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Introduction: Mobilizing Motherhood for the Prevention of HIV

1.A. Research Problem

Women's studies have noted that social movements can capitalize on the symbolic power of motherhood by focusing on women's roles as devoted mothers who love peace and fight together for the survival of their children and families. Such movements can emerge when emigration or economic crises render men as heads of households and breadwinners absent, or when the role of nurturance assigned to women becomes impossible to fulfil. To distinguish them from feminists, Snitow (1990) classifies women who fight for their families as 'motherists'. But few studies to date have examined motherist movements.

Motherist movements have demonstrated their power in peaceful action, mobilizing the image of mothers as patient, peace-loving, and devoted to family to challenge existing policies. Most famously, the Mothers of La Plaza de Mayo confronted military dictatorships responsible for the 'disappearance' of their children in Latin America (Hernandez, 2002; Trully, 1995). Another example comes from the US, where women successfully used their status as mothers to wage a long, peaceful struggle in Washington DC to reform welfare policies, beginning with the Poor People's Campaign led by 5,000 African-American women on Mother's Day in 1968 (Valk, 2000). Woman-to-woman support has been effectively used

within mental and emotional healthcare settings in Australia to support women's health (Hunt, 1998), while appeals to motherhood have mobilized social support among women who have suffered infant loss (Layne, 2003; Layne, 2006).

In Indonesia, one of the most committed motherist movements is *Suara Ibu Peduli* (The Voice of Women Who Care). Established in response to the economic crisis in 1988 – which witnessed skyrocketing prices for basic commodities including a 400% rise in the cost of formula milk – its members demanded government action by carrying out peaceful demonstrations, carrying banners, and handing out flowers to passers-by and the police (Arivia, 1999; Doxey, 2007).

The social construction of motherhood not only encourages motherists to fight for the welfare of their families. It also makes all programs which aim to improve the welfare of mothers, children, and families a concern of motherist organizations, even if the program does not easily fit the image of motherhood. Such is the case with the Prevention of Mother-to-Child Transmission of HIV/AIDS (PMTCT) program which is the focus of this study.

The first PMTCT intervention in Indonesia was a pilot project conducted by the NGO *Yayasan Pelita Ilmu* (Pelita Ilmu Foundation or YPI). Since 1999, YPI has focused its efforts in Jakarta, extending its reach to six other provinces in 2007. Its PMTCT project – which involves two motherist organizations to spearhead implementation – has become a model for other NGOs and a basis for developing PMTCT guidelines by the Indonesian Ministry of Health.

The PMTCT program differs from other women's health programs. Most HIV prevention programs are aimed at high risk populations such as injecting drug users (IDUs) or sex workers, meaning that they are severely stigmatised; the social stigma surrounding HIV/AIDS in Indonesia also affects the PMTCT program. This PhD project therefore examines the strategy of mobilizing motherhood through two women's organizations – the *Pembinaan Kesejahteraan Keluarga* (Family Welfare Movement or PKK) and *Tim ODHA Perempuan* (Seropositive Women's Team or Top Support) – to make the PMTCT program more socially acceptable.

Despite the growing number of new cases of HIV/AIDS in Indonesia, the progress of prevention programs has been slow. While there are many policies, there is a lack of actual and sustainable implementation at the national level. Low prevalence is always stated as a reason for delaying HIV prevention programs and to justify slow progress in implementation, even though the government of Indonesia has set itself the target of decreasing the rate of new HIV cases as part of its commitment to

achieving the Millennium Development Goals (MDGs) by 2015¹. The prevention of mother-to-child transmission of HIV/AIDS has also moved very slowly in Indonesia. As a response to the 2001 UNGASS convention, the National Strategy 2003-2007 prioritized improving PMTCT. This entailed reducing the number of seropositive children by 20% by 2005, and by 50% by 2010, and ensuring that 80% of pregnant women attending antenatal clinics received information, consultation, and services to prevent HIV transmission to their babies (Priohutomo, 2005). Indonesia's Ministry of Health, however, only launched its national PMTCT guidelines in 2006, and there is still no PMTCT program at the national level.

