the lived experiences of HIV-positive women during birth and for more studies to examine how measures to prevent HIV transmission from mother to child are in fact being carried out on the ground (Hancart Petitet 2004; Lingam and Mankad 2004).

In this book I provide precisely the kind of ethnographically grounded study that the contributors to Cohen and Solomon's book say is needed. This kind of richly textured ethnographic analysis is critical so that policy makers, health care providers, and social workers engaged in designing HIV/AIDS prevention and care programs can provide women with the information and options necessary to make informed reproductive choices.

### From There to Here

My interest in studying the intersections of HIV/AIDS and reproduction emerged in the mid- to late 1990s when I was engaged in my dissertation research on the medicalization of childbirth in Tamil Nadu, a study that resulted in the publication of my book *Birth on the Threshold: Childbirth and Modernity in South India* (Van Hollen 2003a). Talk of AIDS was beginning to percolate into conversations with doctors, community health workers, and friends during my dissertation research. I recall two conversations in particular.

A friend asks in hushed tone: "What does AIDS look like? You must see it in America, no?" I reply: "There is a virus called HIV and you can have that for a long time without having it affect your health. But after some time, you develop AIDS and then your immune system begins to break down and you can get other diseases that your body cannot fight against." He persists: "But what does it *look* like? How can I know if someone has AIDS?" I say, "You may

be able to see that people have some disease that their immune system cannot fight, but you cannot know that they have AIDS just by looking at them.” He seems frustrated by my answer. I tell him that I really don’t know much about it myself. (Chennai, February 1995)

I am interviewing an obstetrician in one of the Corporation hospitals in Chennai (which was then still called Madras). At the end of the interview, she says: “Now, if you don’t mind, may I please ask you a question?” “Yes, of course” I say. And she asks me: “What are people in America doing to prevent the spread of HIV/AIDS? What are people doing in the hospitals there?” “Well,” I say, “there are lots of advertisements about the importance of using condoms. You see them in public places, like the metro stops and in magazines.” I am thinking about a particular advertisement I remember seeing in a San Francisco magazine which says “Sex is Good”<sup>5</sup> and which has a picture of a heterosexual couple and a gay couple, each naked in an erotic embrace. The advertisement was encouraging responsible, safe sex and health awareness. I find I am too uncomfortable to describe this ad to this Indian doctor, thinking it might seem improper to her. Later I realize I am the one being prudish. She presses me again with her question: “What are people doing about this in the hospitals there?” I sheepishly tell her that I don’t really know about that. (Chennai, July 1995)

With each of these encounters the presumption was that I, as an American, would have a wealth of information about HIV/AIDS that could be helpful to share in India for either personal or professional reasons. Although the first case of AIDS in India was detected in 1986 in a sex worker in Chennai (the capital of Tamil Nadu), the initial response among government officials and the general public was one of denial that this disease could become a problem in India. It was assumed that because Indians had a highly traditional sense of morality when it came to sexual practice, they would not be affected by this disease in the way that seemingly promiscuous societies, such as the United States and countries in sub-Saharan Africa, would be (Dube 2000; K. Jain 2002: 156). It was not until the mid-1990s that policy makers in India began to wake up to reality and had to step away from their moral superiority complex in the face of a mounting epidemic. As it turned out, Chennai was then emerging as a hub of civic activism to tackle this disease and provide care and dignity to those suffering from it, and the Tamil Nadu state government was demonstrating a unique political commitment to addressing the problem of HIV/AIDS. I was not aware of all these developments in Chennai when people were turning to me for advice. These queries made me more aware of how little I myself knew

about social responses to HIV/AIDS around the world, other than what I had seen of gay activism in the United States, especially in the San Francisco Bay Area, where I had been living.

Anthropologists argue that blame is the primary universal response to the HIV/AIDS crisis and that imagined national and ethnic identities are forged in the construction of the dangerous “other” responsible for AIDS lurking “out there” and threatening “our” borders and bodies (Farmer 1992; Hyde 2007). As Paul Farmer writes, “Of all the responses registered, accusation—the assertion that human agency had a role in the etiology of AIDS—is the dominant leitmotiv” (Farmer 1992: 192). Indeed this was a widespread response when AIDS was first detected in India. Yet, in those few moments when HIV/AIDS snuck into conversations during my research in 1995, it was not in the spirit of blame but in the form of a sincere interest in cooperation.

