

2007

Navigating HIV, Pregnancy, and Childbearing in South India

Cecilia Van Hollen
Syracuse University

Follow this and additional works at: <https://surface.syr.edu/ant>

 Part of the [Anthropology Commons](#)

Recommended Citation

Van Hollen, C. (2007). Navigating HIV, pregnancy and childbearing in South India: Pragmatics and constraints in women's decision-making. *Medical Anthropology*, 26(7), 7.

This Manuscript is brought to you for free and open access by the Maxwell School of Citizenship and Public Affairs at SURFACE. It has been accepted for inclusion in Anthropology Faculty Publications by an authorized administrator of SURFACE. For more information, please contact surface@syr.edu.

This is an author-produced, peer-reviewed version of this article. The published version of this document can be found online in *Medical Anthropology: Cross-Cultural Studies in Health and Illness*. (<http://dx.doi.org/10.1080/01459740601021186>) published by *Routledge*.

Navigating HIV, Pregnancy, and Childbearing in South India: Pragmatics and Constraints in Women's Decision Making

Cecilia Van Hollen, Syracuse University

Based on ethnographic research conducted in 2004 and 2002–3, this article examines how poor women living with HIV in Tamilnadu, India navigate decisions about pregnancy and birth, and demonstrates that these decisions are influenced by a complex web of sociocultural factors. I argue that these decisions are informed by: 1) institutional interests of the state, NGOs, and international aid donors; 2) cultural constructions of gender and of the self; 3) Christian-based organizations; and 4) support group organizations, known as “networks” for people living with HIV=AIDS. Childbearing decisions emerged through a synthesis of coexisting structures and discourses which sometimes converged at the same conclusion despite differences in their underlying logics. I argue that the discourse of “positive living” fostered by the networks provided women with a framework for making reproductive decisions that was enabling. The article highlights how women pragmatically negotiated these various factors as they engaged in reproductive decision-making.

If I had known I was HIV+ when I was pregnant, I would have aborted the babies. (HIV+ widow aged 39; mother of six children; four children are HIV+) ¹

If it [HIV test] is positive it will be difficult for me to the extent that I will die; I will kill myself. There would be quarrels in the family. There would be no peace of mind. My husband would leave the house. Keeping the children, I would suffer, wondering whether I would live or die. I would not have the child. (20-year-old mother with a three-year-old daughter, now in the eighth month of her second pregnancy. She had just given blood for an HIV test in a Chennai public hospital and had not received the results) ²

If a pregnant woman is HIV+, it is good to abort the baby. It is a “waste” if the child is born. And the mother will also get a bad name. (Twenty-one year-old pregnant woman in eighth month of pregnancy who had just received her HIV— test result at a Chennai public hospital) ³

Speculations about how one would respond to an HIV+ diagnosis during pregnancy may lead to decisive statements such as those above, made by women from poor communities in Tamilnadu, South India. In the minds of these three women there is no question that they would choose not to continue with the pregnancy and birth. Studies suggest that this opinion prevails in India (Yadav 2001; Ananth and Koopman 2003). Yet reality is more complicated and fraught with ambiguity. In fact, many poor women in Tamilnadu do continue with childbearing despite an HIV+ test, and this trend is increasing. Based on ethnographic research conducted for six months in 2004 and one month in 2002—03, this article examines how women living with HIV navigate decisions about pregnancy and birth, and it demonstrates that this decision is influenced by a complex web of sociocultural factors.

Of the 50 HIV+ women whom I met, 12 found themselves in the situation of knowing that they were HIV+ while they were pregnant. All 12 of these women opted to continue with childbearing. Their decision was informed by: (1) institutional interests of the state, NGOs, and international aid donors (in terms of the structures of maternity health services available and in terms of the government’s Prevention of Parent to Child Transmission [PPTCT] of HIV Program);⁴ (2) cultural constructions of gender and of the self—particularly the centrality of motherhood—expressed by women themselves and also by people in women’s personal networks (especially husbands, in-laws, and parents); (3) Christian-based organizations in Tamilnadu that cater to lower-class, lower-caste communities; and (4) support group organizations, known as “networks,” for people living with HIV=AIDS. Women’s decisions to continue with childbearing were not made through favoring one factor over another but, rather, emerged through each woman’s own synthesis of coexisting structures and discourses. Sometimes these syntheses resulted in the same conclusion, despite differences in their underlying logics.

There is an assumption 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 American women have substantially more

decision-making power and act as free individuals. Much has been written about the interests that are served by such “othering” discourses regarding “non-Western” or “Third World women” (see Mohanty 1991 and Raheja and Gold 1996 on South Asia; see Abu Lughod 1993 on the Middle East). 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 (2001:54) definition of agency as “the culturally constrained capacity to act,” I draw attention to women’s agency as they frame their decisions in response to the above mentioned set of factors.

Ever since Giddens’s (1979:95) theory of “structuration,” which accounts for both the “strategic conduct” of agents that results in potentially transformative action and institutional structures that reproduce social systems simultaneously, anthropologists have sought to achieve this balance in their ethnographic analyses. Since the 1990 s, feminist anthropology has highlighted the ways in which women around the world exert their agency in the face of local and global structures of patriarchy (MacLeod 1991; Abu Lughod 1993; Raheja and Gold 1996; Mankekar 1999; Ahearn 2001; Seizer 2005). For example, MacLeod (1991) challenges Western assumptions that unequivocally equate veiling in Muslim societies with the control of women.s She describes the new veiling practices that emerged in Egypt in the 1970s as “accommodating protest” (Chapter 6) because the Egyptian women whom she met experienced them, simultaneously, as confining and as a means of engaging in protest. In a similar vein, through an ethnography of television viewing in North India, Mankekar (1999) stresses the importance of “foregrounding women’s agency” as a counterpoint to Western stereotypes of Third World women. She defines agency as the “ability to actively engage with, appropriate, challenge, or subvert the hegemonic discourses” (28) while, like MacLeod, reminding us that “resistance and compliance are not mutually exclusive” and that women may, in fact, exercise their agency so as to participate in the construction of hegemonic discourses (29). Ahearn (2001:55) echoes this point when she writes that agency “may also involve complicity with, accommodation to, or reinforcement of the status quo.” Also articulating the links between resistance and accommodation, but coming at this issue from the opposite angle, Seizer (2005:325) states that “all too often, compliance is the most effective way to resist an oppressive power.” My work contributes to these poststructural feminist studies of agency and structure.

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 (Oakley 1984; Martin 1987; Jordan 1993), toward documenting how women actively engage with new forms of medical science and technology in complex, context-specific, and sometimes contradictory ways (Lock and Kaufert 1998; Ragone´ 1994; Rapp 2000; Becker 2000; Inhorn and Van Balen 2002; Van Hollen 2003). As Margaret Lock and Patricia Kaufert (1998:2) wrote in the introduction to their 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.” Ultimately, they suggest that “ambivalence coupled with pragmatism may be the dominant mode of response to medicalization by women” (2). Given the fact that the women in my research were engaging with the medicalization of their reproductive processes within the unique context of an HIV+ diagnosis, indifference was never a response that I encountered. But “ambivalence coupled with pragmatism” perfectly characterizes the nature of these women’s responses and decision-making processes. It is precisely this that I hope to convey in this article.

My work differs somewhat from the above-mentioned works in that it argues that some structures provide women with the possibility of making reproductive decisions that are more enabling and=or satisfying than others. I argue that, of the four main structural factors listed above (all of which contributed to HIV+ women deciding to continue with their pregnancy), it was the influence of the networks for people living with HIV=AIDS that was most enabling. Unlike the other factors, the networks allowed women to make decisions that they felt would lead to beneficial outcomes (without having to sacrifice core aspects of their identity, such as their religion).

Social scientific studies on women and HIV=AIDS globally have tended to focus on women’s vulnerability and risk for contracting HIV and their knowledge of both risks and prevention worldwide (with particular attention to commercial sex workers and domestic violence) (Schoepf 1992; Asthana and Oostvogels 1996; Farmer 1999, chap. 3; London and Robels 2000; Wojcicki and Malala 2001; Epele 2002; Mill and Anaffi 2002; Miller 2002; O’Neil et al. 2004; Lichtenstein 2005). The importance of gender roles and identities has also been explored in relation to attitudes and practices surrounding HIV testing (Lupton et al. 1995; Biehl et al. 2001; Painter 2001). Other studies have examined the relationship between gender and psycho-social responses to and support for women living with HIV=AIDS (Siegel and Schrimshaw 2000; Gielen et al. 2001; Hough et al. 2003; Knowlton 2003; Luginaah et al. 2005; Lyttleton 2004; Doyal and Anderson 2005). In the area of reproductive health, social science studies have examined such things as HIV+ women’s experiences with sterilization (Hopkins et al. 2005); how HIV contributes to infertility (Inhorn and Van Balen, 2002, Part 3); morbidity and mortality associated with pregnancy among

women living with HIV=AIDS (Berer 1999); and ethical issues of providing anti-retroviral therapies in order to prevent mother-to-child transmission in “developing” countries (Hankins 2000). 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) has written an important report on women’s decision-making processes and difficulties with regard to preventing pregnancy as well as dealing with pregnancies (both wanted and unwanted).

Yet neither de Bruyn’s report nor the studies mentioned above have provided a nuanced analysis of the relationship between global and local processes, and between structure, agency, and the pragmatics of HIV+ women’s reproductive decision making, within a specific sociocultural context. This is what I attempt to do in this article. I believe that this kind of richly textured ethnographic analysis is critical for policy makers, health care providers, and social workers engaged in designing HIV=AIDS prevention and care programs as it enables them to provide women with the information they need in order to make informed reproductive choices.

METHODOLOGY

This article is part of a larger project on women and HIV=AIDS that was carried out in Tamilnadu. I conducted ethnographic interviews with 50 women living with HIV=AIDS. The interviews focused on how these women came to know about their HIV status; how they and others have responded to their HIV+ 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. I met 37 of these women through organized networks of HIV+ people in Chennai (the capital of Tamilnadu), Namakkal (the center of the trucking industry in South India), and Coimbatore (a major industrial city). I met three women living with HIV=AIDS in maternity hospitals, where they had recently delivered babies through a PPTCT program. I met eight women through an NGO called Zonta Resources, located outside of Chennai. And I met two women through a PPTCT counselors’ evaluation meeting. Interviews with these HIV+ women lasted approximately one hour each (some were longer, and in some cases I interviewed the same women up to three times). I also conducted 15 sessions of participant-observation in support group meetings, public hearings, and legal literacy and media workshops.

Further, I conducted 65 interviews with pregnant women in government hospitals with PPTCT projects and observed patient-counselor interactions. None of those 65 pregnant women were known to be HIV+. These interviews focused on women’s experiences of and opinions about HIV testing for themselves and their partners during pregnancy. They also explored their opinions concerning the risks of HIV in India and recommendations for prevention. The interviews lasted approximately half an hour each. In addition, I met with policy makers (in Chennai and Delhi) and with people working for international and local non-profit organizations involved in HIV=AIDS prevention and treatment programs. Finally, I met doctors and counselors at the Government Hospital for Thoracic Medicine in Tambaram (near Chennai) and at the private YRG Care hospital in Chennai.⁶ Interviews with policy planners and medical personnel focused upon their assessment of the successes and future needs of HIV=AIDS prevention and care programs.

SOCIAL BACKGROUND OF THE 12 WOMEN

As mentioned above, 12 of the 50 HIV+ women whom I met found themselves in the situation of knowing that they were HIV+ before having had all of their children. It is these 12 women who are the focus of this article. These women came primarily from the lower socio-economic segment of society. This is, in part, due to the fact that very few middle- or upper-class women living with HIV=AIDS AIDS participated as members of the networks or attended government hospitals for their maternity health care needs. However, as far as income levels are concerned, my sample is reflective of overall global trends as HIV is now known to disproportionately affect people living in poverty. Poverty curtails access to health care, nutrition, and education and may contribute to high rates of migration as well as drive people into sex work and/or substance abuse, all of which place people at risk for HIV (Farmer 1999; Singer 1994a and b). One of the 12 women in my study was living in a World Vision hostel (see below) when I met her, and she had no income. Of the remaining women, the average total household income reported was 3,164 Rupees (Rs.) per month. This is the equivalent of US\$72 per month or US\$864 per year.⁷ Four of these twelve women were employed by networks for HIV+ people when I met them. One woman earned a very limited income through selling oil for World Vision. And the remainder identified themselves as “housewives,” though all reported having engaged in some kind of employment in the past, most of which involved “coolie” wage labor. Two reported having previously earned money as sex workers.