The PMTCT project is NGO-initiated and donor-driven, with limited government support. Funding depends on foreign donors, in this case the Global Fund, which means that in practice the receipt of money is often erratic. In the midst of government indifference towards HIV prevention, YPI is trying to implement a comprehensive PMTCT program that will deliver a continuum of care, in accordance with the four prongs established by the WHO².

HIV/AIDS prevention is generally not considered a priority by the Indonesian government or the population. In a country with low prevalence and significant stigma surrounding HIV/AIDS, YPI faces an uphill battle in advocating its PMTCT program, particularly for low-risk, respectable groups such as mothers. Motherhood and HIV/AIDS are seen as contradictory concepts. For most Indonesians, motherhood is a woman's sacred role, while HIV/AIDS is a disease that only affects people who behave 'badly'. A devoted mother is considered highly unlikely to be infected with HIV. If she is, she will be stigmatized as a prostitute.

Nevertheless, the presence of the word 'mother' in PMTCT has allowed YPI to involve two motherist organizations – the PKK and TOP Support – to conduct advocacy for its project. The PKK is socially and politically structured from the very lowest level in the community up to the national level. All married women in Indonesia are automatically members of the PKK. Those who actively involve themselves in its activities are housewives, mostly mothers. The PKK has previously been involved in the development of reproductive health programs through the

1 There are eight Millennium Development Goals, which were signed by 185 countries (including Indonesia) in September 2000, to be achieved by 2015. They are: 1) eradicate extreme poverty and hunger; 2) achieve universal primary education; 3) promote gender equality and empower women; 4) reduce child mortality; 5) improve maternal health; 6) combat HIV/AIDS and other infectious diseases; 7) ensure environmental sustainability; and 8) develop a global partnership for development. Prevention of mother-to-child transmission of HIV incorporates targets number 3, 4, 5, and 6

2 According to the WHO, PMTCT has to be administered as part of a continuum of care based on a four-pronged strategy: 1) preventing HIV infection among women of reproductive age; 2) preventing unwanted pregnancies among HIV positive mothers; 3) preventing mother-to-child HIV transmission; 4) providing psychological and social support and treatment to HIV positive mothers, their babies, and their families.

Safe Motherhood Movement (*Gerakan Sayang Ibu* – GSI) and the Family Planning Program (*Keluarga Berencana* – KB). TOP Support is a women’s support group created by YPI that provides psychosocial support to seropositive mothers. Its members are mostly (ex-)injecting drug users or their partners, who typically discovered themselves to be HIV positive after their child or husband had died of AIDS. Among the seropositive women’s support groups in Jakarta, TOP Support is the only one which is an established part of the PMTCT continuum of care³.