In this book I present the voices and opinions of many players involved at the intersection of HIV/AIDS and reproduction, most notably the voices of those who often go unheard: lower class women living with HIV/AIDS, women attending public maternity hospitals, and counselors working in these hospitals. The discourse of blame runs throughout these ethnographic accounts, whether the object of blame is a husband, a nurse, a doctor, a hospital, an NGO, or the government. I relay these critiques not in the interest of exacerbating the cycles of blame but in the spirit of cooperation, with the belief that how people interpret and respond to this disease—and the concerns they have about how the disease and the social responses to the disease affect their lives—needs to be heard so that the international community, national and local governments, and NGOs can continue to strive not only to stem the tide of HIV/AIDS but to provide care and treatment to people affected by this disease in the most humane way possible. Lamenting the inadequacies of the global response to HIV/AIDS in the world at the beginning of the twenty-first century, former secretary-general of the United Nations Kofi Annan once said, “What sort of people are we? Can we use the words compassion, humanity, dignity of our fellow man and woman? They all become hollow.”<sup>6</sup> Countless people have, of course, responded with compassion, humanity, and dignity worldwide, but there is always room for more, and I hope this book is a further contribution to that end.

In the spring of 2000 I learned that the government of India was piloting the new PPTCT program in select Government Hospitals around the country. Three of the eleven hospitals selected to pilot this program were in the state of Tamil Nadu, all in Chennai (Kuganatham 2004: 117). Given that Tamil Nadu was considered one of five high-prevalence states for HIV and given the long

history of Tamil Nadu's (particularly Chennai's) prominence in hospitalized births in India (Van Hollen 2003a), it was not surprising that this state would play a leading role in this new program. My interest was piqued. I wanted to know more about what pregnant women attending these hospitals would think about such a program. How would this fit into their broader experiences of childbirth, medical institutions, and the state about which I had already been writing?

After meeting in Washington, D.C., in the fall of 2002 with several people who were affiliated with governmental and nongovernmental organizations engaged in HIV/AIDS prevention projects in India, in December 2002 I stepped off a plane at the Chennai International Airport with my family and Sharon Watson, one of my undergraduate students from the University of Notre Dame (where I was then on the faculty) who had come along to work as my research assistant. I had received support from the University of Notre Dame to explore the possibility of doing research on HIV/AIDS and reproduction in the context of the government's goal to formally integrate its PPTCT program into its maternity hospitals.

During this one-month exploratory study in India, I traveled to Chennai, Delhi, and Kochi to meet with members of governmental and nongovernmental organizations and with medical practitioners involved in HIV/AIDS prevention and care projects whose work in one way or another related to maternity health care and the PPTCT program. This brief visit provided me with an overview of the landscape of organizations working on HIV/AIDS prevention and care in India generally and in Tamil Nadu in particular. I was encouraged by all to return for further ethnographic study.

But my lasting impression from that trip was this: Over the course of my trips to India in 1991, 1993, 1995, and 1997 for dissertation research, I saw many changes. After all, 1991 was the year that India liberalized its economy, and the shift to a consumer-oriented culture, driven by the rising income of the middle class, was palpable in Chennai: Foreign cars and the new compact Indian Marutis were quickly filling the streets and replacing the rounded white Indian Ambassador cars, and new, gleaming buildings, including high-rise Internet technology offices and grandiose shopping arcades, were sprouting up in the center of the city and in the newly emerging suburbs. Despite all this change, though, one thing remained constant: the ubiquitous inverted red triangle, a symbol of the Family Planning program in India since the 1960s. Often accompanied by the phrase "We Two, Ours One" (thus the two top points of the triangle leading down to the one), the red triangle could be seen on posters

in hospitals, outside shops, at bus stands, and always on the back of the three-wheeled auto-rickshaws that plied the busy streets. By the end of 2002, however, the red triangle was scarcely visible, except in faded form on the rickshaws and on the walls of some hospitals for obstetrics and gynecology. Something else had taken its place, something that would have seemed unimaginable only a few years ago. In the place of prominence that had once been occupied by the red triangle throughout the bustling streets of Chennai, there now sat—or rather danced—a cartoon of a smiling condom guy. On one sign the condom guy stands with a shield in one hand and a spear in another, saying (in Tamil), “To prevent AIDS, I alone can help. Wear a condom. Prevent AIDS.” In another ad the condom guy stands with his arms held high, his hands creating a cover over his head. The caption reads (in Tamil), “For a house, a thatch roof is important. For safe sex, a condom is important. There is no medicine for AIDS. There is no treatment. One can avoid AIDS. There is no cure.” And on a huge 6 by 3 foot banner I saw a comic strip (also in Tamil) with several scenes in which the condom guy is having a conversation. The conversation begins with a woman named Rani; she is complaining to the condom guy that she cannot suggest to her husband that he use a condom without raising his suspicions. Next the condom guy has a longer conversation with the husband, Ravi, in which he tries to convince Ravi of the birth control and preventive health benefits of using a condom, dispel Ravi’s concerns that sex with a condom is less pleasurable (the pleasure lasts longer!), and reassure Ravi that condoms made in India are of high quality (they are even exported to other countries!). In the end, Ravi accepts the condom, and for this newlywed couple “happiness bloomed in their family life.”