Education levels of most of these women were also very low. This is not surprising, given the fact that many were born into families living in poverty. The average level of education of all 12 was the sixth standard (sixth

grade). Five out of the 12 reported that they had not received any education at all, and one had a college degree. All 12 of these women came from lower caste communities. Six identified themselves as Hindu and the other six reported that they had been born into Hindu families but had converted to Christianity. The average age of these women was 28.⁸ All 12 women had been married at some point. Ten had been in arranged marriages, and two (both of whom had a history of sex work) had been in love marriages. Four of the women were in their second marriages when I met them: two of these had been widowed (due to AIDS) and had remarried, while the other two had chosen to leave their first husbands and were remarried. Three women were unmarried when I met them: two of these had been widowed and one had chosen to leave her husband and was now single. At the time of my interviews, two of the women had no children (one had a stillborn baby and one miscarriage, the other delivered a baby who died five days after birth); the remaining ten had either one or two live children.

OVERVIEW OF HIV/AIDS SCENARIO IN INDIA AND TAMILNADU IN 2004

The National AIDS Control Organization (NACO) in Delhi estimated that in 2004 the HIV prevalence rate for India was 0.91 percent (as opposed to some sub-Saharan countries such as Botswana, with a 37.3 percent prevalence rate, and South Africa, with a 21.5 percent prevalence rate) (NACO 2005a; UNAIDS 2005). Since prevalence in India was reported to be less than 1 percent, it was considered to be a “low prevalence” country. Due to its large population, however, India was second only to South Africa with regard to the number of HIV+ people. NACO estimated that there are approximately 5.1 million people living with HIV=AIDS (PLHA) in India (as opposed to 5.3 million in South Africa) (NACO 2005a; UNAIDS 2005).⁹ Estimates also suggested that only 10 percent of those 5.1 million were aware of their HIV+ status.¹⁰ Therefore, many speculated that the potential for the virus to spread quickly and for HIV=AIDS to become a full-blown epidemic in India is great. India has been identified by the Center for International and Strategic Studies (CSIS) as one of the countries (along with Russia, China, Ethiopia, and Nigeria) that, unless it enforces strong prevention measures immediately, could witness what is referred to as the “second wave” of the global HIV=AIDS epidemic (Hamre et al. 2004). Some argue that India will soon become the country with the most PLHA in the world. Richard Feacham, the executive director of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, goes farther, claiming that the number of HIV+ people in India far exceeds the government’s statistics and that India ranks first in the world with regard to the number of HIV+ people.¹¹ In the midst of this politicized debate over statistics, the international community (including U.S. governmental and non-governmental organizations) has become increasingly concerned about and involved in HIV prevention efforts in India.¹²

It is important to note that HIV-prevalence rates within India vary across regions. Six states are reported to have “high prevalence” rates; that is, rates above one percent among prenatal mothers. These six states are: Maharashtra, Andhra Pradesh, Tamilnadu, Karnataka, Nagaland, and Manipur (NACO 2005b).¹³ Higher HIV rates in the northeastern states of Nagaland and Manipur are attributed to high intravenous drug use in the region. The other three high prevalence states are all located in south and central India. In my discussions with members of governmental and nongovernmental HIV=AIDS organizations three explanations for this emerged. Some pointed to the fact that HIV=AIDS entered into India through the major port cities of Chennai and Mumbai, where commercial sex workers were the first reported victims of the disease. The higher rates in Tamilnadu and Maharashtra, and the adjacent states of Andhra Pradesh and Karnataka, can, therefore, be attributed to the fact that the virus has had a long period of time to spread in the region. Others suggested that the south and central regions have been hard hit by this disease because of the new industrial and high-tech growth in the south, which has resulted in high levels of migration in the region as people seek new employment opportunities. Migration is known to be a contributing factor to the spread of HIV throughout the world (Herdt 1997; Campbell 2004). The third explanation given for higher prevalence rates in south and central India is that this is simply a reflection of better epidemiological surveillance in this region and that rates may, in reality, be much higher in other states but are not recognized due to a less developed HIV surveillance infrastructure.

According to NACO, in 2004 approximately 39 percent of all people living with HIV=AIDS (PLHA) in India were women (NACO 2005a).¹⁴ Dr. Suniti Solomon of YRG Care told me that the spread of HIV to women is increasing and may soon catch up to the rates for men.¹⁵ Since poverty puts people at risk for HIV globally, there is a global trend for rates of HIV infection to become higher for women than for men because the former, as a group, are economically more vulnerable than the latter (Schoepf 1992; Obbo 1995; Farmer 1999; Quinn and Overbaugh 2005). Furthermore, gender-based discrimination in the form of sexual violence and unequal access to nutrition, health care, and education also put women at increased risk for HIV (MacNaughton 2004). Therefore, it seems likely that, at some point, rates of HIV prevalence in women in India will exceed rates among men.

Tamilnadu has been a central focus for HIV=AIDS in India for two reasons. First, it is the state in which the first case of AIDS in India was detected (in 1986),¹⁶ and it is known to be a high prevalence state (1.1 percent at the start of my research) (TANSACS 2003).¹⁷ Second, Tamilnadu is the state that has been the most proactive with regard to developing programs for HIV=AIDS prevention and care at both governmental and non-governmental levels. Programs developed in this state have been used as models for other states.

CONTEXT FOR DISCOVERING HIV+ STATUS AMONG MOTHERS

Nine of the 12 women who knew they were HIV+ during their pregnancy first learned of their status through HIV-testing as part of their prenatal care, either in government hospitals with PPTCT programs that required “informed consent”¹⁸ or in private clinics where testing was routinely carried out without informed consent. Two of the 12 women came to know of their HIV+ status not in the context of prenatal care but, rather, as a result of their first child’s illness and subsequent HIV+ diagnosis. One such woman, Amaldevi,¹⁹ was already pregnant with another child when she learned that she and her first child were HIV+. The other woman, Punitha,²⁰ came to know of her HIV+ status while her first child was dying, but she chose to become pregnant and give birth to a second child anyway. Another woman, Karpagam,²¹ was tested for HIV as a result of her own illness and history of commercial sex work. Knowing her HIV+ status, she and her husband chose to conceive and give birth to two children.

SOCIAL RESPONSES TO HIV STATUS

How these women responded to discovering their HIV+ status and how others responded to them was reflective of dominant social responses to HIV=AIDS that have been documented globally: accusation, stigma, and discrimination (Shilts 1988; Sontag 1989; Farmer 1992; Goldin 1994). Since the modes of transmission of HIV involve taboo topics such as sex and drug use, the moral accusations associated with this illness in India have been particularly acute (Dube 2000; Jain 2002). In Tamilnadu (as in most of South Asia), HIV=AIDS is interpreted predominantly through the lens of sexual morality. The prescribed norm in Tamilnadu is that sexual relationships be confined to marriage. Sex before marriage and extra-marital sexual relationships are culturally and publicly defined as immoral. In India, recent studies have revealed that sexual practice does not always conform to these normative ideals (Goparaju 1998; Puri 1999; Jejeebhoy 2000; Verma et al. 2004). Furthermore, a tacit double standard that tolerates men’s pre- and extra-marital sexual relationships prevails. The English translation used for the Tamil phrase for pre- and extra-marital relationships—*tahaata udaluravu*—is “illegal intercourse,” “illegal sex,” or “improper sex.” The assumption is that someone with HIV has engaged in “illegal sex” (i.e., any sex that occurs out of wedlock) and is therefore to be blamed for having this disease. Even when speaking in Tamil, the English translations of this term, particularly the use of the English word “sex,” are used more often than is the Tamil phrase. Stacy Pigg has found this to be the case in Nepal as well. She argues that this kind of linguistic code-switching provides a more neutral, safer way for people to discuss taboo topics while simultaneously marking them as modern (Pigg 2001:512–524). This explanation also applies to the south Indian context.

Due to the double standard with regard to sexual mores, women tend to be blamed for “illegal sex” more often than men, and HIV+ women often face greater stigma and discrimination than men (CFAR and PWN 2003). This has also been the case in other cultural contexts (Leclerc-Madlala 2001; Ogden and Nyblade 2005:24–25; Center for Reproductive Rights: 2005). Many women in India only discover their HIV+ status after the death of their husbands. Not only are they blamed for their husbands’ deaths but they must also suffer the added indignity of having the stigma of their HIV+ status exacerbated by the stigma of being a widow (Lamb 2000).

Many poor HIV+ women in India become widows at a young age. In my sample of 50 HIV+ women (whom I interviewed), over half were widowed and the average age was 30. These HIV+ widows find it extremely difficult to support themselves as they must contend with poverty and low levels of education, which prevent them from finding employment opportunities and from seeking legal recourse regarding rights to their husbands’ property. Their difficulties are compounded due to the stigma of HIV=AIDS, which shuts them out of jobs and homes, denies them and their children access to medical care, and may lead to their children being expelled from school. It is because of such extreme cases of stigma and discrimination that media reports of HIV+ women committing suicide are not uncommon.

Yet women also engage in a discourse of blame. When discussing their life stories, women invariably began by blaming someone for infecting them, thereby exempting themselves from responsibility. The need to blame is clearly a symptom of the intensity of the stigma attached to having HIV. The most extreme manifestations of this were found in two cases in which women flatly denied that they were HIV+ despite the fact that medical personnel claimed that they were indeed positive.²²

The story of Punitha provides a window into understanding how gender and class place women at risk for HIV. It also illustrates the multiple layers of blame, stigma, and discrimination that result when women discover their HIV+ status as well as the complex, pragmatic decision making that occurs once they are faced with an HIV+ diagnosis.

Punitha was an only child, born and raised in Chennai. Her father died of tuberculosis when she was five years old. When Punitha came of age, her mother was eager to arrange a marriage as soon as possible. The reason for this was that her mother feared it would be difficult to do this without a father as people would suspect that the family would not be able to provide an adequate dowry.

Punitha discontinued her education after completing the eighth standard, and a marriage was arranged for her when she was 16. She was married to a 26-year-old man. Punitha was opposed to the marriage: “When he came to see me, I did not like his appearance. I told this to my mother. He was very thin and had ulcers and sores in his mouth. But my mother went ahead with the engagement.” Given this description of him, it is very possible that Punitha’s husband was already suffering from opportunistic infections associated with HIV=AIDS. Indeed, several women I met believed that their husbands knew of their HIV status before marriage, and this led to a heated debate about the merits of mandating premarital HIV testing.

Following the patrilocal tradition, Punitha went to live with her husband’s family. Within three months, she got pregnant and eventually gave birth to a girl. Her baby was constantly sick, and finally a doctor told her to take her husband and daughter to a government hospital for blood tests. All three of them received a blood test; all three were found to be HIV+. Punitha said that there was no process of informed consent before taking the test and that they did not receive counseling after getting the results. The only thing she remembers being told at that time (in the late 1990s) was that they would all die within four to five months. Although she and her husband have lived much longer, the baby died soon after the diagnosis.

Within Punitha’s family, the response to the HIV+ status was a predictable layering of blame and counter-blame and of assumptions and accusations of improper sexual behavior. The first person to know of their status was Punitha’s father-in-law as the doctor had informed him directly (breaching codes of confidentiality). The father-in-law’s response was to make sexual advances toward Punitha, saying that she must have been promiscuous and that since she was dying anyway, she had nothing to lose by having sex with him.

