

2010

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Recommended Citation

Van Hollen, C. (2010). HIV/AIDS and the gendering of stigma in Tamil Nadu South India. *Culture, Medicine, and Psychiatry*, 34(4), 633.

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HIV/AIDS and the Gendering of Stigma in Tamil Nadu, South India

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Abstract

Drawing on the seminal theoretical work on stigma by Goffman, this article analyzes stigma through the lens of Parker and Aggleton, who call for the joining of Goffman and Foucault to better grasp relationships among stigma, power and social inequality. Studies on the social impact of HIV/AIDS globally have demonstrated that women tend to be blamed for the spread of HIV/AIDS, and as a result, HIV-positive women face greater stigma and discrimination than HIV-positive men. Based on ethnographic research among 50 HIV-positive women in South India in 2002–2003 and 2004, my research supports this standard argument. However, my findings suggest that the gendering of stigma and discrimination is more complex and context specific. The gendering of stigma varies depending on the social context of private versus public spheres. The tendency to stigmatize women is due in part to cultural constructions of gendered bodies and not only to a gendered double standard of sexual morality, as has been previously reported. Even when a cultural argument about women's wayward sexuality is evoked, this rhetoric must be understood in part as a strategy to mask economically motivated responses, rather simply being attributed to sexist ideology per se.

Introduction

Pulli Raja had become a household name in Chennai by the end of 2003. Like his Mumbai counterpart known as Balbir Pasha, Pulli Raja was a fictitious character created by Population Services International's (PSI) media blitz HIV prevention campaign launched under the aegis of the Tamil Nadu State AIDS Control Society in September 2003. This "self risk perception" social marketing campaign, which targeted men between 18 and 34 years of age from lower socioeconomic groups, began with what in media-speak is called a "teaser," in this case an advertisement placed on giant hoardings (billboards), posters and television screens, posing the question: "Pulli Rajakku AIDS Varumaa?" ("Will Pulli Raja Get AIDS?"). This simple question created speculation: Who is Pulli Raja? Why might he get AIDS? Will he get AIDS? Follow-up ads provided further questions and, finally, information about abstinence, fidelity and condom use with stylized, stereotyped images of female commercial sex workers hovering as the threat to married men and their wives. Members of some women's organizations in Chennai complained that these ads were sexist, that they portrayed women—particularly female sex workers—in a negative light and that this served to perpetuate the social perception that ultimately women are to be blamed for the spread of HIV/AIDS in India.¹

By the time that I arrived in Chennai, the capital of the South Indian state of Tamil Nadu, in January 2004 to spend 6 months on a research project on HIV/AIDS and gender, I discovered that I had just missed the Pulli Raja ads, since women's organizations had successfully put an end to the campaign. Although the Pulli Raja hoardings had been painted over, the perception among members of some women's organizations (especially HIV-positive women's organizations) that women in India bear the brunt of the stigma and discrimination that have crested in the wake of the HIV/AIDS epidemic was still very palpable.

As the medical anthropologists Arthur Kleinman and Paul Farmer (2001) wrote in the early years of the HIV/AIDS pandemic:

All illnesses are metaphors. They absorb and radiate the personalities and social conditions of those who experience symptoms and treatments.... The way in which a person, family, or a community responds to AIDS may reveal a great deal about core cultural values. (353–356)

Gender ideologies and gendered social relationships are brought into sharp focus when examined through the lens of HIV/AIDS worldwide. This is of course glaringly apparent when we consider that HIV prevalence rates

among women are outstripping rates among men in most parts of the world. 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 women as a group are economically more vulnerable than men (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). According to India's National AIDS Control Organization (NACO), during the time of my research in 2004, approximately 39% of all people living with HIV/AIDS in India were women (NACO 2005).² Dr. Suniti Solomon, one of the leading experts in the treatment and care of HIV/AIDS patients in India, told me that, based on her clinical experience, the spread of HIV to women was increasing, and she predicted that HIV prevalence among women in India would soon catch up to, and later exceed, rates for men for the same reasons mentioned above.³ However, NACO's report from 2008 to 2009 suggests that the HIV adult prevalence rate among adult women still lags behind that of adult men in India (NACO 2009, 5).

Gender ideologies and gendered social relationships are also made apparent when we explore the gendering of stigma and discrimination of people living with HIV/AIDS. Like the women who were protesting the Pulli Raja ads in Chennai, scholars studying the social impact of HIV/AIDS globally have argued that women tend to be blamed for the spread of HIV/AIDS, and as a result, HIV-positive women face greater stigma and discrimination than HIV-positive men (Ogden and Nyblade 2005, 23; Bond et al. 2003, 9). As I discuss below, this is usually attributed to a double standard that prevails in most societies, including India, which expects women to be the bearers of morality, particularly in the realm of sexuality, while giving men greater license to breach norms of sexual morality.

Although much of my research in Tamil Nadu supports this standard argument, my findings suggest that the gendering of stigma and discrimination in response to HIV/AIDS is more complex and context-specific. Many women living with HIV told me that the different nature of stigma and discrimination experienced by men and women varies depending on the social context. In particular, they pointed out that the gendering of stigma operates differently in the private versus public spheres so that in fact in the public sphere, people are more sympathetic toward HIV-positive women than to HIV-positive men, but women do not necessarily appreciate this sympathy. Furthermore, my research in Tamil Nadu also suggests that the tendency to stigmatize women more than men is due in part to cultural constructions of gendered bodies and not only to a gendered double standard of sexual morality. And finally, I also suggest that even when a cultural argument about women's wayward sexuality is evoked to discriminate against women within the family, this rhetoric must be understood in part as a strategy to mask economically motivated responses, rather than simply being attributed to sexist ideology per se. This paper thus reveals these complex ways in which gender, HIV/AIDS and stigma are intermeshed in Tamil Nadu South India.