The condom guy and the international symbol of the HIV/AIDS red ribbon were two of the new icons of the Information, Education, Communication (IEC) materials being produced with the help of the USAID-funded AIDS Prevention and Control (APAC) Project (an NGO) and the Tamil Nadu State AIDS Control Society (TNSACS). When I visited the APAC office, I came away with a stack of these IEC materials, including five different illustrated pamphlets of “side-splittingly hilarious condom jokes” (in English) and a Snakes and Ladders board game in Tamil (known as Chutes and Ladders in the United States). Snakes and Ladders is an ancient Indian game originally created to teach children lessons about Hindu morality, karma and moksha. Here too it was being used to teach morality to prevent the spread of HIV and AIDS: Have a monogamous married relationship or wear a condom, and you climb the ladders to become a winner; have sex with a sex worker, and you slide down a snake to

end up in a hospital bed with an IV drip. HIV/AIDS was no longer something hidden and only to be discussed in hushed tones. It was becoming part of the fabric of mainstream public culture.

By 2004, when I returned to Chennai, the PPTCT program had been officially inaugurated with technical support and training from UNICEF. This time I had received funding from the Fulbright Foundation to spend six months conducting ethnographic research (the project title was “AIDS, Medicine, and Gender in India: How Pregnant Women Negotiate Options to Prevent Mother-To-Child Transmission of HIV in Tamil Nadu, India”). I made one more return visit to Chennai in 2008 for one month of research on the same project with funding from the American Institute for Indian Studies. The material presented in this book comes from all three trips to India (2002–2003, 2004, and 2008). The bulk of the ethnographic data come from the 2004 and 2008 research trips.

One of my anthropology professors at Berkeley, where I did my doctoral work, once told me that the primary methodology of anthropology was serendipity and that we must remain open-minded and flexible to allow for that serendipity. Of course we must have well-developed methods, but flexibility is a premium in cultural anthropology because we never know precisely what we will be able to do or what will be most important to do methodologically until we are in fact making our way through the social landscapes we planned to investigate.

I faced my share of the mundane and predictable frustrations of waiting long hours to meet with government officials or medical personnel, who may not have even showed up for the appointment, and of needing to be flexible and change course to focus more on the networks when government permissions to carry out research in certain hospitals were not granted as quickly as I had hoped. Indeed, the shift in focus proved to be rewarding. Throughout, I knew that what mattered most about my research method and what makes the anthropological method unique was the quality of the interactions I had (the interviews, observations, and participatory research)—the attention to understanding individuals within the context of their life histories and within the context of the local, national, and global contours of the historical moment in which they live. One of the strengths of anthropology is to be witness to people’s lives and to present the voices of people and to situate those voices within their broader social and cultural contexts. I sometimes am envious of those researchers working with large teams who can access enormous amounts of data—both qualitative and quantitative—to generate generalizations about patterns of behavior and thought. The smaller scale, more localized research



of solo anthropologists working in concert with a small group of research assistants may in some respects be less generalizable. Yet there is something profound about the kind of embodied knowledge that can be gained by individual anthropologists that is simultaneously analytical and emotional, allowing for empathy. In the realm of ethnographic research on a topic such as childbirth and HIV/AIDS, this kind of embodied knowledge is crucial to understanding women's lived experiences. My hope is that this ethnography provides the analytical rigor necessary to understand the complexity of context while simultaneously conveying empathy.

Given the inherent flexible nature and contingencies of the ethnographic method and its attention to long-term qualitative research, it is impossible to fully describe everything that goes into the research process itself. Nevertheless, what follows is a snapshot of how I went about gathering the information on which this book is based.

A central component of this research involved ethnographic interviews with seventy women living with HIV/AIDS.<sup>7</sup> The interviews, which I conducted in 2004 and 2008, focused on how these women came to know about their HIV status, how they and others responded to their HIV-positive diagnosis, what role they think gender plays in social responses to people living with HIV/AIDS, and their recommendations for improving HIV/AIDS prevention and care. Thirty-two of these women knew their HIV status before giving birth to all of their children. Interviews with these thirty-two women included discussions about how they made decisions to continue (or not) with their pregnancy and delivery after receiving an HIV-positive diagnosis, what their experiences were like during birth, how they made decisions about infant feeding, and what they thought about the decisions they had made.

I met thirty-seven HIV-positive women through networks of HIV-positive people in Chennai, Namakkal District (a largely rural district and home to one of India's trucking centers), and Coimbatore (a major industrial city) (see Map 2). Twenty of the women I met were recruited through the Y. R. Gaitonde Centre for AIDS Research and Education (YRG Care), where they were receiving maternity health care.<sup>8</sup> I met three women living with HIV/AIDS in government maternity hospitals, where they had recently delivered babies through a PPTCT program. I met eight women who were living in a home on the outskirts of Chennai and were receiving care and support through an NGO called Zonta Resources. Finally, I met two HIV-positive women through a PPTCT counselors' evaluation meeting because they had been hired as counselors in the government PPTCT program.