Punitha and her husband fled the advances of the father-in-law and went to live with Punitha’s mother in Chennai. Punitha was quick to blame her husband: “Until today, he has not accepted responsibility for having infected me.” Punitha’s husband blames Punitha’s father, saying that her father must have been HIV+ and contracted tuberculosis as a result. He then claimed that Punitha’s father must have transmitted HIV to Punitha’s mother, who then transmitted it to Punitha at birth, who in turn transmitted it to him. When I first met Punitha, she suggested that this was ludicrous because, according to her, her mother was not HIV+.

But when I attended the next PWN+ support group meeting Punitha’s mother, Manjula,²³ was there, and while I at first assumed she had come to accompany her daughter, I soon discovered that she was herself a member of the network—that she too was HIV+. When I interviewed Manjula in her home, it was clear that she had her own theories concerning who was to blame for her HIV+ status. Accusations seemed to tumble out in a heap, despite the fact that I never asked her how she got infected: “My son-in-law used to visit often before he married my daughter. He wanted to marry her but Punitha refused. In an argument he bit my hand.” And: “My son-in-law cut his hand with a blade and I held it tight to stop the bleeding.” And: “I was washing my daughter’s cloth sanitary pads after she had her baby and I must have gotten it through that blood.” As always, the goal seemed to be to exempt oneself from blame even if, as in this case, it meant implicating one’s own daughter.

Manjula’s neighbors soon came to know that members of the family had “AIDS.” They were ostracized and forced to leave their home. So they fled once again, this time to a new, treeless government housing development on the far southern outskirts of Chennai built to relocate squatters from the city. Punitha, her husband, her mother, and her second child were living in a one-room apartment there when I met them in 2004. They were doing their best to keep their HIV status secret from their new neighbors.

HOW TO DECIDE WHETHER TO CONTINUE WITH CHILDBEARING

Despite the intense stigma and discrimination women faced upon discovering their HIV+ status, they decided to continue with childbearing. Punitha became pregnant again following the death of her first child and decided to give birth to the second child. In most other cases women discovered their HIV status for the first time during their pregnancy. The remainder of this article explores the factors that were involved in their decisions.

I am not suggesting that the unanimous decision among my informants to continue with childbearing is representative of all women living with HIV in Tamilnadu. Nine of the 12 informants were selected through

networks promoting “positive living,” and three were selected through hospitals with PPTCT programs. Such women may be more inclined to continue with childbearing than others. Nevertheless, there is reason to believe that the trend for women living with HIV to continue with childbearing is on the rise, at least in Tamilnadu. Therefore, a close examination of the complex decision-making processes of women who do choose to continue with childbearing could benefit those engaged in HIV=AIDS prevention and treatment efforts, whether they are policy makers, health care providers, or social workers. Ultimately, such an understanding could benefit future HIV+ women as it could contribute to creating policies that enable women to make fully informed, voluntary decisions.

Detecting HIV Late in Pregnancy

Nine of these women received their first HIV test at a late stage in their pregnancy:²⁴ two in the ninth month, two in the eighth month, three in the seventh month, two in the fifth month, and one in the fourth month. Typically, hospitals that provide HIV-testing do so at the very first prenatal visit. And, indeed, my research suggests that most women do undergo testing on their first or second prenatal visit. The late stage at which these women detect their HIV status supports the already documented fact that poor women in Tamilnadu who attend government maternity hospitals often do not seek out prenatal care until late in their pregnancy (Zurbrigg 1984). According to Dr. Srilata of UNICEF, for approximately 40 percent of government hospital deliveries in Tamilnadu, the woman’s first visit to the hospital is at the time of delivery.²⁵ This is due to the fact that, when family resources are limited, women’s health is not a priority, especially if seeking health care involves time away from paid labor or housework and involves transportation costs— problems that are most pronounced in rural areas that have few medical facilities. Half of the 12 women in my sample came from rural villages, even though they were getting maternal health care in towns or cities. Furthermore, based on evidence from my previous research, it may also be the case that some women put off seeking prenatal care in government hospitals due to concerns that, because of their class and caste status, they might be mistreated by medical staff or pressured into accepting family planning procedures (Van Hollen 2003).

In short, a combination of cultural constructions of gender and inadequate resources devoted to women’s reproductive health, along with the government’s stepped-up efforts to screen for HIV during pregnancy, seem to have resulted in a situation in which women are increasingly learning about their HIV+ status late in their pregnancy.

Women usually perceive the diagnosis of an HIV+ status very late in a pregnancy as precluding the option of having an abortion. Abortion, referred to as “MTP” (medical termination of pregnancy), is legal in India under certain conditions. According to Indian law, abortion in the first trimester is legal with one doctor’s certificate and does not require the consent of a family member. During the first trimester of pregnancy (months one through three), it is relatively easy to get the medical certificate as this is in line with the state’s interest in family planning. In the second trimester (months four through six), abortion is legal with two doctors’ certificates and the consent of a family member. For a doctor to certify an abortion in the second trimester there must be a medical reason (relating either to the mother’s health or to the health of the fetus). These certificates are also relatively easy to procure. Abortion is legal in the third trimester (months seven through nine) of pregnancy only if it is deemed medically necessary in order to save the mother’s life. These certificates are difficult, but not impossible, to obtain. Studies have also shown that, in India, many unlicensed practitioners perform abortions illegally and that such abortions have been associated with maternal morbidity and mortality (Ganatra 2000). Ganatra’s review of studies of abortion in India indicates that the majority occur in the first trimester and that those who delay abortion until the second trimester tend to be adolescents and unmarried women and, increasingly, women seeking sexselective abortions (207). Her review of the literature does not include discussion of third trimester abortion.

With the exception of the woman who discovered her HIV status in the fourth month of her pregnancy, all the women stated that they could not consider an abortion because of the late stage of the pregnancy. It is interesting to note that even those women who were in the fifth month (second trimester) of their pregnancy stated that they could not consider an abortion because it was too late (see Amaldevi’s statement below). Women did not elaborate on what precisely they meant when they stated that it was “too late,” but I believe that they were responding to a perception of the illegality late-stage abortion and of the social stigma associated with it. Further studies could clarify this issue. For some, saying that it was “too late” may have been a way of buttressing other reasons for wanting to continue with childbearing (see below).

The Role of the PPTCT Program

The prevention of parent to child transmission (PPTCT) of HIV program was the name of the Government of India's program, which was administered in select government maternity hospitals and provided free counseling and HIV-testing to all pregnant women. It also provided single-dose nevirapine to HIV+ mothers and to their newborns. This anti-retroviral treatment alone, without any other interventions, has been shown to reduce the risk of transmission from 25 to 30 percent to 8 to 10 percent.²⁶ The more standard, worldwide appellation for such programs is prevention of mother to child transmission (PMTCT). The Government of India chose to use the title PPTCT instead of PMTCT, substituting "parent" for "mother," in order to increase husbands' involvement in the program (including HIV-testing), to decrease the stigmatization of HIV+ women, and to acknowledge and raise awareness about the fact that husbands have been primarily responsible for infecting their wives.²⁷ A pilot project to see whether such a program would be effective was initiated in 2000.²⁸ Due to the perceived success of this pilot project, the PPTCT program was inaugurated in 2002.²⁹ Tamilnadu was selected as a key state for implementing the pilot project and the final program. At the time of my research in 2004 there were 65 hospitals in Tamilnadu participating in the PPTCT program; and, according to UNICEF, this meant that, in 2004, approximately 20 to 25 percent of all pregnant women in Tamilnadu were being covered by it.³⁰

Whereas in the past, medical personnel encouraged abortions for poor HIV+ women—and this was the path endorsed and pursued by most women in India (Yadav 2001; Ananth and Koopman 2003)³¹—now, thanks to the government's PPTCT program, poor women can have the option of pursuing childbearing at reduced risk. So the presence of this program is clearly a critical factor in poor HIV+ women deciding to bear more children. However, the role of the PPTCT program in these decisions is more complex than that.

In fact PPTCT counselors glossed over abortion in pre-test counseling, and, rather than discussing probabilities, some stated that, with medication, HIV would not be passed to the baby. This is demonstrated in the following three excerpts from counselors speaking to patients in pre-test counseling sessions. I observed these interchanges in public hospitals:

If one gets the HIV test, just like one has other blood tests, HIV will be prevented from passing on to the child. [There was no mention of medication in this session.]³²

By giving medicine to the mother before the child is born, HIV will be prevented from passing to the child. It comes to the child through the umbilical cord, during childbirth, and by breastfeeding. This is prevented by medicine. So it is good to get tested for HIV.³³

If the mother is HIV+ during the pregnancy, medicines can be given to the mother and you can stop the HIV from going to the child. But it is only if the mother gets the HIV test during pregnancy that it can be known and it is only if medicines are given that you can stop HIV from going to the child.³⁴

Counselors also avoided discussing stigma in pre-test counseling, and they did not explain that there was, at that time,³⁵ no government provision of anti-retroviral medication (ART) for the sake of the mother's health. The Indian government (as well as the Centers for Disease Control in the United States and the World Health Organization) does not recommend prescribing ART treatments until a patient's CD4 count³⁶ dips to at least 200. It usually takes several years after HIV infection before CD4 counts fall to that level. Therefore, since most women in Tamilnadu bear their children soon after marriage, assuming that they were infected after marriage, their CD4 counts are not likely to be so low at the time of their births that they would be eligible for ART even if it was available. But decisions surrounding whether or not to continue with childbearing are not necessarily so short-sighted, and women often take into consideration their long-term ability to care for their future children. Failure to mention abortion, discrimination, and the lack of long-term availability of medical treatments for the mothers themselves thus seemed to encourage women to get tested during pregnancy and to continue with childbearing if they were found to be HIV+. By not providing women with full information about the consequences of this decision, the structure of these counseling sessions tended to foreclose the possibility of women exercising their agency. A 2005 report by the Center for Reproductive Rights (2005:6) states:

As programs to prevent mother-to-child transmission of HIV become increasingly available, there is a strong incentive to raise enrollment in those programs by scaling up HIV testing of pregnant women. Expanding women's access to HIV testing during pregnancy is a necessary component of any campaign to prevent mother-to-child transmission. It is crucial, however, that efforts to increase testing be complemented by similar commitments to pretest counseling.

My research, emphasizing the importance of the quality of the counseling, underscores the need to heed this advice in the Indian context. MacNaughton's (2004) analysis of women's health care and HIV=AIDS globally suggests that lack of fully informed consent for HIV testing in pregnancy is a widespread problem in many parts of the world and one that needs to be addressed as a human rights issue.

Most of the PPTCT counselors in Tamilnadu were trained through a Chennai-based organization called the South India AIDS Action Programme (SIAAP). During their SIAAP training they were told not to fixate on getting immediate high acceptance rates for HIV testing. In fact, Shyamala Natraj, SIAPP's program director, tells counselors that if a patient refuses testing after the first counseling session, then this is a sign of good counseling. This is because the point of counseling is to allow individuals to make their own decisions. Natraj contended that refusal of testing after the first session should be interpreted as a sign that the individual wants time to reflect on the pros and cons of testing and to discuss the issue with family members before returning to have the test done, preferably bringing her partner along for testing as well.³⁷

Yet, based on my discussions with PPTCT counselors and on my observations of a three-day monthly review meeting to evaluate counselors, it was apparent that counselors felt that they were being evaluated by the Tamil Nadu State AIDS Control Society (TANSACS) according to levels of acceptance of testing and treatment. During the counselor evaluation meeting I observed one situation in which a counselor with low HIV-testing acceptance rates was transferred from his city post to the rural hill station of Kodaikanal. From the expression on the blue-jeaned urbanite's face, this was clearly perceived as a punishment. Counselors felt that there was a contradiction between what they felt was essential to good counseling and what was expected of them on the job. As one of the more disgruntled counselors put it (in English): "We are not doing counseling work. We are only doing clerical work. We are clerks. The counseling idea from the West is good. But in Tamilnadu we have a way of turning everything into clerical work only. They [TANSACS] are happy only if we keep good records and have good numbers. They don't care about the counseling."³⁸ Of course prenatal HIV counseling in the West is not always as comprehensive as this counselor seems to think. As de Bruyn (2005:4-6) points out, there is a growing concern that the turn to the "opt out" approach to prenatal HIV-testing in some countries in the West may result in insufficient information and questionable consent in prenatal care.