Understanding how gender relates to HIV/AIDS-related stigma in a particular sociocultural context is not merely an exercise in cultural analysis for the sake of better understanding gender, but also of critical importance for policymakers as they develop programs for the care and treatment of HIV-positive people, as well as for HIV prevention, since stigma itself is known to be a major obstacle to prevention. Erving Goffman (1963) wrote that the discrimination resulting from stigma has the effect of reducing "life chances" for the stigmatized (5). To study stigma is, therefore, one way of understanding the unequal distribution of "life chances." This is a key point to keep in mind in this paper, especially in light of the fact that the HIV/AIDS disease itself already reduces "life chances," without the added factor of stigma-based discrimination. The compounding of the effects of the disease and the stigma-based discrimination was particularly acute among the people involved in my study since many of them were people living in poverty who had very little access to medical treatment for HIV/AIDS and little, if any, financial savings. Richard Parker and Peter Aggleton have argued that the majority of social scientists studying HIV/AIDS-related stigma have tended to theorize stigma in overly individualistic, psychological ways and have selected those aspects of Goffman's work on stigma that support their approach. Instead, Parker and Aggleton (2003) suggest a different reading of Goffman and a joining of the work of Goffman and Foucault to reconceptualize stigma as a social process that "plays a key role in producing and reproducing power and control.... Ultimately, therefore, stigma is linked to the workings of social inequality" (16). When we approach stigma thus, they argue,

it becomes possible to understand stigma and stigmatization not merely as isolated phenomenon, or expressions of individual attitudes or of cultural values, but as central to the constitution of the social order. (17)

The study of gender and HIV/AIDS-related stigma thus must be situated at the center of social theory, in particular, of theories of power.

Methodology and Profile of the HIV-Positive Women Interviewed

This paper is part of a larger project on women and HIV/AIDS in Tamil Nadu, which is based on research conducted for 6 months in 2004 and 1 month in 2002–2003. I conducted ethnographic interviews with 50 women living with HIV/AIDS, most of whom I met through organizations called “Networks,” which are advocacy and self-help groups run by and for people living with HIV/AIDS. I met with members of these Networks in Chennai, Namakkal (the center of the trucking industry in South India) and Coimbatore (a major industrial city). I also met some women living with HIV/AIDS in public maternity hospitals and some through an NGO called Zonta Resources, outside of Chennai. I did participant observation in support group meetings, public hearings and legal literacy and media workshops. In addition, I met with policymakers (in Chennai and Delhi) and with people working for international and local nonprofit organizations involved in HIV/AIDS prevention and treatment programs. Finally, I met doctors and counselors at the Government Hospital for Thoracic Medicine in Tambaram and at the private YRG Care hospital (both near Chennai), as well as in government maternity hospitals with HIV prevention programs.⁴

The 50 women living with HIV whom I interviewed came primarily from the lower socioeconomic segment of society. This is due in part to the methodology that I used to make contact with these women since very few middle- or upper-class women 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 since HIV is known now to disproportionately affect people living in poverty (Singer 1994a, b; Farmer 1999). Fourteen of the women I met were living in institutional centers such as the Zonta Resource Center or a World Vision home (or were unemployed but temporarily supported by World Vision)s and therefore did not have any household income. Two other women were homeless, engaged in sporadic commercial sex work and had no steady household income. Of the remaining women, the average total household income was Rs. 4,643 per month. This is the equivalent of US\$106 per month, or US\$ 1,272 per year.⁶ Twenty-four of the women I interviewed had some kind of employment. Several of the women who were employed were working for the Networks, and two worked as counselors in the government’s Prevention of Parent to Child Transmission program in maternity hospitals. Others had low, daily-wage jobs in factories. The remaining 26 women either identified themselves as “housewives” or were unemployed because they were being supported by institutions.

The 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. Fifteen (30%) of these women reported that they had never received any formal education. The average level of education of all 50 was the seventh standard (seventh grade).⁷ Most women came from lower-caste, dalit communities. Thirty-four of the women were Hindus. Fifteen were Christian, fourteen of whom had recently converted from Hinduism.⁸ One woman was a Muslim. The average age of these women was 30.⁹ Most had been married at some point (80% had arranged marriages; 20% had “love” marriages), yet slightly more than half were already widows of husbands who had died due to HIV/AIDS. Some women were in their second marriages when I met them. Twelve of the women had a history of commercial sex work (including some who were married at the time of the interviews). Thirty-seven (74%) of the women had children; 13 (26%) were childless, representing an exceptionally high rate of childlessness given the sociocultural context that places a premium on motherhood and in which the expectation is that a woman should bear a child as soon after marriage as possible.

The focus of this paper is on heterosexual HIV-positive women’s own perspectives on the gendering of stigma. This obviously results in biased opinions, and interviews among HIV-positive heterosexual men or among men and women with nonheterosexual sexual identities, including “third-gender” groups (such as hijras), would undoubtedly reveal different viewpoints. Furthermore, studies based on observations of social interactions of HIV-positive men and women within households and in public contexts would further yield a more nuanced perspective than a study, such as this one, based primarily on interviews. Finally, due to my recruiting method, a disproportionate number of the women interviewed were in one way or another associated with Networks and, therefore, had been influenced by a transnational discourse of rights of people living with HIV/AIDS and, more specifically, a transnational, feminist discourse critiquing the discrimination against the rights of women living with HIV/AIDS. This, too, no doubt results in a bias in the comments of my informants, and research with a larger pool of women who were not affiliated with Networks might bear different ethnographic data. These methodological limitations do not, however, invalidate the importance of understanding the perspective of the sample of 50 HIV-positive women in Tamil Nadu in this study.

Theorizing Stigma

Erving Goffman's (1963) book, *Stigma: Notes on the Management of Spoiled Identity*, still stands as one of the most important theoretical analyses of the sociology of stigma. His work is arguably better known today than ever, since it is referenced not only by academic social scientists, but also by the swelling number of individuals and institutions engaged in HIV/AIDS prevention and care programs around the globe. This is so because the dominant social responses to HIV/AIDS documented globally have been accusation, stigma and discrimination (Shilts 1988; Sontag 1989; Farmer 1992; Goldin 1994; Ogden and Nyblade 2005). Jonathan Mann, the Director of the World Health Organization's former Global Programme on AIDS, considered stigma itself an epidemic in need of controlling (Mann 1987, as cited in Parker and Aggleton 2003, 13).

Goffman defines stigma as a "social identity" and an "attribute that is deeply discrediting" which emerges through social interactions. Such a discredited individual is "reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman 1963, 2–3) and is differentiated from "normals" to the degree that "we believe the person with the stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances" (5).

Goffman views stigma as a fluid, contingent identity that is constantly created, recreated, resisted and transformed through social practice. Reading Goffman through the lens of Parker and Aggleton (via Foucault), the social negotiation of such interactions should be seen as a struggle over the power to determine the parameters of normalcy and, thus, of the social order. This is not to say that the stigmatized necessarily resist their stigmatization. In fact, Goffman clearly demonstrates how the stigmatized often internalize the stigma and thus participate in the reproduction of categories of normal and nonnormal even to the detriment of their own lives. Parker and Aggleton (2003) argue that Bourdieu's notion of "symbolic violence" and Gramsci's concept of hegemony are both important theoretical concepts to help us understand this phenomenon whereby individuals collude in their own stigmatization and, thus, their own oppression (18).