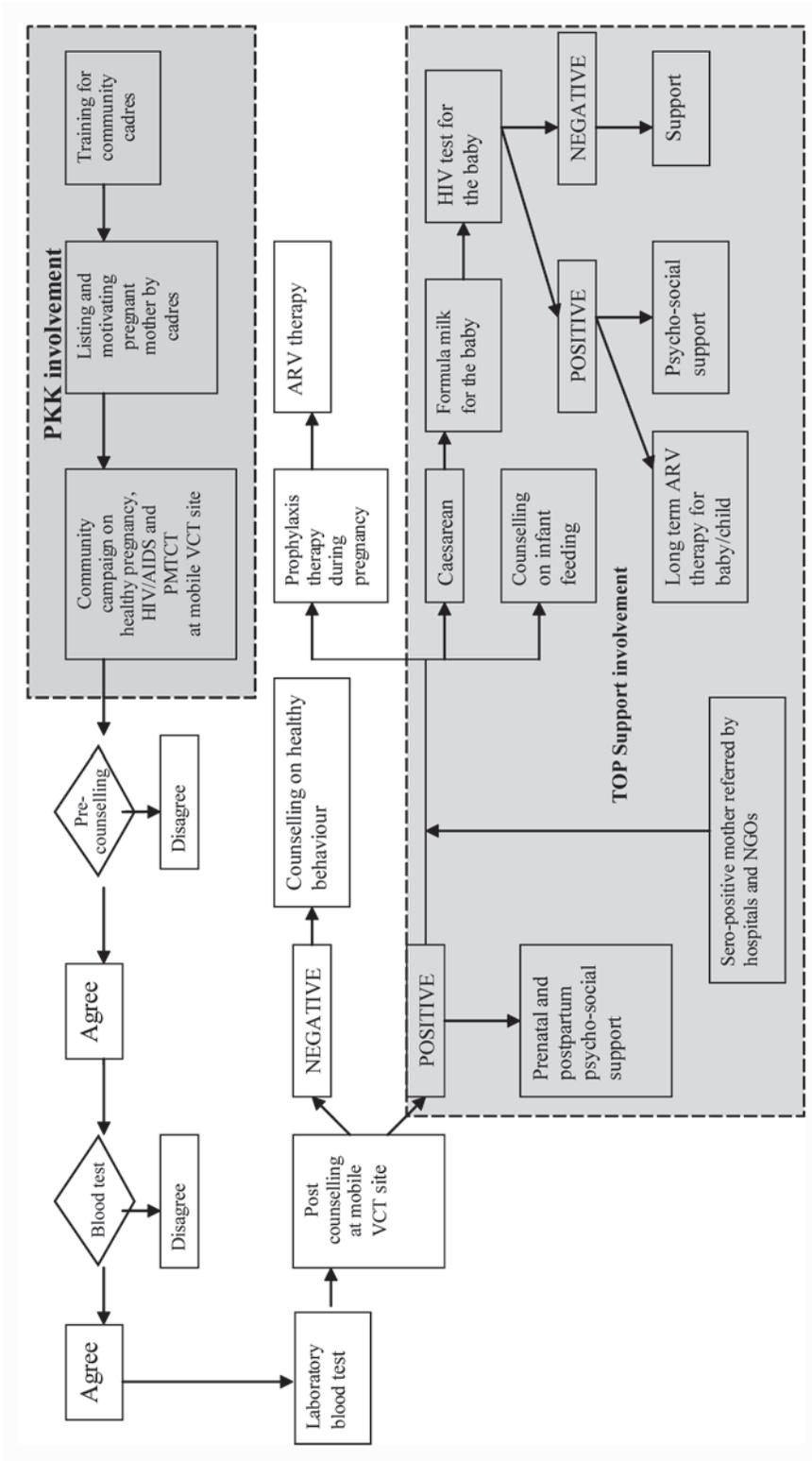
YPI involves the PKK in its PMTCT project to help prevent perinatal HIV transmission, in line with prong 1 of the PMTCT continuum of care. The role of PKK cadres is to mobilize pregnant women in their locale to attend a mobile voluntary HIV counselling and testing (VCT) service. TOP Support plays an important role in prong 4 of the PMTCT continuum of care: to support seropositive mothers by providing interpersonal psychosocial support.

Members of the PKK and TOP Support use the social capital they gain by being associated with these organizations to promote the PMTCT pilot project, utilizing motherhood to gain trust and build networks among mothers to make issues related to HIV/AIDS more socially acceptable. PKK cadres rely on the community’s trust in their organization and the highly organized PKK network to mobilize pregnant women to access the mobile VCT service, while TOP Support members, through public testimony, invoke the image of the devoted wife and mother infected by her badly-behaved husband to gain support, avoid stigma, and promote PMTCT. In promoting the pilot project, PKK cadres and TOP Support members convert the social capital derived from motherhood into opportunities to access economic capital. Both PKK cadres and TOP Support members receive material rewards, for example in the form of ‘transportation fees’ which can be used to supplement family income. These economic benefits enable women to fulfil their role as mothers responsible for their families, especially when the husband/father cannot satisfy the family’s economic needs.