The goal of the PPTCT program seemed at times to be to generate statistics that would demonstrate a high percentage rate of HIV testing and of HIV- babies born to HIV+ mothers. Counselors had to provide reports to TANSACS, which, in turn, sent reports to the National AIDS Control Organization (NACO) in Delhi. According to Shyamala Natraj, international aid organizations providing funding for counselor training took these statistical reports into consideration when allocating funds. Thus the PPTCT program seemed to operate within an unstated international, national, and statewide target approach that was the mainstay of the family planning program through 1996 (Van Hollen 2003). Under these conditions, pregnant women were not provided with complete and balanced information about their reproductive health options. Other studies have pointed out that the Bush administration's policy of not funding international organizations that provide abortion counseling or services—known as the Global Gag Rule—has also influenced HIV counseling and services for pregnant women worldwide (de Bruyn 2002:18). This may also be a contributing factor in PPTCT counseling, although no one stated that directly.

PPTCT counselors may have felt that they had a stake in dissuading HIV+ women from opting for an abortion. Evidence of this is supported by statements made by two women who discovered their status in the second trimester and who felt that abortion was not an option. For example, Amaldevi stated: "I was five months pregnant when I tested HIV+ so I couldn't abort. The counselors said that there was medicine in the hospital to stop HIV from passing to the baby." Saroja,³⁹ who discovered her HIV+ status in the fourth month of her pregnancy, stated: "I asked if my baby will get HIV. They [counselors] said that they will give medicines so that this will not happen. I felt reassured. So I decided to continue my pregnancy. My husband also agreed." In these statements we see how HIV diagnosis late in the pregnancy and the nature of the PPTCT counseling become neatly linked so as to close off perceived decision-making options for women. It is difficult to know whether the counselors spoke with such absolute confidence about preventing the spread of HIV as these statements suggest. I was unable to observe post-test counseling of HIV+ patients, so I cannot corroborate these statements. It is possible that mothers remembered what they wanted to hear. However, given the certainty with which counselors discussed the effectiveness of nevirapine in pre-test counseling, it seems highly possible that this was the position presented during post-test counseling as well. What is evident from these statements is that counselors were not highlighting the abortion option, despite the fact that both these women were in the second trimester of their pregnancy.

I want to stress that I am not suggesting that HIV+ pregnant women should opt for an abortion or that counselors should steer them in that direction. Such suggestions would be a violation of human rights for people living with HIV=AIDS (de Bruyn 2005:7-8). De Bruyn suggests that movements to designate HIV=AIDS as a specific indication for legal abortion could lead to further stigmatization of HIV+ women and could even lead to a

tendency to coerce these women into having abortions. Instead, she suggests that “it could be better to advocate for the full reproductive rights of WHA [Women Living with HIV=AIDS] and to advocate for the passage and implementation of laws that permit abortion for ‘chronic conditions that may endanger a woman’s health,’ without naming HIV=AIDS specifically (de Bruyn 2002:22).

I agree with de Bruyn that women should be presented with all reproductive options so that they may be able to make the decision that best serves their interests. Tamilnadu has the highest incidence of abortion in the country, at a rate of 5.2 percent of all pregnancies as opposed to the national rate of 1.7 percent (Anandhi 2004). According to ethnographic research on abortion in Tamilnadu, abortion is practiced among married and unmarried women both as a family planning method and as a tool to negotiate domestic violence and other oppressive social conditions (ibid.).⁴⁰

Given the context discussed above—in which most HIV+ women are living in poverty, are widowed at a young age, and are unable to find employment or remarry due to the triple stigma of being HIV+, an HIV+ woman, and a widow—women must be provided with full disclosure of their reproductive options and of their medical, social, and psychological benefits and risks.

The Parental Mandate

The cultural imperative to be a mother weighed heavily on the decision of some of the women. Similar tensions between fears of transmitting HIV to a child and anxiety surrounding the failure to bear children have been found in other cultural settings throughout the globe (Mill and Anarfi 2002; Doyal and Anderson 2005). The HIV+ women I met who became widows due to AIDS before conceiving went through an intense period of grieving not only for their husbands but also for their chance to become mothers. For a woman to be married and not to produce a child would lead not only to a sense of personal loss but also to a feeling of public shame. In Tamilnadu a woman is expected to conceive within the first year of marriage, and if this does not happen, it can sometimes be grounds for the husband’s family to seek a new wife.

Maliga,⁴¹ whose husband, mother, and brother all encouraged her to abort the fetus even though she was eight months pregnant, explained it to me this way: “Some said there was a ten percent chance that the baby would be HIV+.⁴² So they felt it would be better to abort. For me . . . I am a woman . . . there is no reason to live if I do that. For a complete family you need a baby. Otherwise I shouldn’t live.” According to Dr. Solomon at YRG Care, this imperative to be a mother was so strong that HIV- women sometimes knowingly put themselves at risk of infection from their HIV+ husbands so that they could become mothers.⁴³ Because of this, YRG Care was embarking on a clinical trial to give ART to the positive person in a discordant couple in order to prevent transmission to the negative partner. She felt that this was particularly important for women since women would put themselves at risk of getting HIV in the hope of conceiving.

Punitha’s story (discussed above) provides another example of the parental mandate. One month after the death of her first child, pregnant again, Punitha was determined to keep the baby, despite the fact that her husband and her mother were opposed and wanted her to get an abortion. In this case, Punitha’s mother said that Punitha was determined to have another child in order to please her in-laws and reconcile a broken family.

The case of Vijaya also demonstrates a woman’s agency with regard to her choice to keep a baby, despite the fact that, as with Punitha, Vijaya’s motivation can be viewed within a broader patrilineal and patriarchal context. Vijaya, who came from a village in Namakkal district, was 34 years old when I met her. She held her two-month-old baby in the lap of her sari and intermittently fed her with a bottle during our conversation. When she discovered her HIV+ status during her pregnancy she already had a sevenyear- old child from her first marriage, so she did not feel that it was critical for her to have another child as she was already a mother. She explained to me that she wanted to keep the baby not for herself but, rather, for her husband and his family.

Vijaya’s first husband (who was her father’s sister’s son—a crosscousin) had died, and she had then married his older brother. Cross-cousin marriage and marriage to one’s husband’s brother on the death of one’s husband (known as levirate marriage) are both normative practices in Tamilnadu. Vijaya knew that her first husband had been HIV+ and that he had died due to AIDS, but she did not know about her own HIV status until she had remarried and was in the ninth month of her pregnancy with her second husband’s child. At that time she was tested during her prenatal check-up at a PPTCT center. She tested HIV+ and VDRL+⁴⁴ (i.e., she had a positive syphilis test). Vijaya explained that, although she was aware that she herself could have contracted HIV from her first husband, she did not know that she could transmit HIV to her baby or to her second husband. She said that, had she had known that earlier, she would not have agreed to remarry.

Vijaya’s second husband, who tested HIV+, had not been married before and did not have any children. Vijaya was worried that her child from her first marriage would not treat her second husband like a father. She was

concerned that this child would not take care of her second husband in his old age or if he got ill. This was particularly worrisome since she imagined that, due to her HIV status, she would die before her husband. For these reasons she felt that it was important to have another child with her second husband—a child that would have a strong filial bond with him and enable her to die in peace, knowing that her husband would be cared for. Furthermore, although she already had a child, she felt that it was important for her husband to have his own child in order to carry on the family lineage. She believed that this was important for her husband's family as well. Although his family did already have a grandchild (Vijaya's daughter), they did not yet have a grandson. And since a son was crucial to carrying on the family lineage, Vijaya felt that she should try to give birth to one. Clearly, Vijaya is motivated not only by love for her second husband but also by patrilineal kinship structures that contribute to son-preference.

This imperative to bear children and to continue the family lineage, despite one's HIV status, is not surprising in a cultural context where demands for infertility treatments are intense and where adoption is rare (Bharadwaj 2002). People in India seek out multiple modes of fertility treatments, ranging from in-vitro fertilization, to Ayurvedic and Siddha remedies, to vows and prayers made to deities (as evidenced, for example, by the tiny cloth cradles hanging from the branches of trees at many Hindu temples in Tamilnadu). For HIV+ men who can afford it, sperm washing before in-vitro fertilization is one method increasingly being sought out by couples longing for a biological child.

The fact that women would decide to bear children for the sake of their in-laws or their husbands is not surprising in a cultural context in which the conception of the self is said to be more sociocentric, or "dividual," than ego-centric (as, for example, in the North American cultural context) (Dumont 1970; Marriott 1976). Anthropologists have described this Indian conception of the self as "fluid," pointing to the notion that person-substance flows from one individual to another through multiple social interactions, from the most intimate sharing of body substance between mother and child or husband and wife, to the more intermediate sharing of food, to the more remote transference of person-substance through touching the same object (Daniel 1984; Lamb 2000). Within this context, women's reproductive decisions are influenced not only by social factors such as patriarchy and class but also by social and emotional connections to a broad kinship community.

The Role of Christianity

Six of the 12 women (50 percent) considered their Christian faith to be an important factor in their decision making. These were all lower-caste women who had converted to Christianity, reflecting a broader trend of lower-caste conversion in Tamilnadu, beginning in the colonial era and continuing into the present. All six had converted to Christianity after having learned of their HIV+ diagnosis. Those women who claimed that their Christian faith was an important factor in their decision to continue with childbearing told me that abortion was not problematic for Hindus but was unacceptable for Christians. Maliga, for example, went against her Hindu husband's wishes for an abortion. As she put it: "I was against abortion. Hindus do not see abortion as a sin, but Christians do. I have turned Christian. It was only Bible reading that prevented me from committing suicide [after discovering HIV status]. The Bible gave me strength and hope. My husband tried his best to abort the child." It is important to note that Maliga not only made a reproductive decision that went against her husband's wishes but that she also decided to convert from Hinduism to Christianity despite his wishes. When we take into consideration the fact that, in the predominantly patrilineal Indian cultural context, a wife is expected to adopt her husband's family's religious identity and practices (assuming she does not already belong to the same religious group), we see that Maliga displays a particularly high degree of autonomy and agency. She was born into a Hindu dalit caste, and her marriage was arranged when she was 26. Maliga had adopted the Christian faith as a result of her interactions with a Christian Ayurvedic doctor who was treating her for HIV=AIDS. When I met this doctor in Maliga's apartment in 2003 he claimed that his Ayurvedic treatments could cure HIV=AIDS (Van Hollen 2005).

Maliga's statement—"Hindus do not see abortion as a sin"—was echoed by others, but it begs for clarification. Above all, attempts to uncover a "Hindu perspective" on the topic of abortion reveal the absence of a homogenous Hindu viewpoint. The different perspectives offered seem to reflect the researchers' own political and moral positions on the topic. On the one hand, some scholars provide evidence from ancient Hindu texts (including the Vedas, Upanishads, Dharmasastras, and the medical treatises of the Cararaka Samhita and Susruta Samhita) to argue that, according to Hindu belief, abortion is antithetical to Hindu notions of ahimsa (non-violence) and that it is a heinous crime, a mahapataka equal to killing one's own parents or to killing a Brahmin (Thandaveswara 1972; Lipner 1989). These scholars point to the fact that Hindus believe that the soul joins matter at the moment of conception and that it moves through a series of incarnations, each of which is determined by the karma of the previous life, towards the goal of liberation (moksa). In this light, abortion is viewed as thwarting the unfolding of

karma and the soul's movement toward moksa, particularly since incarnation as a human being indicates the soul's proximity to the latter.

On the other hand, Sandhya Jain (2003) argues that, although it is true that abortion is considered to be a mahapataka in some of the classical texts, Hinduism also rejects absolutism. She points out that the ancient Ayurvedic medico-religious texts, such as the Caraka Samhita and the Susruta Samhita, tolerate abortion to save a mother's life and even recommend abortion if a fetus is said to be "defective." Furthermore, these texts prescribe methods for abortion (Jain 2003). She goes on to argue that Hindu notions of dharma (proper conduct) encourage flexibility in that they accommodate individual circumstances and social changes through time:

In such a radically changed environment, it stands to reason that the demands of dharma must be appropriate to the demands of the time in which we live. The stability of the social order now necessitates adoption of the small-family norm, and dharma includes the notion of public duty and public responsibility. Hence, the small-family norm, achievable through contraception and family planning methods (including abortion in rare or necessary cases), is entirely consistent with, and in no way opposed to, the Hindu concept of dharma (Jain 2003:139).