Goffman (1963) makes an important distinction between "discredited" and "discreditable" persons, where the former applies to individuals whose "differentness" is obvious through social interactions and the latter applies to those whose "differentness is not immediately apparent" (42). HIV-positive people, particularly those who have not yet developed AIDS, typically belong to this category of "discreditable" people who must constantly "manage information" such as "to display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and to each case, to whom, how, when and where" (42). In the ethnographic examples provided in this paper, these concerns are glaringly apparent.

Goffman addresses many conditions that give rise to stigma, including such physical traits as being blind, deaf or crippled, as well as behaviors that are morally condemned by society, such as engaging in prostitution or being a criminal. The HIV/AIDS disease has proven to be a stigmatizing condition on both accounts, both because of the (largely unfounded) fear of physical contagion associated with the disease and because of the moral issues that it evokes. Stigma has also been found to be more pronounced when it is associated with a condition that is incurable, such as HIV/AIDS (Ogden and Nyblade 2005). Since the modes of transmission of HIV include taboo topics and practices of sex and drug use, the moral accusations associated with this illness have been rampant around the globe.

The association between HIV/AIDS and immorality has been acute in India (Dube 2000; Jain 2002). In fact, when HIV/AIDS was first detected in India in 1986 in the case of a commercial sex worker in Chennai, many government officials and citizens were slow to respond with prevention efforts due to a belief that because India, as a society, had higher moral standards (compared to the United States and parts of sub-Saharan African, for example), this disease would not pose a threat to the country (Dube 2000; Jain 2002; Panda et al. 2002). Some feel that India is now paying the price of this initial self misrepresentation and denial of the reality of sexual practice in India, since the country is now home to 2.4 million people living with HIV/AIDS. This ranks India as the country with the third largest HIV-positive population worldwide, following South Africa and Nigeria (UNAIDS 2008).

As in most parts of India, in Tamil Nadu (one of the states hardest hit by the epidemic), HIV/AIDS is interpreted predominantly through a lens of the morality of sex. The proscribed norm in Tamil Nadu is that sexual relationships should be confined to marriage. Sex before marriage and extramarital sexual relationships are culturally defined as immoral. [Recent studies have revealed that sexual practice does not always conform to these normative ideals in India (Goparaju 1998; Puri 1999; Jejeebhoy 2000; Verma et al. 2004)]. The English translation used for the Tamil phrase for pre- and extramarital 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 out of wedlock) and is therefore to be blamed for having this disease.

Despite Goffman's detailed analysis of the processes of managing stigma in social interactions, he does not address the fact that the experiences of stigma vary among people with the same condition, depending on various categories of social identity, such as gender, ethnicity, class and sexuality. These differences can sometimes be pronounced, again underscoring the relationship between stigma and the production of social inequality.

As mentioned above, scholars writing about gender and HIV/AIDS-related stigma in other parts of the world have reported that HIV-positive women carry a disproportionate stigma burden vis-a-vis HIV-positive men. For example, based on a comparative analysis of HIV/AIDS-related stigma in Ethiopia, Tanzania, Zambia and Vietnam, Jessica Ogden and Laura Nyblade (2005) write, "HIV-positive women tended to be more highly stigmatized than men" (23). And they explain this phenomenon thus:

Given the close associations between HIV and moral impropriety, the findings in all sites that the harshest stigma is reserved for those expected to uphold moral laws and the moral fabric of society should not be surprising. In all sites, for example, HIV-positive women tended to be more highly stigmatized than men. (23)

In another study on HIV/AIDS-related stigma conducted in Zambia, Bond et al. (2003) wrote, "Women are more susceptible to, and impacted by, HIV related stigma" (9). They argue that women living with HIV/AIDS are stigmatized not only because of the association between HIV/AIDS and improper sexuality, which falls outside of the acceptable cultural script for women, but also because it renders women "everything they should not be." As they explain,

Women living with HIV and AIDS (or more often, suspected to be living with HIV and AIDS) are regarded as everything they should not be – sick and slim when they should be healthy; being cared for when they should be caring for others; sexually deviant when they should be sexually righteous. To be HIVpositive is not to be a proper woman. (45)

During my research in Tamil Nadu, women members of the Networks with which I was involved in Chennai, Namakkal and Coimbatore frequently made the same argument. They explained to me that due to a double standard of sexual mores, women tend to be blamed for tahaata udaluravu more than men and that, since HIV is assumed to result from this, HIV-positive women often tend to face greater stigma and discrimination than HIV-positive men.¹⁰ This paper proceeds with an analysis of interviews with women who supported this viewpoint and then moves onto a discussion of other perspectives presented to me in order to highlight the need to complicate this standard argument.

Engendering Stigma Part I: "Women Face Greater Stigma Than Men"

One of the questions that I asked women during my interviews was, "Is there a difference between how society treats HIV-positive women vs. HIV-positive men? If so, what are those differences, and why do you think such differences exist?"¹¹ I analyze women's responses to this question while situating their responses within the context of their life histories, particularly as their life histories intersect with HIV/AIDS. My focus is, therefore, on women's own perceptions of this issue while trying to understand how their perceptions corresponded to or departed from their own personal experiences.

Some women's responses clearly supported the argument made by others, such as Ogden and Nyblade, as well as Bond et al., that HIV-positive women face greater stigma and discrimination than HIV-positive men. For example, Vijaya,¹² whose first husband had died from AIDS and who had discovered her HIV-positive status when she became pregnant with her second husband's child, explained:

Members of society will treat HIV-positive women worse than they treat HIVpositive men because if a woman is HIV-positive they say that she is immoral (tappu) but they don't say that about men. For me, the fact that I got HIV from my first husband was demeaning. Now that I am HIV-positive and my new husband is HIV-negative it is impossible to explain that to the village without the other villagers thinking that I am immoral (tappu).¹³

Following a pattern of levirate kinship, after the death of her first husband, Vijaya's parents had arranged a second marriage with the brother of her first husband. These two brothers were distant relatives of hers, which is not uncommon, given the Tamil cultural practice of cross-cousin marriage. Her second husband was extremely supportive and caring toward Vijaya through the trauma of learning of her status and continuing with childbirth. She

felt that perhaps her husband's unequivocal support for her was a result of the fact that he knew that his brother had died of AIDS and he recognized that it was because of his own brother that she had contracted HIV. Though her husband was supportive, she felt that others in the village were not at all prepared to accept her situation, that it was problematic enough to be an HIV-positive woman, but to be an HIV-positive woman married to an HIV-negative man could only bring scorn to her and to her family. So, to prevent anyone from knowing, she had never even informed either her own parents or her husbands' parents about her status. Such lack of communication with or awareness of both sets of parents about one's HIV status was a situation that was atypical in my research.