Unfortunately, PMTCT in Indonesia has remained a YPI project since its inception in 1999. PMTCT is not considered a necessity, either by members of PKK or TOP Support, who tend to see it a means to meet the economic needs of their families. Alongside the stigma attached to HIV prevention, the PKK does not see access to VCT during pregnancy as part of the overall fight for women’s reproductive rights. TOP Support members do not see PMTCT as a means to gain medical access as they already have this through YPI. Most TOP Support members have not experienced full-blown AIDS and do not feel that they have particularly suffered. Furthermore,

3 Most of the support groups set up exclusively for seropositive women are not part of the PMTCT program. Women who join mixed support groups, in which most members are injecting drug users, are also not part of the PMTCT program.

Figure 1: PMTCT Pilot Project



Indonesian women are not socialized to make demands for their own needs or to fight for their rights. Motherhood is limited by its domestic social identity, meaning that the activities women can pursue cannot interfere with or violate their domestic role as mothers. Motherhood, as a form of social capital, is thus constrained in fighting for issues outside the domestic sphere. PKK and TOP Support therefore do not feel that it is necessary, or that they are able, to fight for PMTCT as a woman's right to reproductive healthcare. Following Snitow, I ask: "Is the general marginality of women's groups a strength or weakness? To what extent is motherhood a powerful identity, a word to conjure with?" (Snitow, 1990, pp. 20-21).

1.B. Research Objectives and Questions

Studies of motherist movements such as the Mothers of La Plaza de Mayo and the Poor People's Campaign focused on how motherhood was mobilized to achieve common goals based on the domestic responsibilities of women to their families. While motherhood is often seen as a weak and disempowered identity, it can be used to promote women's programs even when, as described in this study, the program suffers from social stigma.

This study suggests that mobilizing motherhood is an effective means to advocate for PMTCT at both the individual and organizational levels, though influence at the national level remains constrained. The social capital mobilized by women in the PKK and TOP Support derives from their identity as mothers, which is regarded within communities as the ultimate identity of Indonesian women. Motherhood generates identity-based trust which forms the basis for individual mothers to establish social relationships, which can then bind individuals to achieve common goals. Mutual trust is an important precondition for meaningful interaction at the individual level, which later becomes the foundation for positive social relations at the level of organizations and communities (Falk & Kilpatrick, 2000). At the organizational level, motherhood becomes a basic formation to generate support for PMTCT.

The overall objective of this study is to examine the effectiveness of mobilizing motherhood through two women's organizations – the PKK and TOP Support – in promoting a socially stigmatised HIV prevention program. In particular, this study will answer the following questions:

1. How does motherhood inform social relations among PKK and TOP Support members?
2. How do they make use of the social values and trust surrounding motherhood at the organizational level?

3. How do they mobilize their social and organizational networks to promote PMTCT?
4. How do mothers active in PKK and TOP Support benefit from the PMTCT program and maintain these benefits?
5. How effective was the strategy of mobilizing motherhood to promote PMTCT at the national level?

1.C. Research Significance

Although PMTCT has remained a YPI project, preventing the mother-to-child transmission of HIV has inspired communities and the government to broaden their perspective on HIV/AIDS and start discussing prevention for the general population, not only for high risk groups. Success in raising the issue of PMTCT, as one aspect of HIV/AIDS prevention, cannot be separated from the efforts of senior YPI staff who hold strategic positions in government. YPI's pilot project was used as a model to develop the PMTCT guidelines issued by the Ministry of Health. Some points within these guidelines are based on lessons learnt from the pilot project, for example that PMTCT should be integrated within maternal and child healthcare services, and that societal mobilization aids implementation. The model of prevention used by the pilot project also receives support from the government (particularly the Ministry of Health) and other donors (particularly the Global Fund), which has allowed it to spread its network to six other provinces in Indonesia.

There are number of reasons to study the PMTCT pilot project in Indonesia. First, because HIV/AIDS prevention programs for women and children hardly exist in Indonesia, this research will provide valuable input for the development of further HIV/AIDS prevention initiatives. This will help the Indonesian government to meet its stated target of achieving the Millennium Development Goals (MDGs) by 2015. Second, it is fascinating to examine how members of the PKK and TOP Support promote PMTCT by uniting the highly respected community symbol of motherhood with the highly stigmatized disease of HIV/AIDS. Finally, this study sheds some light on the importance of motherhood within women's organizations more generally.