Ethnographically based research directed by S. Anandhi (2004) in predominantly Hindu communities in Tamilnadu suggests that, previously, abortion was considered shameful not because the procedure itself was viewed as a sin but, rather, because it pointed to one's sexuality. Anandhi's study found that, among the younger generation, women felt that having a large family or being pregnant relatively late in life was much more shameful than having an abortion. She also reports that pregnant women commonly consult with "the local priest (samiyar) or persons who are 'possessed'" to determine whether or not to elect to have an abortion (17). She quotes one woman as saying that a local village priest insisted that she should abort in the seventh month of her pregnancy because he felt that the fetus was possessed by a ghost and would harm the male members of the family if it were born. It is interesting to note that, in this particular example, the advice of the priest legitimated the pregnant woman's own desires, which she had been unable to act on because her husband and mother-in-law were against the abortion. According to this woman, once the priest had issued the warning and sanctioned the abortion, the husband too "insisted on the abortion" (17-18).

Regardless of the debates about "the Hindu perspective" on abortion, abortion was legalized in India in 1971 under the Medical Termination of Pregnancy (MTP) Act. It is practiced by members of all religious communities and has not been politicized to the degree that it has in other parts of the world, in large part because of overarching state concerns with family planning and population reduction (Van Hollen 2003; Anandhi 2004).⁴⁵ Maliga's contention that "Hindus do not see abortion as a sin, but Christians do," which was also voiced by other women I met who had recently converted to Christianity (see below), may be indicative of an attempt among anti-abortion groups to make this a religiously charged political issue. This claim, of course, requires further research and documentation.

One and a half years after her baby had been born and had been officially declared HIV -, Maliga became pregnant once again. Although she claimed that her Christian faith's opposition to abortion was her primary reason for having given birth to her other child, when she became pregnant this time her husband once again wanted her to get an abortion and she consented. She recounted the event:

When I became pregnant a third time [her first pregnancy had resulted in a stillbirth], my husband took me out of the city to his sister's place. His sister knew a doctor who would perform an abortion. At that time I had to attend a housewarming function. So I decided to go for an abortion after the function. I don't think I will conceive again. We calculate safe dates. My husband doesn't want another child. But he is against permanent sterilization. My mother too is against it since I am weak. But he will not agree to get himself sterilized. He thinks his libido (veeriyam)⁴⁶ will go down.

Maliga's story suggests to me that it was the need to become a mother, more than her Christian opposition to abortion, that was the strongest factor in her decision to keep her baby after discovering her HIV status during pregnancy. Her Christian faith seems to have served to bolster her argument in favor of keeping the earlier baby. But with a healthy baby boy in her arms, she was willing to concede to her husband's wishes to abort the next time round.

The women I met who were converting to Christianity all did so after discovering their HIV+ status. Many converted as a result of their association with a Christian organization called World Vision. World Vision is one of the largest Christian relief and development organizations in the world.⁴⁷ Founded in 1950, World Vision is a private Christian organization structured as a global partnership, with no formal affiliations to a particular denomination and

working primarily in the area of children's emergency relief and development in 99 countries.⁴⁸ World Vision is associated with Protestant groups worldwide and has been described by one scholar as being among the most influential forces in the rise of the post-Second World War evangelical coalition (Carpenter 1998:823) and by another as having "link[s] with Protestant groups in the United States that emphasize religious conversion" (Cruz 1999:381–382). Yet in a section on the World Vision website entitled "Frequently asked questions," we find the question, "Is evangelism a part of World Vision's projects?" And it provides the following response:

Educational activities based on Christian values are included in World Vision projects if appropriate and desired by the community. However, World Vision respects the religious beliefs and practices in countries where it operates, and seeks mutual understanding with people of all faiths. World Vision does not proselytise. We do not coerce nor demand that people hear any religious message or convert to Christianity before, during or after receiving assistance.⁴⁹

Punitha converted to Christianity after learning that she was HIV+ and had come into contact with members of World Vision. She recounted:

I have changed from being a Hindu to being a Christian. My husband observed a fast after he knew his HIV status and went to Sabarimalai [Hindu pilgrimage site].⁵⁰ He became very sick on his return. The doctor said that he had jaundice. They gave up on him, saying that he was dying, and he was sent home. He became bedridden. A neighbor came and prayed every day for his recovery. That lady was a Pentecost. She told us about World Vision. We too started praying and developed faith in Christianity. He improved slowly. We were baptized after that.

This account suggests that she felt that the Hindu gods at Sabarimalai were not as capable of healing as was the Christian god. In addition to the neighbor's daily prayers, World Vision had begun to provide her husband with free ART. Punitha and her daughter also received free medical treatment from World Vision. Similarly, Amaldevi, who discovered that she and her two-year-old lame child were HIV+ when she was pregnant, was put in touch with World Vision, which provided her child with ART. She told me: "The government has not done anything for HIV+ people. People must not reject them. I prayed to Jesus that my son must walk and become free of HIV. I vowed that if he could walk I would become a Christian. Jesus takes care of me. He gave me courage. Now my son has strength to stand up. Jesus gave me hope to have the second baby so I didn't want an abortion."

Renukha⁵¹ discovered her HIV+ status while pregnant, and she, too, was put in touch with World Vision. Here is what she said: "When the child was in the womb, we would pray for its welfare. I became a Christian. Among Hindus, an HIV+ lady is rejected. Neither my mother and father nor my husband's family have helped me. They are all Hindus." Renukha told me that she was opposed to the idea of abortion and that, as a Christian, if she prayed to god, her baby would be saved. Renukha and her HIV+ husband were also receiving medical support from World Vision, and Renukha was earning approximately 50 rupees per day selling oil for World Vision. And Karpagam, who began attending World Vision meetings and receiving medicines for free when she was seven months pregnant, said: "Before I was a Hindu. But then I vowed to Jesus that I would get baptized if my child lived. I prayed to Him to save my children from HIV. The first boy was saved, but the second was HIV+. This was because I breastfed the second baby." World Vision was providing ART for the second child.

None of the women I met who were affiliated with World Vision stated unequivocally that this organization was opposed to abortion or that abortion was not permissible within their new religion. However, as Amaldevi stated above, these women felt that putting their faith in Jesus was preferable to pursuing an abortion. The World Vision website does not include an official statement on abortion, and my phone calls for interviews with World Vision in Chennai were not returned, so I do not know with certainty whether World Vision in Tamilnadu has a particular position on abortion. Through an Internet search on the issue, I did locate a World Vision "Topic Sheet" document entitled "Population and Poverty: What's the Connection?" published in 1998, which supports family planning but which also states: "As a Christian organization, World Vision highly values life, and does not support abortion as a means of family planning" (World Vision 1998).

The HIV+ women I met who, at different times, had stayed in the World Vision hostel had all converted to Christianity during their stay. Those who were interviewed while they were living at the World Vision hostel or living in housing subsidized by World Vision said that they had freely chosen to convert. However, Devi,⁵² who had previously lived in the hostel but who was now living with her husband in their own rented thatch house and who was still receiving medical treatment from World Vision for herself and her children, said: "World Vision asked me to become a Christian and I did. I think Jesus saved my son. They allowed me to stay in that hostel only because I

agreed to become a Christian. World Vision gives my son ART. Before taking ART my son was only four kilograms. Now he is ten kilograms [within eight months]. Now he does not get ill so often.’’

The decision to continue with childbearing in these cases evokes a sense of hope and of the possibility that these women might be able to make their own reproductive decisions, independent of their families (husbands, mothers, mothers-in-law, etc.). However, these decisions also suggest a complex web of factors that tend to limit women’s options, compelling them to continue with childbearing. Their comments suggest that: (1) they needed a place to live and/or medical treatment for themselves and their children, and they felt that, whereas the government was not providing for those needs, World Vision would; (2) they felt that they were being stigmatized by their Hindu community, and they believed that the Christian community offered through World Vision would provide them with psychological and spiritual support; and (3) as a result of their association with World Vision they expressed their new identity as Christians through opposition to abortion and faith that Jesus would provide them with healthy babies. These women’s conversions, which occurred under circumstances that fostered anti-Hindu sentiment and a sense of the superiority of Christianity, is particularly problematic when we take into consideration the fact that World Vision was founded in the United States and that much of its funding comes from the West. I am not claiming that World Vision was explicitly proselytizing by making treatment and care contingent upon conversion. I do not have evidence to prove such a claim. But clearly World Vision did not appear to have actively attempted to prevent women like Devi from having that perception.

Positive Networks: Positive Living

Finally, four of the 12 women living with HIV explained that they opted to give birth because they felt they could be good mothers, regardless of their HIV status, and that their children could lead satisfying lives whether they were born with HIV or not. Women who made such statements were all affiliated with the networks for HIV+ people. Networks for HIV+ people began to emerge in India in the mid-1990s as these people organized to combat the extreme forms of stigma and discrimination that they faced at home, in the workplace, and in medical institutions.⁵³ Several of the individuals who formed these networks had been working at NGOs involved in HIV prevention, but even in those organizations they felt stigmatized and marginalized. The first statewide network was the Tamil Nadu Network for Positive People (TNP+), which was registered as an organization in 1995. The Indian Network for Positive People (INP+) based in Chennai was founded in 1997 as a central organizing body for the newly emerging statebased networks. The Positive Women’s Network (PWN+), also based in Chennai, was the first female-specific network, and it was formed in 1998. Common goals of these networks involve promoting social acceptance of people living with HIV=AIDS and overcoming stigma and discrimination; protecting the human rights of HIV+ people (e.g., by providing legal aid); providing HIV+ people with access to information and medical treatment; promoting the employment of people living with HIV=AIDS; and providing a forum for networking and counseling. Funding for these organizations comes through a variety of sources, including Family Health International (FHI), USAID, UNIFEM, and governmental bodies such as TANSACS in Tamilnadu.

Women I met who attended support group meetings at the PWN+ in Chennai, the Society for Positive Mothers’ Development in Coimbatore (SPMD), and the HIV Ullor Nala Sangam (HUNS Network) in Namakkal came to know more about the PPTCT programs, and this information influenced their decision to continue with childbearing. More important, through talking and interacting with other HIV+ women and children, these women were exposed to the possibility that HIV+ mothers and children could ‘‘live positively.’’

For most people in Tamilnadu this was a novel concept as, up until recently, most of the HIV=AIDS prevention campaigns were aimed at instilling fear into people in the hope of dissuading them from engaging in ‘‘risky’’ behavior. Remnants of earlier campaigns could still be seen on a few posters adorning hospital walls, such as a black and red poster that read ‘‘AIDS ¼ Death,’’ which I saw in a back room of one of the PPTCT center hospitals. The common Tamil term for AIDS is uyir kolai noy (life-killing disease). Most people did not know about the difference between HIV and AIDS and believed that once someone got the virus it led to sudden death, whereas in fact there is usually a period of six to ten years during which an HIV+ person is asymptomatic.⁵⁴ In 2004, brightly colored green and yellow posters covering the walls of the hospitals with PPTCT programs admonished stigmatizing HIV+ people and advocated positive living. And women attending positive network support group meetings came to understand that an HIV diagnosis did not mean an imminent death.

This was the situation for Punitha. Although motivated to keep her baby for her in-laws as well as by her new-found Christian faith, Punitha said that the most important factor in this decision was that she had been actively attending PWN+ support group meetings. When she became pregnant and went for her prenatal consultation with her doctor, she had already made up her mind to continue with the pregnancy, despite her family’s wish for her to abort. As she said: ‘‘When the doctor first explained to me that even with the medicine to prevent transmission of

HIV, there was still a chance that the baby could be HIV+, I told the doctor that I could live a happy life myself even with the HIV virus and I told him that I knew how to raise a baby whether the baby was HIV+ or HIV _ .’