Like Vijaya, Angamma felt that HIV-positive women were stigmatized more than HIV-positive men. Her husband was a lorry driver whom she described as a heavy drinker. She said that she knew without a doubt that he was having affairs with several women. When she saw posters about HIV/AIDS on the outside walls of a government hospital, she realized that she herself had many of the symptoms listed on the poster, including herpes and eczema, and she became very worried, especially since she had two relatives who had died of AIDS.

She had visited a potter for treatment of the herpes and the potter had smeared mud and chicken's blood on her body but that had not cured her so she then consulted an allopathic doctor. The doctor would not treat her herpes unless she agreed to have an HIV test. The doctor said that if she treated Angamma and the herpes went away, Angamma would never come back for an HIV test and it was critical to get an HIV test. Angamma, however, was concerned that if she tested HIV positive without having her husband tested, her husband would blame her for the HIV. Her husband refused to get tested and so Angamma's herpes went untreated for the time being.

Eventually, Angamma's husband developed such severe sores on his mouth that he was unable even to eat. At that time, Angamma and her husband were living with her husband's sister and brother-in-law, who helped Angamma's husband get an HIV test but kept the positive test result secret from Angamma. When her husband stopped speaking to Angamma, and when his mother, his brother and his brother's wife suddenly came to visit them for no apparent reason, she grew increasingly suspicious. One day, while her husband was sleeping, she saw what looked like a receipt sticking out of his pocket. She removed it from his pocket and saw the HIV-positive test result. After telling him that she knew of his HIV-positive status, she went back to the doctor and agreed to get tested herself. She also took their two-and-a-half-year-old son to get tested. Though she was positive, her son was HIV negative.

Her husband asked her to take their son, leave his house and return to her parents' home. She, however, was too ashamed to go back home, even though her parents knew about her HIV status and wanted her to come home. Her husband drank more and more and became disruptive to the household so that finally his sister sent them away to live on their own. Living on their own, her husband became increasingly violent, and when her parents heard about this, they insisted that she come back home and that they would take care of her and their grandson. Finally, with the acceptance of the village panchayat, she left her husband, returned to her parents' house and filed for a divorce.

When I asked her whether society treats HIV-positive women differently than HIV-positive men, she replied:

Society is more unkind to HIV-positive women. The women are condemned and blamed more. My parents-in-law never scold their son. But they often ask me: "In which inauspicious time did our son marry you?" [i.e., astrologically speaking] and say that I have brought HIV and all these problems into the family. Gossip is also much more focused on HIV-positive women than on positive men. People always say: "She was so good and so well once upon a time. But now look what has become of her."

In another case, Saraswati discovered that she was HIV positive through prenatal testing when she was 5 months pregnant with her first child and her husband tested positive shortly thereafter. When I asked if her in-laws had been supportive of her and her husband, she said:

They only created problems. They blamed me for having infected him. My husband would join his mother in accusing me. Once I tried to jump into a well. I climbed down the ladder steps of a well. I was going to jump in. But when I reached the last rung, at the last moment, I got scared and thought of my son.

Saraswati herself had reason to believe that her husband knew of his HIV status even before their marriage since he had been taking medication from the Majeed clinic in Kerala, a clinic known primarily for its Ayurvedic treatments to "cure" HIV/AIDS (Van Hollen 2005). However, Saraswati did not make this connection until after her HIV-positive diagnosis.

After her marriage, Saraswati had moved into her in-law's home with her husband, following the patrilocal tradition. For the birth of her child, she moved temporarily to her own parents' house and she stayed with them for a few months after the birth, as is customary in Tamil Nadu. Her parents and sister, who knew of her HIV-positive

status, asked her to stay with them even longer so they could take care of her. But rather than remain with them, she felt that because of her HIV-positive status she would now be a liability to her family in their efforts to arrange a marriage for her younger sister. She returned to her in-laws' home, and despite the fact that her in-laws and her husband jointly made her life miserable by blaming her for having infected her husband, she resolved not to return home until her younger sister was married. She even attempted suicide once rather than going home and jeopardizing her sister's future. In the end, her husband died of AIDS before her sister was married and so, she said, she had no choice but to return to her parents' home with her son.

This case not only points to that fact that in-laws often blame the daughter-in-law for infecting their son, despite evidence to the contrary, but also demonstrates the very powerful way in which stigma comes to attach itself not only to the individual who has the discrediting trait, but also to others with whom one has close social connection. In this case, we see how the stigma threatens to extend to Saraswati's sister, possibly preventing her parents from finding a suitable spouse. As Goffman (1963, 30) writes:

In general, the tendency for a stigma to spread from the stigmatized individual to his close connections provides a reason why such relationships tend either to be avoided or to be terminated, where existing.

It is interesting to see that in Saraswati's case, it was she herself who seemed most concerned about avoiding contact with her sister, whereas the sister and her parents wanted Saraswati to stay with them so that they could take care of her. Goffman (1963, 7) also pointed out that indeed it is often the stigmatized person who internalizes the stigma with the most vigor, leading to feelings of shame, selfhate and self-derogation.

Vasuthi's case also demonstrates the idea that stigma attaches itself to those people with whom one has close connections. Like Saraswati, Vasuthi thought her husband probably knew of his HIV-positive status before marriage and said that her suspicions were supported by her neighbors' reports that her husband had been frequently sick before he was married. When I asked if she thought premarital HIV testing was a good idea, she said:

Yes, it is a good idea. But there will be many problems. If the girl or boy tests HIV-positive, all the siblings will be under suspicion. If there are younger sisters or brothers, then their marriages will also get affected. The family name will suffer. So it is better not to test.

Vasuthi contracted herpes soon after marriage but had received treatment for that and had been cured. Three months after their marriage in 2000 Vasuthi's husband received an HIV-positive test at a private lab and he took her there to get tested as well, though he never explained what she was getting tested for. Her test also came back positive, but even though her husband's parents and her own mother, sister and sister's brother were informed about the HIV-positive status, Vasuthi herself would not come to know about this until one and a half years later, long after her husband had already died from AIDS. Her husband died 1 month after having the test, just 4 months after they were married. She said that her parents had kept the news secret from her for fear that she might have committed suicide if she had known.