1.D. Methodology

1.D.i. Description of the Project

This PhD project was part of the larger research project 'Towards a Continuum of Care in Prevention of Mother to Child Transmission Programs: Proposal for Partici-

patory Action Research in Vietnam and Indonesia', conducted by the Medical Committee Netherlands Vietnam, Hanoi Medical University, the Indonesian NGO *Yayasan Pelita Ilmu*, the Department of Social Welfare in the Faculty of Social and Political Sciences at the University of Indonesia, and the Medical Anthropology Program at the University of Amsterdam.

My research began with a rapid assessment of PMTCT in Indonesia. The main actors included the Department of Health, the Ministry of Women's Empowerment, the Indonesian Association of Paediatricians, the Indonesian Breastfeeding Promotion Association, the Family Planning National Coordinating Board, the Indonesian Parenthood Association, the Indonesian Children's Health Foundation, and the Working Group Study on AIDS (*Kelompok Studi Khusus*– Pokdisus) at the Faculty of Medicine at the University of Indonesia. Actors also included NGOs such as *Yayasan Mitra Indonesia* (Mitra Indonesia Foundation) and *Yayasan Kusuma Buana* (Kusuma Buana Foundation); practitioners including medical doctors, nurses, PMTCT programmers, trainers and counsellors; PMTCT community cadres, seropositive mothers, informal leaders, single and young girls, and pregnant women. Data gathering for the rapid assessment was conducted between May and December 2005. Documentary data on general programs for HIV prevention came from the Community Based Survey, the Behavioural Surveillance Survey, the Human Development Index, the Demographic Health Survey, the National Socio-Economic Survey, PMTCT guidelines, and seminar proceedings on reproductive health. Qualitative data were collected through focus group discussions, semi-structured in-depth interviews, and observation.

The rapid assessment revealed that the only established PMTCT continuum of care program in Indonesia is run by YPI, with the involvement of PKK and TOP Support. Based on this finding, this PhD project pursues an in-depth study of the involvement of the PKK and TOP Support in implementing the PMTCT program. In this, I benefitted from the network and rapport I had built up during the rapid assessment.

YPI conducts a mobile VCT program at the district level involving the PKK as community cadres. I initially interviewed 17 PKK members involved in the mobile VCT program and held focus group discussions with all PKK members involved in the mobile VCT in 11 villages. I visited and interviewed PKK cadres and held focus group discussions during their training. To gain further insight into the VCT program, I interviewed 20 pregnant women who had participated in it and pursued two in-depth case studies of pregnant women who were found to be HIV positive through the mobile VCT. I then observed, until 2007, the activities of the mobile VCT, which had been expanded to other provinces. I was involved in several capacity-building trainings of PKK cadres organized by YPI as well as a YPI community rally to prevent HIV transmission to babies. Through these activities I gained the trust of the PKK cadres.

I initially conducted in-depth interviews with 15 TOP Support members and held focus group discussions to gain knowledge about the group. I conducted informal interviews with all TOP Support members. At the time of my fieldwork in 2005-2007, there were 24 seropositive mothers involved in TOP Support. TOP Support members, however, cannot be said to be representative of seropositive mothers in general. It was difficult to interview women found to be HIV positive through the mobile VCT as they refused interviews out of fear of disclosure to the neighbourhood. Most TOP Support members were referred by their medical doctors, hospitals, or NGOs.

YPI counsellors helped me to contact seropositive mothers so that I could regularly visit them. I became closely involved in TOP Support activities, observing the daily activities of members and visiting their homes as part of my data gathering. I held capacity training programs and became involved in income-generating activities, which was also part of the main research project funded by MCNV and the University of Amsterdam. Only by working with them was I able to gain the trust of TOP Support members. I developed very close relationships with some of the women; even now I maintain regular contact, receiving up to date information via telephone, email, and text message. Sadly, some of them have passed away since I conducted my fieldwork.