Like Punitha, Renukha also opposed family pressure to abort. Renukha was in her second marriage and pregnant for the first time when she discovered her HIV+ status. Her first marriage had been arranged when she was 19 years old. She said that her first husband turned out to have bad habits (ketta palakkam). According to her, he was a drunkard, smoked ganja, and visited sex workers (vilai pengalidam poradu). So she left him and married her older sister’s husband (while he was still married to her older sister). He already had two children with his first wife (Renukha’s sister). Polygamy is not commonly practiced in Tamilnadu, particularly not among Hindus (Renukha and her new husband were Hindu when they were married but converted to Christianity after discovering their HIV+ status). And for a man to marry two sisters simultaneously is certainly not normative behavior in Tamilnadu. Renukha described this second marriage as an exceptional act of empathy and concern for her well-being on the part of her second husband and her sister.

Renukha became pregnant soon after the second marriage and discovered that she was HIV+ through prenatal HIV-testing in the seventh month of her pregnancy. Her new husband was then tested, and he too was found to be HIV+ but her sister was HIV—. Initially, Renukha’s sister was angry with Renukha and blamed her for passing HIV to their mutual husband. But Renukha blamed her first husband for his bad “character” (using the English word).⁵⁵ She did believe that she had transmitted HIV to her second husband, and she felt a sense of remorse for this as well as a sense of humiliation that her first marriage had failed. In her mind, the blame lay squarely on her first husband’s shoulders.

Renukha had decided to continue with the birth of her first child and had received zidovudine⁵⁶ treatments under the PPTCT pilot project. Five months after her first baby was born, she found herself pregnant once again. She and her husband recounted that moment:

Renukha: I became pregnant a second time just five months after my first delivery. My parents as well as my husband wanted to end the pregnancy. We even quarreled over this.

Husband: My wife was not well informed about HIV at that time. Why should we have another child when we ourselves are going to die soon?

Renukha: I was strong in my decision that I wanted this baby and that I would not have an abortion. But my husband took me to the hospital for an abortion. I told the doctor that I didn’t want an abortion. I told him: “Why should I have an abortion when my first child had been born without a problem?” This doctor asked me to go to the same hospital where my first baby was born. Doctors used to take good care in those days. But now they do not. Now they ask me to sit separately and do not touch me. Actually, we people who have HIV do not need counseling. It is the doctors who need counseling. Society rejects HIV+ people. Doctors also do this.

Renukha delivered her second child in a PPTCT government hospital in Chennai. Renukha said that PWN+ support group meetings had made her aware of the problem of stigma. She was not going to be cowed by fear of such stigma; she refused to let this deter her from having the children she wanted.

In rare instances couples entered into a marriage knowing that they were both HIV+. This trend was increasing and was facilitated by organizations such as YRG Care, the support group networks, and even through Internet listservs such as AIDS-INDIA and SAATHII.⁵⁷ When they got married, Karpagam and her husband each knew that the other was HIV+. Karpagam had been sold into commercial sex work in Vellore at the age of 15 and believed that that was where she contracted HIV. Although she had taken birth control pills to avoid getting pregnant, at that time she had no knowledge about condoms and HIV=AIDS. She was arrested three times. Upon her third arrest she was taken to the “Vigilance Home” in Mylapore, Chennai. It was while she was in the Vigilance Home that she came to know that she was HIV+, and it was also during that time that she met her husband (who was also HIV+). He worked for an organization that was involved in providing food to women in the home. She and her husband were open about their previous sexual history. As she said, “He had been a fisherman in Bombay. At that time he had ‘sex’ with many women and thus became HIV+. So he married me even though he knew that I too had had ‘sex’ with other men.”

After Karpagam and her husband were married, she was released from the Vigilance Home. She began attending PWN+ support group meetings, and her husband attended the TNP+ support group. She said that it was primarily due to the confidence she and her husband gained through attending these meetings that they chose to have two children through the PPTCT program and that her husband’s parents supported them in this. When I met her she had two sons, aged nine and seven. She had not breastfed her first son (who was HIV _) for fear that HIV could be transmitted through breast milk. After the birth of the second son, she said she could not afford alternate feeding, so

she breastfed for one year and guessed that it was because of this that her second son was HIV+. He was receiving ART from World Vision, and she kept his status secret from the school.

CONCLUSION

As stated above, it is often assumed that poor women in India have little or no control over their own reproductive decisions. The stories shared by the women involved in my study, however, provide a very different impression of women's roles in making decisions about reproductive health. Although these women's decisions were constrained by patriarchy, limited by class and caste, and affected by the demands of the target-like approach of the PPTCT program as well as by the interests of evangelical Christian organizations, they negotiated these various factors pragmatically. In several instances we even see women making decisions that went against the will of their husbands, their parents, and their in-laws.

Of all the factors contributing to these women's decisions, the role of the networks, with their "positive-living" discourse, was the most enabling. Women who made their decision within this framework chose to continue with childbearing because it would result in a fulfilling life for themselves and their future children. This decision was not driven by a sense that childbirth and motherhood were their only viable options but, rather, by a belief that they were just as entitled to motherhood as was any other woman and that their children should have the opportunity to live lives that were just as satisfying as those of any other children. Furthermore, this type of positive living was not dependent upon changing one's religious identity or denigrating another religious community.

None of these women, however, stated that their decisions were based solely on one factor; instead, they pointed to a complex configuration of competing influences. It was clear that their decisions reflected the kind of "ambivalence coupled with pragmatism" that Lock and Kaufert (1998:2) have described as characteristic of women's engagement with the medicalization of reproduction. For example, Maliga and Amaldevi claimed that, essentially, they had no choice but to continue with childbearing as they had learned of their HIV status so late in their pregnancies. And yet both women felt compelled to rationalize their decision by drawing on other explanatory logics.

Maliga was in the eighth month of her pregnancy when she discovered her HIV status. Even though she was in the third trimester, her husband, mother, and brother were encouraging her to have an abortion. So the late stage of the pregnancy was not the only factor with which she had to contend in making her decision to keep the baby. She also drew on her new-found Christian faith to take a stance against abortion and, in so doing, she constructed herself as morally superior to her Hindu husband, who wanted her to abort. She also drew on the cultural construction of motherhood as the defining characteristic of being a woman in order to formulate her argument for going against her family's wishes. When we consider that she later willingly agreed to an abortion, the pragmatics of her use of Christian anti-abortion rhetoric becomes starkly apparent.

Amladevi was five months pregnant with her second child when she received her HIV diagnosis. Although she believed that abortion was not an option at this stage in her pregnancy and she seemed to have been convinced by the PPTCT counselors that medication could guarantee that HIV would not pass to her baby, she also felt compelled to justify her childbearing decision along religious lines. Critical of the government, which she felt "has not done anything for HIV+ people," she found support only with World Vision, converted to Christianity, and claimed that "Jesus gave me hope to have the second baby so I didn't want an abortion."

For Maliga and Amaldevi the late-term HIV-diagnosis was not, in and of itself, a deterrent to the abortion option. Similarly, Renukha and Punitha's strident confidence in "positive living" was not the sole explanation for their decisions. In addition to Punitha's confidence about "positive living," which enabled her to defy her husband's and mother's wishes for her to abort and emboldened her to stand up to her doctor (she told him, "I know how to raise a baby"), she also stressed that prayer and her new-found faith in Christianity gave her the strength to continue with childbearing. And her mother pointed out that Punitha wanted to have the baby so that she could regain respect from her parents-in-law, who had spurned and harassed her after she and her husband were found to be HIV+.

Likewise, Renukha drew upon the positive-living discourse of the networks when she made the cutting remark: "We people who have HIV do not need counseling. It is the doctors who need counseling." But the human rights-based positive-living discourse was not the only factor she cited as informing her decision. Feeling cast off by her Hindu parents and her in-laws (since "among Hindus, an HIV+ lady is rejected"), she found support within the Christian World Vision community. She said that, as a Christian, she was opposed to abortion.

The fact that these women drew upon multiple logics to explain their childbearing decisions points to "ambivalence coupled with pragmatism" (Lock and Kaufert 1998:2). Multiple explanations may be developed as pragmatic strategic responses to the competing and varied opinions of family members, medical personnel, religious

organizations, and networks with whom these women interact as they navigate the decision-making process. On the other hand, these explanations may also be a sign of the ambivalence that these women continued to feel regarding a decision that they had already made. Such ambivalence is not surprising, given the fact that many people in Tamilnadu—like the three women quoted at the beginning of this article—felt that HIV+ women should not bear children. Such ambivalence is also not surprising given the fact that these women and their children face an uncertain future. But it need not be so. I believe that with (1) increased access to early prenatal care, (2) PPTCT services that provide women with information and options with regard to making informed reproductive decisions and that provide treatment without discrimination, and (3) access to free ART treatment (not only to prevent mother-to-child transmission but also to treat all people living with HIV=AIDS), it may be possible to envision a future in which these women's decision-making experiences will be characterized as "confidence coupled with pragmatism."

NOTES

1. Interview on April 5, 2004. Unless otherwise indicated, all quotes from interviews are translated from Tamil. English words used in the original interview will appear in quotations. The research on which this article is based was conducted during research trips to India over a period of six months in 2004 (January to July) and one month in 2002–03 (December to January). The 2004 research was supported by a Fulbright Scholar Program Research Award. Pilot research in 2002–03 was funded by the University of Notre Dame's Institute for Scholarship in the Liberal Arts, Pilot Fund for Faculty-Student Research in the Social Sciences. My deepest gratitude goes to the women who participated in the research. In addition, I would like to thank all the individuals working for HIV=AIDS prevention and care organizations who facilitated the research in India. In particular, I am grateful to the following people for helping to make arrangements for my interviews: P. Kousalya, president of Positive Women's Network (PWN+); Dr. P. Kuganatham, UNICEF consultant, PPTCT; Jeypaul of both INP+ and HIV Ullor Nala Sangam (HUNS Network), Namakkal; R. Meenakshi, president, Society for Positive Mother's Development, Coimbatore; and Janaki Krishnan, treasurer, Zonta Resource Centre. I would also like to thank S. Padma, Ms. Punitha, Jasmine Obeyesekere, and Sharon Watson, who have worked as research assistants on this project both in India and the United States. I am also indebted to Rajeswari Prabhakaran, Dr. Dasaratan, and Sheela Chavan for their assistance with translations of interviews. A version of this article was presented at the Society for Applied Anthropology Annual Meeting, Santa Fe, April 7, 2005, and also at the South Asia Center and the Gender and Globalization group of the Maxwell School, Syracuse University, April 19, 2005. I would like to thank the organizers and participants of those events for their useful feedback. Finally, I would like to thank Ann Gold, Susan Wadley, Maureen Schwarz, Christa Craven, and Jasmine Obeyesekere for their insightful comments on this paper.
2. Interview on February 10, 2004
3. Interview on February 4, 2004
4. This is the same thing as PMTCT (Prevention of Mother to Child Transmission), which is the more standard appellation. I explain why the Indian government has chosen this particular terminology below, in the section on the PPTCT program.
5. See also Fadwa El Guindi (1999).
6. These are two of the best known hospitals for the treatment of HIV=AIDS patients in India. YRG stands for Y.R. Gaitonde (a name).
7. The highest household income reported for this group of 12 women (without considering the one in the World Vision hostel) was Rs.8,000=month, and the lowest was Rs.800=month. The exchange rate during the first half of 2004 was Rs.44.00 to US\$1.00.
8. The youngest was 22 and the oldest was 35.
9. By the time that this article was going to press in September 2006, the UNAIDS website reported that the number of people living with HIV=AIDS in India had reached 5.7 million, exceeding the 5.5 million reported for South Africa at the same time (See www.unaids.org/en/default.asp, accessed on September 8, 2006).
10. Interview with Abraham Kurien, president of Indian Network of Positive People (INP+), December 20, 2002, Chennai.
11. See BBC News, World edition, April 19, 2005. Feacham claims that the underestimates by NACO reflect a lack of reliable infrastructure for gathering data on HIV in India. Such claims have angered NACO officials, who assert that their prevention efforts are showing positive results.
12. For example, the Bill and Melinda Gates Foundation has allocated \$200 million for a five-year prevention program in India. The Gere Foundation and the Clinton Foundation have also been actively supporting HIV=AIDS projects in India. The chief of USAID's Implementation Support Division reported that "in fiscal year 2004, the US

government committed approximately \$27.5 million to fight HIV=AIDS in India,” approximately half of those funds coming from USAID (See “US helps India to fight AIDS,” Washington, July 16, 2005 [PTI] posted on the AIDS-INDIA List-serv on July 18, 2005). And, on March 17, 2005, India was made the 16th country on the Bush administration’s President’s Plan for Emergency AIDS Relief (PEPFAR) list.