Soon after her husband's death, Vasuthi began having problems with her mother-in-law so she returned to her mother's house and stayed there. Although she did not have formal nursing training, she was able to get a job doing nursing work for a doctor in a hospital. One day the doctor there told her that she had to get a blood test to test her blood sugar levels. As it turned out, he was getting her tested for HIV, and when the result came back positive, he terminated her job and told her that she would die within a year or two. Eventually, she was able to get better counseling and treatment and joined a Network for HIV-positive people, and since she had nursing experience she was soon able to get a job as an outreach health worker with the Network. It was through this job that she met and fell in love with a man who was working for an HIV/AIDS prevention nongovernmental organization (NGO), and even though he was HIV negative, they soon got married. She said that they were planning to adopt children in the future.

When I asked Vasuthi if she thought there were differences in how society treats HIV-positive women versus HIV-positive men, she explained:

In my own experience, this has not been the case. But in my fieldwork experience, I find that 90 percent of the time the family will blame the wife and say that it is because of the wife that HIV has come to the husband. Only in a few houses will people have pity [paavam] for the wife, saying that the husband gave HIV to the wife.

And when I asked her why she thought people had this reaction, she explained:

People usually say that HIV/AIDS is a *pombalai viyaathi* [colloquial for “woman’s disease”]. They see that in advertisements. So maybe that’s why people act and think like that. In many areas where I go, people will ask me about *pombalai viyaathi*. People say that this disease comes because of the woman. That’s what they think. They don’t understand. Lots of people say that it comes when women have sex.

Vasuthi’s comment that HIV/AIDS is considered to be a “woman’s disease” was echoed by several people whom I met in Chennai, Namakkal and Coimbatore. Women’s bodies were always considered to be the original host for HIV/AIDS, and the disease was associated with sexually promiscuous women, particularly with prostitutes (*virpenn/vilaimaathu*). Another Tamil phrase sometimes used to refer to the disease was “*suhanoy*,” which literally means disease of pleasure and, again, connotes that it is a disease that men get when they engage in pleasure with women. The relationship between morality and the healthy body are announced through this term, serving both as a warning and as a legitimation of the suffering that ensues from too much pleasure, particularly pleasure that does not serve a reproductive function. All sexually transmitted diseases (STDs) come to be viewed under this rubric of *suhanoy* and, by extension, are considered by some ultimately to be *pombalai viyaathi*. Since HIV/AIDS is considered to be a *pombalai viyaathi* and since *pombalai viyaathi* is linked to *suhanoy*, STDs and prostitution, HIV-positive women are easily accused of improper sexuality and of being the original source of this *pombalai viyaathi* that has spread from wayward woman (including wife) to husband. Thus, this particular view of women’s bodies versus men’s bodies must be considered as one reason for the unequal distribution of HIV-related stigma for HIV-positive women.

One would expect that since most HIV-positive husbands were dying long before their wives did, it would be inconceivable that families would argue that the wife was responsible for spreading HIV to her husband. The evidence to the contrary seems incontrovertible. Although the average age of the HIV-positive women I interviewed was 30, over 50% were already widows whose husbands had died from AIDS. It was typically while their husbands were on their deathbeds or after they had already passed away that the in-laws would blame these women and accuse them of having been promiscuous and of transmitting the disease to their sons. From a biomedical perspective on the relationship between HIV/AIDS and the relatively long incubation period in which HIV-positive people remain asymptomatic, it is likely that in most cases the reason the husbands died years before their wives even got sick was that the husbands had contracted HIV long before their wives and the virus had had more time to develop into AIDS. But medical anthropologists have pointed out that people throughout the world often hold multiple systems of knowledge about illness and the body simultaneously and draw from these different knowledge systems to make sense of illness in a variety of contexts.

Indeed, some women whom I interviewed provided a different explanation for the earlier deaths of their husbands. According to these women, HIV/AIDS progresses much more slowly in women and is less damaging to women’s health because women partially rid themselves of HIV every month through menstruation, whereas men do not. Furthermore, I was told that when women give birth, they purge themselves of even more of the disease than through their monthly periods. This flow of women’s blood is culturally viewed as a ritually “polluting” process and much has been written about this particular cultural construction of the body (Ferro-Luzzi 1974; Jeffery et al. 1989; McGilvray 1994). But whereas anthropologists writing about menstrual and childbirth “pollution” have typically focused on the polluting nature of this bodily process while it is occurring, the comments of these HIV-positive women point to the view that, although “polluting” during the time of the blood flow, the end result is that women are purified through this process and that their regular bleeding brings with it the possibility of restored health. This idea is supported by studies by Mark Nichter and Mimi Nichter (1996), anthropologists working in South India and Sri Lanka, who write that women are perceived as being most “pure” immediately following menstruation (5). Adhitya Bharadwaj’s (2011) research shows that this idea has a textual basis in the Hindu legal codes of Vasishtha, Manu and Vishnu.

Interestingly, this idea finds parallels in Victorian American conceptions of menstruation described by Carol Smith-Rosenberg (1985, 189), in which menstruation is considered to promote health through purging, but in that case the emphasis was on the purging of the contagion of the blood itself, which was, in Judeo-Christian folklore, said to be women’s punishment for Eve’s sins. Emily Martin (1987) also noted an historical shift away from a view of menstruation as being beneficial to women’s health, because of its role in releasing heat and balancing hot-cold properties of the body, in premodern Europe to a view of menstruation as pathological in the industrialized West, culminating in the medicalization of the “premenstrual syndrome.” Despite the very general similarities about the beneficial role of menstruation in maintaining women’s health, the HIV-positive women in Tamil Nadu’s perspectives differed from these earlier European and American cultural constructs insofar as the Tamil women were suggesting that some amount of the disease itself exits the body with each flow. During educational presentations by counselors in hospitals and in Network support group meeting, I frequently heard HIV referred to

as “HIV-kirumi.” Kirumi can be literally translated as a “worm” or “maggot” (Winslow 1979) but it is also a term used in colloquial medical conversations to refer to what could be glossed as “germs” or even “microbes” (Cre-A 1992). Through blood flow, women are felt to be able to flush out some of this HIV-kirumi. Men’s bodies, however, do not have such a mechanism, and, consequently, HIV-positive women are felt to outlive their male counterparts. Because of this cultural construction of gendered bodies, the earlier deaths of the husbands do not necessarily prove anything about the direction of HIV transmission within the family.