In collecting field data, I received the informed consent of my informants and assured them that confidentiality would be maintained. For this reason, all informants' names have been changed to pseudonyms. In total, I conducted 63 in-depth interviews and six focus group discussions among PKK cadres and TOP Support members. To complete my data, I interviewed YPI counsellors and staff as well as medical doctors at the district level.

To gain insight into the many issues surrounding HIV, I held in-depth interviews with policy-makers and studied newspaper articles, policy documents, and statistics. As it is distributed nationwide and is relatively gender sensitive, the national daily newspaper *Kompas* from 1994-2010 served as my main source of news media. I also looked at other daily newspapers, such as the *Jakarta Post*, though they rarely report on HIV-related issues. I completed my analysis of policy with statistical reports from the Directorate General CDC and EH⁴, Ministry of Health. In theory, all medical institutions report the number of HIV/AIDS cases they deal with to the Ministry of Health through their Local Health Office; the statistics are then used by other institutions to show the spread of the epidemic in Indonesia.

Browsing the Internet supplemented my knowledge of issues surrounding HIV and AIDS. For example, I joined mailing lists to follow discussions of HIV/AIDS and PMTCT in Indonesia and abroad.

4 Centre for Disease Control and Environmental Health.

Documents on HIV/AIDS prevention policies, PMTCT guidelines, newspaper articles, and in-depth interviews with policy-makers provided data on the use of social capital within Indonesian healthcare programs. Quantitative data on VCT uptake, PKK cadres, and seropositive mothers –alongside in-depth interviews with NGO and PMTCT staff – addressed how women’s organizations such as the PKK and TOP Support facilitate the implementation of PMTCT. The roles of the PKK and TOP Support within the PMTCT program, as well as the factors supporting the implementation of PMTCT in Indonesia, were addressed through in-depth interviews.

1.D.ii. Research Site

I conducted my research mainly in Jakarta, with field research focusing on the PMTCT activities of YPI. The reason for this was simply because YPI’s pilot project focuses on Jakarta; the city has the highest prevalence rate of HIV/AIDS in Indonesia, according to data from the Ministry of Health. PKK cadres who became informants in this study lived in Jakarta; so did most TOP Support members, though some lived in adjacent areas, i.e. Bekasi, Depok, and Tangerang.

Jakarta is the capital and largest city of Indonesia. Located on the northwest coast of Java, it has an area of 661 km². Jakarta has been a metropolitan centre since at least the mid-eighteenth century, when it was a Dutch East India Company (*Vereenigde Oost-Indische Compagnie*, VOC) trading centre for East Asia, and called the ‘queen of the east’ (Kusumawijaya, 2004, pp. 3-12). Like many big cities in developing countries, Jakarta suffers from major urban problems. The population has risen sharply from 2.7 million in 1960 to 8.3 million in 2000 and 8.8 million in 2004, counting only its legal residents. Its population density was 13,826 per km² square in 2010. As Indonesia’s leading economy, Jakarta has attracted workers from surrounding areas. Rapid population growth has outpaced the government’s ability to provide basic needs. Almost every year during the rainy season, Jakarta suffers from flooding due to clogged sewage pipes and waterways. Rainforest depletion due to rapid urbanization on the highland areas south of Jakarta, near Bogor and Depok, has contributed to this flooding. Flooding was a problem during field data collection; most of my informants lived in flood-prone areas. Administrative reforms following the passing of the autonomy law (UU 22/1999) unfortunately did not address the fundamental problems of flooding, poor public transport, and the city’s slums (Kusumawijaya, 2004, pp. 177-179).

Officially, Jakarta is not a city but a province with special status as the capital of Indonesia. It is therefore headed by a governor rather than a mayor. Jakarta is divided into five municipalities (*kotamadya*) headed by mayors, and one regency (*kabupaten*) headed by a regent. These are: the municipality of Central Jakarta (*Jakarta Pusat*), the municipality of East Jakarta (*Jakarta Timur*), the municipality of North Jakarta (*Jakarta Utara*), the municipality of South Jakarta (*Jakarta Selatan*), the municipality of West Jakarta (*Jakarta Barat*), and the regency of Thousand Islands (*Kepulauan Seribu*), formerly a sub-district of North Jakarta. Jakarta consists of 44 sub-districts and 268 villages. I interviewed PKK cadres from 11 villages, spread across five municipalities in the Jakarta area.