13. See map provided on NACOonline (NACO 2005b).

14. This figured was calculated based on the rural-urban distribution figures provided on the NACO online website at (NACO 2005).

15. Interview with Dr. Suniti Solomon, YRG Care, Chennai, March 9, 2004.

16. The first case was detected by Dr. Solomon of YRG Care.

17. Tamilnadu has some pockets of higher HIV-prevalence, such as Namakkal, where TANSACS reports that prevalence rates are above 2 percent (See TANSACS 2004) and others suggest that it is as high as 6.5 percent (Jain 2002).

18. Based on my observations in four hospitals with PPTCT programs, it is clear that there is a great deal of variation with regard to the extent to which informed consent is fully operationalized and achieved. I have put this term in quotations to indicate this variation.

19. Unless otherwise indicated, all names of participants in this research are pseudonyms. Information about Amaldevi is based on an interview conducted on May 25, 2004.

20. Information about Punitha is based on formal interviews conducted on March 9 and March 10, 2004, and on informal interactions and conversations during my six months in Chennai in 2004.

21. Information about Karpagam is based on an interview conducted on April 16, 2004.

22. These were not just incidents of women denying their HIV status to me; they also denied it to family members and to other people with whom they lived.

23. Information about Manjula is based on an interview conducted on April 4, 2004.

24. This was also found to be an issue in a study conducted in Thailand (cited in deBruyn 2002:19).

25. Interview on March 4, 2004, UNICEF, Chennai.

26. This figure is from an article posted on the AIDS-INDIA Listserv on March 1, 2005. The title of this posting is “Second Phase of Anti-Retroviral Programme Begins—Tamilnadu, INDIA.” The article posted on the listserv was copied from an article published in *The Hindu*, February 28, 2005. According to a 2005 briefing paper produced by the Center for Reproductive Rights, among women who do not breastfeed the risk of transmission without any other interventions is 15 percent to 30 percent (Center for Reproductive Rights 2005:3).

27. During March and April, 2006, there was a discussion on the AIDS=INDIA Listserv debating the usefulness of the distinctive Indian emphasis on “parent” rather than on “mother.” Some argued that this appellation created confusion and detracted not only from the program’s aim to prevent transmission to the child but also from an awareness of the biological fact that transmission to the child (which this program hopes to prevent) comes from the mother.

28. At that time they were using zidovudine instead of nevirapine.

29. At that time they began using nevirapine.

30. Personal communication with Dr. Srilata, UNICEF, Chennai, March 4, 2004. Eight of these PPTCT centers were located in private hospitals, and the others were located in public hospitals.

31. Several people whom I met in 2004 and who were involved in the networks and with maternity care services also concurred that this had previously been the most common response to HIV and pregnancy.

32. Excerpt from PPTCT pre-test counseling session observed on January 23, 2004.

33. Ibid.

34. Excerpt from PPTCT pre-test counseling session observed on January 27, 2004.

35. In April 2004, at the end of my research period, the Government of India did initiate a program to provide free ART, and this program has continued to be phased in. In February 2005 the PPTCT program in Tamilnadu was linked up to the ART program. Information about this linkage can be found in an article posted on the AIDS-INDIA Listserv on March 1, 2005. The title of this posting is “Second Phase of Anti-Retroviral Programme Begins—Tamilnadu, India.” The article posted on the listserv was copied from an article published in *The Hindu*, February 28, 2005. Further studies should explore how this change is affecting the nature of the PPTCT counseling.

36. As Libman and Stein (2003:48) write: “The CD4 cell count correlates highly with the progression of HIV disease and is the main surrogate marker for immunological function.”

37. Counselors reported this to me, and Natraj also said this when I interviewed her at SIAAP, Chennai, on March 4, 2004.

38. Interview with PPTCT counselor conducted on February 4, 2004.

39. Information about Saroja is based on an interview conducted on May 25, 2004.
40. Despite criminalization and widespread opposition to the practice, it has also been used for sex selection in a sociocultural context that increasingly favors male children (Bumiller 1990).
41. Information about Maliga is based on interviews conducted on January 1, 2003; on March 1 and 2, 2004; and on informal interactions and conversations during my six months of research in 2004.
42. The implication here is that this 10 percent possibility would exist even with nevirapine.
43. Interview on March 9, 2004, at YRG Care, Chennai.
44. This stands for Venereal Disease Research Laboratory and refers to an antibody test.
45. The use of abortion for sex selection has, however, been condemned and criminalized.
46. The Tamil term *veeriyam*, meaning potency or strength, is usually used in reference to medicines and seeds.
47. From the Wikipedia website: http://en.wikipedia.org/wiki/world_vision.
48. As stated in the World Vision website page entitled "Frequently asked questions" at <http://www.wvi.org/wvi/childsponsorship/faqsponsorship.htm>, viewed April 19, 2005.
49. See <http://www.wvi.org/wvi/childsponsorship/faqsponsorship.htm>, viewed April 19, 2005.
50. This is a Hindu pilgrimage site for Lord Murugan. For more discussion of this pilgrimage, see Daniel (1984).
51. Information about Renukha is based on an interview conducted on April 1, 2004.
52. This information is based on an interview with Devi on April 14, 2004.
53. Information provided here about the formation of the networks in India is based on my interviews with Rama Pandian, president of TNP+, on March 15, 2004; and with K.K. Abraham, president of INP+, on December 20, 2002. Information on the development of the networks can also be found in Jain (2002:223–240).
54. The length of time it takes for HIV to develop into AIDS is dependent on biological and socio-economic factors, including poverty, which can jeopardize health and weaken people's immune systems, making them more vulnerable to AIDS. Pigg (2001:492 and 510) argues that this distinction is culturally=politically produced and that expressed knowledge thereof serves to create social hierarchy.
55. Sometimes women would simply use the English word "character" (as in: "He had a 'character'") to imply that someone had a bad character.
56. This was the medicine given when the PPTCT program was in its pilot phase. Later, it switched to using nevirapine.
57. In fact, a recent report from Palak Nandi in Ahmedabad in the state of Gujarat found that HIV+ women were responding to matrimonial advertisements of HIV+ men. Many were young widows or divorcees with children who needed the financial and psychological support that a husband could provide (AIDSINDIA Listserv, June 15, 2005).

REFERENCES

- Abu-Lughod, Lila
1993 *Women Writing Worlds: Bedouin Stories*. Berkeley: University of California Press.
- Ahearn, Laura
2001 *Invitations to Love: Literacy, Love Letters, and Social Change in Nepal*. Ann Arbor: University of Michigan Press.
- Anandhi, S.
2004 *Women, Work and Abortion Practices in Kancheepuram District, Tamil Nadu*. In *Abortion Assessment Project in India: Qualitative Studies: A Report*. Pp. 42–63. Mumbai: Centre for Enquiry into Health and Allied Themes (CEHAT).
- Ananth, Prasanna and Cheryl Koopman
2003 *HIV=AIDS Knowledge, Beliefs, and Behavior among Women of Childbearing Age in India*. *AIDS Education and Prevention* 15:529.
- Asthana, Sheena, and Robert Oostvogels
1996 *Community Participation in HIV Prevention Problems and Prospects for Community-Based Strategies among Female Sex Workers in Madras*. *Social Science and Medicine* 43(2):133–148.
- Becker, Gay
2000 *The Elusive Embryo: How Men and Women Approach New Reproductive Technologies*. Berkeley: University of California Press.
- Berer, Marge

1999 HIV=AIDS, Pregnancy and Maternal Mortality and Morbidity: Implications for Care. In *Safe Motherhood Initiative: Critical Issues*. Marge Berer and T. K. Sundari Ravindran, eds. Pp. 30–42. UK: Blackwell Science.

Bharadwaj, Aditya
2002 Why Adoption Is Not an Option in India: The Visibility of Infertility, the Secrecy of Donor Insemination, and Other Cultural Complexities. *Social Science and Medicine* 56:1867–1880.

Biehl, João
2001 Technology and Affect: HIV=AIDS Testing in Brazil. *Culture, Medicine and Psychiatry* 25:87–129.

Bumiller, Elisabeth
1990 *May You Be the Mother of a Hundred Sons: A Journey among the Women of India*. New Delhi: Penguin Books.

Campbell, Catherine
2004 Migrancy, Masculine Identities, and AIDS: The Psychosocial Context of HIV Transmission on the South African Gold Mines. In *HIV and AIDS in Africa: Beyond Epidemiology*. E. S. Kalipeni, Susan Craddock, Joseph R. Oponng, and Jayati Ghosh, eds. Pp. 144–154. Cambridge, MA: Blackwell Publishing.

Carpenter, Joel A.
1998 Review of *On the Boundaries of American Evangelicalism: The Postwar Evangelical Coalition*. *Church History* 67(4):822–824.

Center for Reproductive Rights.
2005 (August). *Pregnant Women Living with HIV=AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV*. Briefing Paper. New York: Center for Reproductive Rights.

CFAR (Center for Advocacy and Research) and PWNp (Positive Women’s Network)
2003 *Positive Speaking: Voices of Women Living with HIV=AIDS*. New Delhi: UNIFEM Publication.

Cruz, Marcelo
1999 Competing Strategies for Modernization in the Ecuadorean Andes. *Current Anthropology* 40:377–383.

Daniel, Valentine
1984 *Fluid Signs: Being a Person the Tamil Way*. Berkeley: University of California Press.

de Bruyn, Maria
2002 *Reproductive Choice and Women Living with HIV=AIDS*. Chapel Hill, NC: Ipas.

2005 *HIV=AIDS and Reproductive Health: Sensitive and Neglected Issues*. Chapel Hill, NC: Ipas.

Doyal, Lesley, and Jane Anderson
2005 *My Fear Is to Fall in Love Again: How HIV-Positive African Women Survive in London*. *Social Science and Medicine* 60:1729–1738.

Dube, Siddharth
2000 *Sex, Lies and AIDS*. New Delhi: Harper Collins.

Dumont, Louis
1970 *Homo Hierarchicus: The Caste System and Its Implications*. Chicago: University of Chicago Press.

El Guindi, Fadwa
1999 *Veil: Modesty, Privacy and Resistance*. New York: Berg.

Epele, Maria Esther
2002 *Gender, Violence and HIV: Women’s Survival in the Streets*. *Culture, Medicine and Psychiatry* 26:33–54.

Farmer, Paul
1992 *AIDS and Accusation: Haiti and the Geography of Blame*. Berkeley: University of California Press.

1999 *Infections and Inequalities: The Modern Plagues*. Berkeley: University of

California Press.

Ganatra, Bela
2000 Abortion Research in India: What We Know, and What We Need to Know. In *Women's Reproductive Health in India*. Radhika Ramasubban and Shireen J. Jejeebhoy, eds. Pp. 186–235. New Delhi: Rawat Publications.

Giddens, Anthony
1979 *Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis*. Berkeley: University of California Press.

Gielen, A. C., McDonnell, K. A. Wu, A. W., P. O'Campo, and Faden, R.
2001 Quality of Life among Women Living with HIV: The Importance of Violence, Social Support, and Self Care Behavior. *Social Science and Medicine* 52(2):315–322.

Goldin, Carol S.
1994 Stigmatization and AIDS: Critical Issues in Public Health. *Social Science and Medicine* 39:1359–1366.