One of my interviews suggested that some people in Tamil Nadu may have similar (though not identical) ideas about health benefits of sex and ejaculation for HIV-positive men. During my interview with Maliga, she repeatedly complained about her husband’s incessant demands for unprotected sex. She explained that even though they were both HIV positive, their doctor had warned them that too much sex could compromise their immune systems and that they should have protected sex since it was possible that they had different strains of the HIV virus and would not want to infect each other with yet another strain. The husband, however, did not heed the doctor’s warnings. As Maliga explained:

My husband needed sex everyday. I would refuse sometimes but would agree on some days. He would often not use condoms. I became scared when my CD4 count was 365 so I did not have sex for twenty-three days. But I could not hold out much longer. Yesterday I agreed to his demand for sex. His CD4 count is only 136. The doctor says we must eat well. My husband eats fruits when his body heat goes up. We must eat nutritiously, be clean, and we must not have too much sex. This is the advice of doctors. But my husband told me that frequent sex boosts his immune power [ethirppu shakti] and raises his CD4 count.

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.” CD4 counts of HIV-positive individuals will typically decrease over time as their immune system becomes compromised. Once a person’s CD4 count dips below 200, it is recommended that they begin antiretroviral treatment if it is available. Lawrence Cohen noted that HIV/AIDS prevention studies in India have represented Indian men, particularly truck drivers, as doubly at risk for HIV transmission due to a cultural belief that truck drivers bodies become overheated and that they must, therefore, engage in more sex to restore the proper hot-cold balance in their body. Cohen remarks that these studies seem diametrically opposed to the anthropological fascination with the value of semen retention and its ties to brahmacharya as being both spiritually and physically fortifying in South Asia (Alter 1992, 1997). Ultimately, Cohen (1997) warns that both approaches have the effect of constructing South Asian men as exotic others who seem to want to engage in either too little or too much sex, when compared with the unstated white Western norm. By quoting Maliga, I certainly do not want to fall into such Orientalizing tropes. The fact that Maliga found her husband’s demands to be excessive itself points to the lack of normativity in this case, and none of the other women I met made precisely the same comments about their husbands. Nevertheless, if it is in fact the case that Maliga’s husband thinks that sex will help his CD4 count to increase, thus reflecting the idea that, for men, sex can boost the immune system (ethirppu shakti), and if he is not alone in this thinking, then this should be addressed in prevention efforts. My research only points to this as a possibility, but further studies would need to be done to determine how prevalent such beliefs are and what their consequences might be.

The opinions of HIV-positive women in Tamil Nadu provided above support widely held assumptions that HIV-positive women face greater stigma and discrimination than HIV-positive men, that due to prevailing gender ideologies about sexuality, HIV-positive women tend to be blamed for spreading HIV to their husbands. Yet these accounts also suggest that, in addition to a double standard of sexuality in gender ideologies, we need to take seriously the fact that cultural constructions of the gendered body also play an important role in the production of disproportionate HIV-related stigma for women. Of course gender ideologies about appropriate sexual practice (among other things, including gendered ideas about purity and pollution) inform cultural constructions of the body, disease and medicine as feminist analyses of the biomedicalization have so powerfully demonstrated (Martin 1987; Davis-Floyd 1992; Ginsburg and Rapp 1995; Davis-Floyd and Sargent 1997). Nevertheless, we must appreciate how knowledge systems about the body are often assumed to be “culture-free” by people who participate in those knowledge systems. In this case, we must acknowledge that the ideas that HIV/AIDS is a pombalai viyaathi and that women living with HIV live longer than men due to menstruation and childbirth are considered to be embodied explanations and legitimations for the unequal blame and stigma attached to HIV-positive women.

Engendering Stigma Part II: “Stigma Affects Men and Women Differently”

Unlike the cases discussed above, however, the responses of several other HIV-positive women challenged presuppositions about gender, stigma and HIV/AIDS. These women differentiated the gendering of stigma for HIV-positive people within the family versus outside the family, a distinction between the public and the private, the home and the world. The similarities of these responses were striking. In short, they argued that society (samuthaayam) supports the woman but blames the man, while the family, more specifically, the husband’s family with whom these women lived after marriage, torments the women and protects the men. As Gayathri succinctly explained:

In society [samuthaayam] people look at HIV-positive women with pity [paavam] but they will say that the man is to be blamed for getting HIV and spreading it to his wife. But in the family it is different. In the family, the parents-in law will say, “It’s only because of you that our son got the disease.”

It seems that here she is speaking based on her experiences as an outreach health worker for a Network more than from her own personal experience, since her account of her husband’s experience with social contacts outside of the family does not bear her argument out. Gayathri’s husband was a lorry driver and when he became too sick to work, he had to leave his job and pawn off all of Gayathri’s jewels to make ends meet. But his fellow lorry drivers, and even his own boss, were very supportive of him, providing him first with (poorly informed) advice about Majeed’s medical treatment to cure AIDS in Kerala and later with advice about treatment through YRG Care in Chennai, and they provided constant reminders about adhering to a healthy diet. Gayathri and other people whom I met in Namakkal district suggested that because lorry drivers, as a group, had become so stigmatized, they tended to be more supportive of HIV-positive people within the public sphere of this occupational community. Gayathri said that the response from her husband’s workplace is atypical of responses to HIV-positive men in most work environments.

Gayathri’s own experience also diverged from her general statement about stigma insofar as, unlike the parents of people like Angamma or Saraswati, Gayathri’s husband’s parents were far from supportive toward him. When they learned of his HIV status, they informed him that he would not receive a share of the family property, saying that since he and his wife had HIV/AIDS, they would die soon and Gayathri’s son, who was then one a half years old, would die soon (despite the fact that the son was later found to be HIV negative). His parents said that if they gave him a share of the property, it would only end up in the hands of Gayathri’s family, so they refused. Shortly thereafter, Gayathri’s husband committed suicide by poisoning himself. The in-laws then sent Gayathri and the son back to her parents’ home, only giving her 25% of her rightful share in cash and saying that her son might be able to have access to a greater share only after he turned 18 years old. The panchayat had agreed to this arrangement. Despite these personal experiences, Gayathri’s work with other HIV-positive people led her to hold a very clear perception that, generally speaking, HIV-positive men are blamed by the public but supported within the family.

Leelavathi, who was also working for a Network in Namakkal, held the same view when I interviewed her on a separate occasion. As she put it:

Society [samuthaayam] sympathizes with HIV-positive women since they have the idea that the women got HIV from their husbands. Society blames the men who get HIV. But the in-law’s family [maamiar viidu] always blames the woman.

