Pressure to bear: gender, fertility and prevention of mother to child transmission of HIV in Vietnam
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My interest in AIDS and gender issues started in 1992 when I was living in New York and documented performances of gay and lesbian gender benders for almost a year. Most of them were black, Hispanic and poor men making a living doing odd jobs, including sex work, with little or no protection. At the time AIDS medicines were just being developed. By the mid-nineties many of my friends had died of AIDS or violence, suggesting that documentary film making was not particularly useful in actually improving the lives of the poor and disenfranchised. This experience led me, although with a quite a few detours, to pursue a career in international health.

The topic of this thesis reflects my professional experiences and interests, but is also very personal. I was pregnant with my first child when I started to work on care and support for HIV-infected mothers in Togo, West Africa. One of the first strategies to be applied in countries with increasing rates of infection of HIV but limited resources is prevention of mother to child transmission (PMTCT). PMTCT is a commonly used term for programs and interventions designed to reduce the risk of mother-to-child transmission (MTCT) of HIV. PMTCT was introduced at the global level at a time when anti-retroviral drugs (ARV) were still so expensive that treatment access in poor countries was problematic. The use of ARV to reduce transmission from mother to child was considered feasible, but ARV for the mothers was not yet available. Few pregnant women visited the PMTCT services because there was little incentive. International organisations encouraged people to “live positively”. But because ARV medicines for mothers were not available, AIDS workers involved in care and support programs, such as myself, watched young mothers die while expensive PMTCT facilities were underutilized.

In Vietnam, my current home, I was pregnant again when my Vietnamese colleague and I initiated a care and support program for HIV-infected young mothers. In Vietnam ARV were available but these were not accessible for women at the time. Our mission was to improve comprehensive care and support for HIV+ pregnant women and young mothers, using very concrete indicators to measure program progress. We started the first Vietnamese self-help group for HIV+ mothers, the Sunflowers, with a group of four HIV+ women. This pilot project has developed into a large program involving hundreds of active, healthy and vibrant HIV+ women. Dozens of similar and not-so-similar self-help groups have now sprung up all over the country.
This thesis was inspired by my professional work with HIV+ women and their families. During my work it became very clear that cultural notions concerning gender roles and family lineages shape not only the medical practices designed to prevent mother-to-child transmission of HIV, but also the ways in which agency of the target population of women is circumscribed, as well as empowered. With this research I hope to examine these issues while also contributing to a growing body of academic work on gender, power, agency and HIV/AIDS.

I also hope to share some of the lessons learned in PMTCT programs with international health professionals so that the quality of life of HIV+ women and their families can be improved.

Public health and medical anthropology are both multidisciplinary fields, and HIV/AIDS has long ceased to be considered just a medical problem. Having received academic training in political science, anthropology, public health and media studies, I feel uncomfortable claiming to belong or represent one discipline, and feel more comfortable working in an interdisciplinary fashion. The cross-disciplinary approach is reflected by the different backgrounds of my promoters. Prof. Anita Hardon is a medical anthropologist with a science background. Dr Pamela Wright was trained in molecular biology and then moved on to public health education, while Prof. Dr. Frances Gouda is a historian.

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