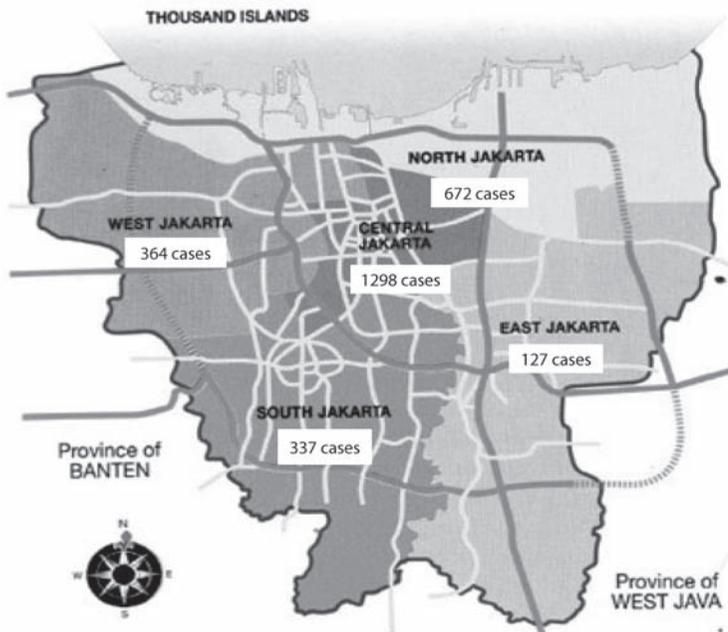
As a metropolitan city, the health service in Jakarta is enormous. Hundreds of public and private hospitals, *puskesmas* (community health centres), clinics, alternative health services, and private doctors and midwives can be accessed, though their costs vary.

The incidence of HIV in Jakarta is on the rise. According to the Ministry of Health's Sero Survey Report 2003-2007, HIV prevalence among Jakarta's prisoners was 12.63 (per 1,000 population) in 2003 rising to 26.25 in 2007; among commercial sex workers, 7.89 in 2005 rising to 14.63 in 2006; and among injecting drug users, 38.00 in 2003 rising to 69.63 in 2006⁵ (MOH, 2010). As of December 2010, Jakarta counted 3,995 cumulative AIDS cases, resulting in 576 reported deaths. The prevalence of AIDS cases per 100,000 people in Jakarta was 44.74 by December 2010, ranking Jakarta third in terms of cumulative AIDS cases in Indonesia after Papua and Bali (MOH, 2011). In March 2009, there were 337 recorded cases of AIDS in South Jakarta, 127 cases in East Jakarta, 1,298 cases in Central Jakarta, 364 cases in West Jakarta, and 672 cases in North Jakarta⁶ (MOH, 2009). As a capital city with a multitude of problems, Jakarta is a priority for HIV prevention.

5 The HIV prevalence rate in selected populations refers to the percentage of people tested in each group who were found to be infected with HIV.

6 Cumulative AIDS cases based on districts has only been reported by the Ministry of Health up to 31 March 2009.

Figure 2: Cumulative AIDS cases in Jakarta, March 2009



Source: (MOH, 2009)

1.E. Challenges in Research

It was a challenge for me to conduct research on issues related to HIV and AIDS. First, even though I had done a lot of research on women and children, this was the first time I had researched issues around women, children, and HIV/AIDS, which remains a sensitive topic in Indonesia. Collecting data from key informants, mainly HIV positive women, was exceptionally challenging. I needed to be very careful so that they would not feel discriminated against or stigmatized, and had to build up trust and develop a good connection with them.