Like Gayathri, Leelavathi’s own experience contradicted this statement, but only to a degree and only as it pertains to the lack of support that a woman receives from her in-laws. Leelavathi’s case was unique compared to the vast majority of women whom I met insofar as she described a pronounced discrepancy in the treatment that she received from different in-laws. After the early death of her husband due to AIDS, she found her father-in-law to be one of her closest allies, advisors and confidants in her battle against her mother-in-law and brother-in-law, despite the fact that they all lived together. She explained:

My parents-in-law were very supportive of my husband and took care of him while he was sick. But I also had to sell off my jewels that were given to me at marriage in order to pay for my husband’s medical expenses. My own parents and my neighbors have been very supportive of me and my husband. They supported me after my husband’s death. The only place that I have faced discrimination as a result of my status has been in my husband’s family. My mother-in-law is not at all supportive of me. After my husband died, she said that neither I nor my two sons [both HIV negative] would receive any share of the family property. But my father-in-law

was good to me. He has three sons and he gave me my rightful share in the family property after my husband died. Since he knew there would be trouble from my mother-in-law, my father-in-law said: "Write up a document saying that you have lent money to me so that that money will now be entitled to you and I will sign it." In that way, I was able to inherit the house that my husband and I were living in separately. But my mother-in-law is still contesting this and my husband's younger brother doesn't let me make use of the property. That brother came and damaged the property. He took off the roof. The "advocate" [lawyer] whom I just met today said that I could sue since I have the will.

The lawyer whom Leelavathi is referring to was working for the High Court in Chennai and had come to Namakkal with the positive people's Networks to provide free legal aid to HIV-positive women.

Jayanthi, another HIV-positive widow and mother of two HIV-negative children who had come to work for a Network, once again gave a very similar response to my question about gender and stigma. She said:

In the society [samuthaayam] they will blame the husband, saying, "You would have gone to some other woman and got this disease. You spoiled the life of this innocent girl/woman [penn]." So the society will always take the side of the girl/woman. But the in-laws would say, "You spread this to our son."

Jayanthi said that she had seen this scenario played out repeatedly in the families of people whom she now counseled, although she said that this attitude did not apply to her own parents-in-law. After the death of her husband, she and her children had returned to live with her own parents and she had been forced to go out and get a job in a positive people's Network to support the household since her father was unemployed and her mother earned a very measly income as an ayah (maid) at a village school. She reported that all of her in-laws were emotionally supportive of her, that they would come to visit her and the children, that she was free to take her children and go to visit her in-laws and that they never blamed her for transmitting HIV to their deceased son. When I asked her if she was able to receive a share of husband's property, she said that her husband's family owned no property and they had no savings, so there was no question of inheritance. I suspect that the absence of such a property dispute was an important factor explaining why it was that none of Jayanthi's in-laws blamed her for spreading HIV to their son as was the case in many other families.

This raises an important point about the need for a nuanced interpretation of the gendering of stigma and the tendency for the husband's family to blame the incoming wife for bringing HIV to their son. The tendency to blame the incoming wife is clearly due in part to the moral guilt associated with HIV/AIDS more broadly and the desire for parents to absolve their children of moral approbation and to protect the reputation of the family lineage, including the reputation of any unmarried siblings. It may also be due in part to the cultural construction of HIV/AIDS as a "woman's disease" and therefore possible to write off as a problem introduced by the wife. But what struck me in my meetings with HIV-positive women was that this blame seemed to be most intense after the death of the son, when the woman became a widow. This can be partly explained as an emotional response to the premature loss of a son. Furthermore, it reflects what is considered to be a widespread Hindu view with textual basis that widows are inherently responsible for the deaths of their husbands—particularly premature deaths—and widowhood is, therefore, tinged with sin and is itself stigmatized (Lamb 2000). Yet it seems that the blame meted out to the HIV-positive widows in these instances was most acute when the issue of inheritance came into play. Thus it seems that the use of a gendered ideology about the wayward sexuality of women to blame HIVpositive widows for the death of their husbands may at times serve to mask a desperate attempt by families to hold onto whatever property they have and to absolve themselves of the financial responsibility of supporting a daughter-in-law and grandchildren. This financial burden is perceived to be particularly acute given the relatively low levels of education and therefore limited employment opportunities of their daughters-in-law, and given the fact that they expect the HIV-positive daughter-in-laws to soon require substantial sums of money for medical expenses and they expect the children either to require expensive medical treatment, if they are HIV-positive or to become orphaned, requiring full financial support from other family members. These are problems faced by widows more generally in Indian society, but as HIV/AIDS is spreading in India, women are increasingly becoming widowed at a young age. And as HIV/AIDS is already associated with "illegal sex," it may be convenient to place blame on a widow to exempt the family from financial responsibility.

During the time of my research in the beginning of 2004, there was no antiretroviral therapy available free of cost to treat people living with HIV/AIDS,¹⁴ and treatments for HIV/AIDS-related symptoms that were available from both "quacks" and other more legitimate practitioners (many of whom charged more for services to HIV-positive people than for HIV-negative people) often put families into deep debt. Given the fact that many of these families were already severely strapped financially, the added financial burden of caring for these widows and their

children may have seemed simply impossible to manage. The discourse of women's improper sexuality as well as the discourses of gendered bodies could be viewed as means of justifying a decision made in the face of the specter of financial ruin for the husband's family.

Just as some of the women I met noted different degrees of stigma in public versus private spheres of life, Goffman too argued that there may be differences in the degree of stigma expressed in more anonymous public spheres vs. more intimate private spheres, while also recognizing that in some circumstances stigma may be more pronounced in the public sphere, while in other instances it may be more pronounced in the private sphere. As he writes:

There is a popular notion that although impersonal contacts between strangers are particularly subject to stereotypical responses, as persons come to be on closer terms with each other this categoric approach recedes and gradually sympathy, understanding, and a realistic assessment of personal qualities take its place. The area of stigma management, then, might be seen as something that pertains mainly to public life, to contact between strangers or mere acquaintances, to one end of a continuum whose other pole is intimacy. (Goffman 1963, 51)

And yet, he suggests that this "popular notion" is not always accurate when he continues:

In spite of this evidence for everyday beliefs about stigma and familiarity, one must go onto see that familiarity need not reduce contempt.... There are sure to be cases where those who are not required to share the individual's stigma or spend much time exerting tact and care in regard to it may find it easier to accept him, just because of this, than do those who are obliged to be in full time contact with him. (53)

Those HIV-positive women who suggested that stigma varies based on the public/private divide would appreciate Goffman's understanding of the challenges that they face in their intimate familiar relationships. His counterpoint about the possibility of less stigma in the public sphere, however, suggests that the greater acceptance that HIV-positive women sometimes receive from society might have less to do with genuine sympathy and more to do with the fact that strangers are absolved from responsibility for caring, whereas the expectation is that the family will care. The burden of care, thus can exacerbate stigma, as suggested by the fact that it was often only after the deaths of their husbands that HIV-positive women in Tamil Nadu had to contend with the most extreme forms of blame and to face the greatest stigma and discrimination.