Goparaju, Lakshmi
1998 *Ignorance and Inequality: Youth Sexuality in India and Its Implications to HIV Spread*. Ph.D. dissertation, Syracuse University.

Hamre, John, Teresita Schaffer, and Stephen Morrison
2004 Strategy for the Second Wave: Learning from India's Experience with HIV=AIDS. Opening Remarks at the Center for Strategic and International Studies (CSIS), Washington, DC, 9 September.

Hankins, Catherine
2000 Preventing Mother-to-Child Transmission of HIV in Developing Countries: Recent Developments and Ethical Implications. *Reproductive Health Matters* 8(15):57–62.

Herdt, Gilbert, ed.
1997 *Sexual Cultures and Migration in the Era of AIDS: Anthropological and Demographic Perspectives*. New York: Clarendon Press.

Hopkins, Kristine, Regina Maria Barbosa, Daniela Riva Knauth, and Joseph E. Potter
2005 The Impact of Health Care Providers on Female Sterilization among HIV-Positive Women in Brazil. *Social Science and Medicine* 61(3): 541–554.

Hough, Edythe S., Gail Brumitt, Thomas Templin, Eli Saltz, and Darlene Mood
2003 A Model of Mother-Child Coping and Adjustment to HIV. *Social Science and Medicine* 56(3):643–655.

Inhorn, Marcia and van Balen, Frank, eds.
2002 *Infertility Around the Globe: New Thinking on Childlessness, Gender, and New Reproductive Technologies*. Berkeley: University of California Press.

Jain, Kalpana
2002 *Positive Lives: The Story of Ashok Pillai and Others with HIV*. New Delhi: Penguin Books.

Jain, Sandhya
2003 *The Right to Family Planning, Contraception, and Abortion: The Hindu View*. In *Sacred Rights: The Case for Contraception and Abortion in World Religions*. Daniel C. Maguire, ed. Pp. 129–143. Oxford: Oxford University Press.

Jejeebhoy, Shireen J.
2000 Adolescent Sexual and Reproductive Behaviour: A Review of the Evidence from India. In *Women's Reproductive Health in India*. Radhika Ramasubban and Shireen J. Jejeebhoy, eds. Pp. 40–101. New Delhi: Rawat Publications.

Jordan, Brigitte
1993 *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Fourth Edition. Prospect Heights, IL: Waveland Press.

Knowlton, Amy R.

2003 Informal HIV Caregiving in a Vulnerable Population: Toward a Network Framework. *Social Science and Medicine* 56:1307–1320.

Lamb, Sarah

2000 *White Saris and Sweet Mangoes: Aging, Gender, and Body in North India*. Berkeley: University of California Press.

Leclerc-Madlala, Suzanne

2001 Virginty Testing: Managing Sexuality in a Maturing HIV Epidemic. *Medical Anthropology Quarterly* 15:533–552.

Libman, Howard and Michael Stein

2003 Primary Care and Prevention of HIV Disease: Part 1. In *HIV: First Indian Edition*. Howard Libman and Harvey J. Makadon, eds. Pp. 39–64. Philadelphia: American College of Physicians.

Lichtenstein, Bronwen

2005 Domestic Violence, Sexual Ownership, and HIV Risk in Women in the American Deep South. *Social Science and Medicine* 60(4):701–714.

Lipner, Julius J.

1989 The Classical Hindu View on Abortion and the Moral Status of the Unborn. In *Hindu Ethics: Purity, Abortion and Euthanasia*. Harold G. Coward, Julius J. Lipner, and Katherine K. Young, eds. Pp. 41–69. Albany: SUNY Press.

Lock, Margaret and Patricia Kaufert

1998 Introduction. In *Pragmatic Women and Body Politics*. Margaret Lock and Patricia Kaufert, eds. Pp. 1–27. Cambridge: Cambridge University Press.

Lock, Margaret and Patricia Kaufert, eds.

1998 *Pragmatic Women and Body Politics*. Cambridge: Cambridge University Press.

London, Andrew and Arodys Robels

2000 The Co-Occurrence of Correct and Incorrect HIV Transmission Knowledge Salvador. *Social Science and Medicine* 50(8):1267–1278.

Luginaah, Isaac, David Elkins, Eleanor Maticka-Tyndale, Tamara Landry, and Mercy Mathuri

2005 Challenges of a Pandemic: HIV=AIDS-Related Problems Affecting Kenyan Widows. *Social Science and Medicine* 60:1219–1228.

Lupton, Deborah, Sophie McCarthy, and Simon Chapman

1995 “Doing the Right Thing”: The Symbolic Meanings and Experiences of Having an HIV Antibody Test. *Social Science and Medicine* 41(2):173–180.

Lyttleton, Chris

2004 Fleeing the Fire: Transformation and Gendered Belonging in Thai HIV=AIDS Support Groups. *Medical Anthropology* 23:1–40.

MacLeod, Arlene E.

1991 *Accommodating Protest: Working Women, the New Veiling, and Change in Cairo*. New York: Columbia University Press.

MacNaughton, Gillian

2004 Women’s Human Rights Related to Health-Care Services in the Context of HIV=AIDS. *Health and Human Rights Working Paper*. Series No 5. London: Interights.

Mankekar, Purnima

1999 *Screening Culture, Viewing Politics: An Ethnography of Television, Womanhood, and Nation in Postcolonial India*. Durham: Duke University Press.

Marriott, McKim

1976 Hindu Transactions: Diversity without Dualism. In *Transaction and Meaning: Directions in the Anthropology of Exchange and Symbolic Behavior*. Bruce Kapfrerer, ed. Pp. 109–142. Philadelphia: Institute for the Study of Human Issues.

Martin, Emily

1987 *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press.

- Mill, Judy E. and John K. Anarfi
2002 HIV Risk Environment for Ghanaian Women: Challenges to Prevention. *Social Science and Medicine* 54:325–337.
- Miller, Elizabeth
2002 What's in a Condom? HIV and Sexual Politics in Japan. *Culture, Medicine and Psychiatry* 26(1):1–32.
- Mohanty, Chandra Talpade
1991 Under Western Eyes: Feminist Scholarship and Colonial Discourses. In *Third World Women and the Politics of Feminism*. Chandra T. Mohanty, Anna Russo, and Lourdes Torres, eds. Pp. 51–80. Bloomington, IN: Indiana University Press.
- NACO (National AIDS Control Organization)
2005a HIV Estimates: 2004. Available at < http://www.nacoonline.org/facts_hivestimates04.htm > .
- 2005b An Overview of the Spread and Prevalence of HIV=AIDS in India. Available at < http://www.nacoonline.org/facts_overview.htm > .
- Oakley, Ann
1984 *The Captured Womb: A History of the Medical Care of Pregnant Women*. New York: Basil Blackwell.
- Obbo, Christine
1995 Gender, Age, and Class: Discourses on HIV Transmission and Control in Uganda. In *Culture and Sexual Risk: Anthropological Perspectives on AIDS*. H. T. Brummelhuis and G. Herdt, eds. Pp. 79–95. Amsterdam: Gordon and Breach Publishers.
- Ogden J. and L. Nyblade
2005 *Common at Its Core: HIV-Related Stigma across Contexts*. Washington, D.C.: International Center for Research on Women (ICRW).
- O'Neil, John, Treena Orchard, R. C. Swarankar, James Blanchard, Kaveri Gurav, and Stephan Moses
2004 Dhanda, Dharma and Disease: Traditional Sex Work and HIV=AIDS in Rural India. *Social Science and Medicine* 54(4):851–860.
- Painter, Thomas
2001 Voluntary Counseling and Testing for Couples: A High-Leverage Intervention for HIV=AIDS Prevention in Sub-Saharan Africa. *Social Science and Medicine* 53:1397–1411.
- Pigg, Stacey Leigh
2001 Languages of Sex and AIDS in Nepal: Notes on the Social Production of Commensurability. *Cultural Anthropology* 16:481–541.
- Puri, Jyoti
1999 *Woman, Body, Desire in Post-Colonial India: Narratives of Gender and Sexuality*. New York: Routledge.
- Quinn, Thomas C. and Julie Overbaugh
2005 HIV=AIDS in Women: An Expanding Epidemic. *Science* 308(5728): 1582–1583.
- Raheja, Gloria and Ann Gold
1996 *Listen to the Heron's Words: Reimagining Gender and Kinship in North India*. Berkeley: University of California Press.
- Ragone, Helena
1994 *Surrogate Motherhood: Conception in the Heart*. Boulder, CO.: Westview Press.
- Rapp, Rayna
2000 *Testing Women, Testing the Fetus: The social impact of amniocentesis in America*. New York, NY: Routledge.
- Schoepf, Brooke Grundfest
1992 *Women at Risk: Case Studies from Zaire*. In *The Time of AIDS: Social Analysis, Theory, and Method*. Gilbert Herdt and Shirley Lindenbaum,

eds. Pp. 259–286. Newbury Park, CA: Sage.

Seizer, Susan
 2005 *Stigmas of the Tamil Stage: An Ethnography of Special Drama Artists in South India*. Durham: Duke University Press.

Shilts, Randy
 1988 *And the Band Played On: Politics, People, and the AIDS Epidemic*. New York: Penguin Books.

Siegel, Karolynn and Eric W. Schrimshaw
 2000 Perceiving Benefits in Adversity: Stress-Related Growth in Women Living with HIV=AIDS. *Social Science and Medicine* 51(10):1543–1554.

Singer, Merrill
 1994a The Politics of AIDS: Introduction. *Social Science and Medicine* 38: 1321–1324.
 1994b AIDS and the Health Crisis of the U.S. Urban Poor: The Perspective of Critical Medical Anthropology. *Social Science and Medicine* 39:931–948.

Sontag, Susan
 1989 *AIDS and Its Metaphors*. New York: Farrar, Strauss and Giroux.

Thandaveswara, Sri
 1972 The Bearing of Traditional, Cultural, Social, and Moral Attitudes on the Ethical Issues in Abortion: A Hindu View. *Bulletin of the Christian Institute for the Study of Religion and Society* 19(2): 24–32. Bangalore: Christian Institute for the Study of Religion and Society.

TANSACS (Tamil Nadu State AIDS Control Society)
 2003 *Annual Report 2003–04*. Chennai: Government of Tamil Nadu.
 2004 PPTCT (Prevention of Parent to Child Transmission of HIV): A Report, 2003. Chennai: TANSACS. Government of Tamil Nadu.

UNAIDS
 2005 Available at < <http://www.unaids.org/EN/Geographical+Area/by+country/botswana.asp> > and < <http://www.unaids.org/EN/Geographical+Area/by+country/south+africa.asp> > .

Van Hollen, Cecilia
 2003 *Birth on the Threshold: Childbirth and Modernity in South India*. Berkeley: University of California Press.
 2005 Nationalism, Transnationalism, and the Politics of “Traditional” Indian Medicine for HIV=AIDS. In *Asian Medicine and Globalization*. Joseph Alter, ed. Pp. 88–106. Philadelphia: University of Pennsylvania Press.

Verma, Ravi K., Pertti Pelto, Stephen Schensul, and Archana Joshi, eds.
 2004 *Sexuality in the Time of AIDS: Contemporary Perspectives from Communities in India*. New Delhi: Sage.

Wojcicki, Janet and Josephine Malala
 2001 Condon Use, Power and HIV=AIDS Risk: Sex-Workers Bargain for Survival in Hilbrow=Joubert Park=Berea, Johannesburg. *Social Science and Medicine* 53:99–121.

World Vision
 1998 *Population and Poverty: What’s the Connection? Topic Sheet*. Education Services Bureau, World Vision. Melbourne, Australia. Available at < www.worldvision.com.au/resources/files/populationpoverty_9811.pdf > , viewed 15 March, 2006.

Yadav, Priya
 2001 HIV Positive Women Prefer Abortions. *Times of India*, 13 May (cited in de Bruyn 2003).

Zurbrigg, Sheila
 1984 *Rakku’s Story: Structures of Ill-Health and the Source of Change*. Bangalore, India: Center for Social Action.