Second, it was sometimes challenging to separate my role as an activist – who helped some of the key informants gain access to PMTCT – from my role as a researcher. As a researcher, I realized I had to be objective. But I also realized that researching women, let alone through a qualitative anthropological approach, made it tough to be an objective, unbiased researcher.

Finally, English is not my mother tongue. Writing a dissertation in another language has been very challenging for me. I had to read books, articles, journals,

and manuscripts several times before I was able to understand the concepts presented in the materials. This language constraint has also made it tricky for me to translate the expressions of the informants into English. Despite my linguistic abilities, I hope I have been able to make a convincing argument to readers, as well as explain the analysis in this study.

1.F. Structure of the Book

In this introductory chapter, I have explained how the research problem was formulated into questions and discussed my methodology.

In Chapter 2, I assemble the arguments that I use as a basis to analyse the research questions. I explain how the feminine identity of motherhood is highly valued in Indonesia, and has been successfully used by the government to support its policies, and by YPI to promote its PMTCT pilot project. To support my argument, I make use of the concept of social capital, referring to its structural aspects at the individual, organizational and community levels. Both the PKK and TOP Support appeal to the social capital invested in motherhood, not least to women's biological ability to reproduce. Institutionalization of the identity of motherhood – for example through the activities and structure of the PKK, or the central place of motherhood in PMTCT as expressed by the TOP Support group – gives women affiliated to these institutions access to accumulated social capital. But unfortunately, motherhood is also constrained by its restriction to the domestic sphere, so that it becomes a barrier to women fighting for their rights in public. Motherhood becomes a constraint to influence development priorities at the national level, meaning that PMTCT remains a pilot project. To support this analysis, I compare two motherist organizations – the PKK and TOP Support – and explain how they mobilize motherhood in very different ways, regarding: (1) the function of social support in advocating for PMTCT; (2) mechanisms to generate trust; (3) their social organization and networks; and (4) mechanisms to preserve the benefits of participating in the PMTCT pilot project.

In Chapter 3, I describe how the conflicting concepts of motherhood and HIV/AIDS are brought together in PMTCT. I describe the context of HIV/AIDS in Indonesia – in particular how the image of the disease has changed by penetrating the sphere of mothers and children. This implies that the epidemic has spread to the general population and requires attention from the government. HIV/AIDS has been enshrouded in stigma for Indonesian women as it is considered a disease affecting women with no morals. But with the introduction of PMTCT, government and society have been encouraged to look at the epidemic from another perspective, and have begun thinking about prevention for low risk populations, namely women and children.

In Chapters 4 and 5, I describe the PKK's involvement in the PMTCT pilot project. Chapter 4 describes how the government mobilized motherhood to create the PKK and how PKK cadres were involved in promoting the Safe Motherhood Movement and the Family Planning Program. I examine how PKK cadres engage in PMTCT outreach, making use of their identities as mothers to access existing networks of trust. The chapter further looks at how PKK cadres as service providers deal with PMTCT being part of a stigmatised HIV prevention program. Chapter 5 describes the social and economic benefits gained by PKK cadres in their involvement with PMTCT. This chapter also describes how PKK cadres maintain their motherly roles and, to maintain their benefits, do not reach beyond the limits of the domestic sphere.

In Chapters 6 and 7, I examine the involvement of TOP Support in the PMTCT pilot project. Chapter 6 describes how seropositive mothers became members and how TOP Support as an NGO-driven organization supports them. I examine how members interpret and respond to HIV/AIDS as women, in light of the fact that most of them have not experienced full-blown AIDS. Chapter 7 examines how TOP Support members construct their identities as devoted and innocent housewives and mothers to gain trust when promoting PMTCT, thereby allowing them to access economic benefits. I also explain how they preserve these benefits by maintaining their role as mothers who always put their families first, by restricting their activities, and by not publicly disclosing their HIV status if this may jeopardize their family's welfare.

Finally, in Chapter 8, I analyse the PKK and TOP Support as two different kinds of motherist organizations involved in the PMTCT pilot project and examine how they make use of motherhood for their own interests, as organizations and as individual members. This chapter also addresses future challenges that need to be considered when implementing similar programs elsewhere.