The women who stated that the gendering of stigma varies in public versus private spheres typically use the term "paavam" (pity) to refer to society's (samuthaayam) response to HIV-positive women. Outside of the in-laws' family, society is said not only to take pity on women, because they say that it is really the husband who spreads HIV to his wife, but also to take pity on the wife because of the fact that they recognize that the wife is blamed within the in-laws' family, with little means to defend herself or make claims to her rightful share of property after her husband's death.

Some women whom I met took comfort in the pity and sympathy that society provided. In fact, many women commented that, as women, they were able to receive more support from NGOs and Networks working for HIV-positive people than men were. And some men I met said that they felt more alienated than HIV-positive women since they had fewer options for support in public forums.¹⁵ And Vijaya, who was HIV positive while her husband was HIV negative, felt that she was at a distinct disadvantage since, even though her second husband was very supportive of her, it was difficult for her to be identified as innocent and receive sympathy from society due to the nature of the HIV discordance within her marriage. She would have welcomed some pity.

But not all women appreciated the pity. Some women said that pity served to reinforce their feelings of vulnerability and helplessness. Angamma, whose story was discussed above, told me:

Women who are HIV-positive are also given sympathy and viewed with pity [paavam]. We do not like that. Since women cannot talk back to others who make comments about how sad it is that we are HIV-positive, it gives people the license to discuss this and say whatever they want to a woman. But people will not speak this way to men, pointing out how terrible it is that men have HIV, because the men will speak back to them. We do not like it when people pity us. It makes us feel helpless.

Pity calls attention to the perception of abnormality for the pitied and the normality of the one who pities. As such, pity is an expression of stigma. For some women I met this was a welcome response, even though it reproduces social inequality. Women like Angamma, on the other hand, who resist the unequal power that pity enacts, bristle in response.

The statements about “society’s” sympathetic reaction to HIV-positive women and condemnation of HIV-positive men provide a clear example of the discourse of guilt and innocence that haunts social responses to HIV/AIDS worldwide. On the one hand, all HIV-positive people become stigmatized and are viewed as tainted and morally bereft, particularly since HIV/AIDS is associated with sex and intravenous drug use, and these two things are morally charged in most parts of the world today. On the other hand, we also see how societies categorize HIV-positive people as either innocent or guilty, often sequestering children, receivers of blood transfusions and, increasingly, “housewives” as innocent and lumping others—especially commercial sex workers (female and male), intravenous drug users and all men, but particularly “men who have sex with men”—together as guilty and somehow responsible for their fate. This discourse has been pronounced in India, as reported by the journalist Siddharth Dube (2000), who makes a plea to overcome this gross misrepresentation within India when he writes:

This prejudice is wrong, for every reason. As mortals, as people who are, ourselves at risk of contracting HIV/AIDS (or suffering other tragedies), we must remember that every single person infected got it innocently, unwillingly, through no fault of theirs. Nobody deserves to die prematurely and with such suffering. (3)

While observing support-group meetings and other special events of the Networks that catered specifically to HIV-positive women, I sometimes felt that in their efforts to overcome the intense feelings of guilt held by HIV-positive women, they veered uncomfortably close to shifting the blame onto the shoulders of HIV-positive men, thus following the deeply rutted tracks of the discourse on “innocent” versus “guilty” people living with HIV/AIDS. In so doing they made their stated goal of promoting stigma-free “positive living” unattainable. When I asked members of these organizations about this, they acknowledged that this was a dilemma but said that there is such a strong tendency to view women living with HIV/AIDS as “bad women” that women feel an intense desire to absolve themselves of guilt and the Network organizers feel the need to educate women about the cultural construction of gender in order to denaturalize women’s shame.

Conclusion

Although the combination of blame, stigma and discrimination has been a universal (though by no means exclusive) response to the HIV/AIDS pandemic, the nature of this response varies depending on the local context. HIV-related stigma and discrimination refract gender ideologies and gendered social relationships. And since gender varies cross-culturally, the gendering of stigma will also vary. This paper has examined some of the ways in which constructions of gender in Tamil Nadu, South India, result in different meanings attributed to HIV-positive women vs. HIV-positive men and, consequently, different social responses to HIV-positive women versus men.

The argument made by researchers working in disparate parts of the globe, that HIV-positive women face greater stigma and discrimination than men due to the fact that women are expected to uphold social norms of morality and HIV is viewed as a symbol of the transgression of morality, is certainly supported by many of the Tamil women whom I met, as shown above. But this paper also demonstrates that the gendering of stigma in Tamil Nadu is more complex than that in several ways. First, some women feel that it is specifically in the context of interactions with their in-laws in the private sphere that they face disproportionate stigma and blame, whereas in the public sphere, they encounter more sympathy and pity than men. Second, even when they are blamed for transmitting HIV to their husbands, this is not simply due to a double standard of sexual morality, but also due to cultural constructions of gendered bodies. And finally, the fact that the use of the discourse of blaming women for being promiscuous is most pronounced after the husband’s death suggests that this discourse may be strategically deployed to justify and mask an underlying motivation to exempt the husband’s family from financial responsibility for these widows and their children.

These responses to HIV/AIDS in Tamil Nadu thus reflect very specific systems of knowledge and social practices of gender, kinship and the body. At the same time that social responses to HIV/AIDS follow the grooves of normativity—and indeed Goffman (1963) and Parker and Aggleton (2003) suggest that stigma serves to assert and reproduce normativity—people living with HIV/AIDS may negotiate these social responses to best serve their own interests in whatever ways are possible. This is evident in the fact that women voice critiques in their accounts discussed above. Such critiques suggest that the responses to the gendering of stigma may not simply be reproducing gender, kinship and cultural constructions of the body, but also transforming them. Further research needs to examine the nature of these potential transformations.

Acknowledgments

The 2004 research was supported by a Fulbright Scholar Program Research Award. Pilot research in 2002–2003 was funded by the Pilot Fund for Faculty-Student Research in the Social Sciences of the University of Notre Dame's Institute for Scholarship in the Liberal Arts. My deepest gratitude goes to the women who participated in the research for this study. 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 in both India and the United States. I am also indebted to Rajeswari Prabhakaran, Dr. Dasaratan and Sheela Chavan for their assistance with translations of interviews.

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