AIDS, Marriage, and the Management of Ambiguity in Northern Nigeria

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A Dissertation Submitted in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy
in the Department of Anthropology at Brown University

Providence, Rhode Island

May 2010

This dissertation by Kathryn A. Rhine is accepted in its present form

By the Department of Anthropology as satisfying the

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ACKNOWLEDGEMENTS

For the fieldwork upon which this dissertation is based, I gratefully acknowledge the support of the Andrew J. Mellon/ACLS Early Career Fellowship Program, the Fulbright (IIE), Fulbright Hays, and Boren fellowship programs, the National Science Foundation, the Population Studies & Training Center, and the Graduate School at Brown University.

I am indebted to Daniel Smith, my advisor, along with the members of my committee, Marida Hollos, Patricia Symonds, and Kristin Peterson, for their careful reading and feedback. Their generous and committed attention helped advance my scholarship in numerous critical dimensions. I have also been fortunate to be surrounded by many enthusiastic and empathetic graduate students at Brown, without whom I could never have completed this work. Susi Keefe, Salome Wawire, Rebecca Galemba, Rebecca Peters, and Inna Leykin, in particular, have offered insightful suggestions to all of the arguments made within this dissertation. My writing has also benefited from the meticulous copyediting of Andrea Maldonato, Andrea Mazzarino, and Kristin Skrabut.

Thanks must be extended to the Department of Anthropology, the Population Studies & Training Center, and the Cogut Center for the Humanities at Brown for providing me congenial environments for writing my dissertation, as well as vital assistance in navigating the bureaucratic challenges that have accompanied this research. I would like to acknowledge the support of Kathy Grimaldi, Margie Sugrue, and Matilde Andrade in Anthropology, as well as Kelley Smith and Tom Alarie at the PSTC.

In Nigeria, I wish to thank the staff at the Plateau State Specialist Hospital, Faith Alive Hospital, Ahmadiyya Hospital, and Aminu Kano Teaching Hospital, as well as the University of Jos and Bayero University Kano. In particular, I would like to thank Dr. Chris Isichei and Dr. Yusuf Adamu, and their respective families and colleagues, and Dr. Abdulatif Salisu and Dr. Bola Gobir with AIDSRelief, all of whom have facilitated this research. Since I first came to Nigeria, I have had the support of the Public Affairs Section at the US Embassy in Abuja. I thank Atim George and James Maloom, as well as their colleagues at PAS for their continued assistance and encouragement.

I have always been in the company of great friends throughout my time in Nigeria. Laura Dobson, Carmen McCain, Brent and Eugenie Friedrichs, and Laura Arntson have been some of my closest confidants. I have traveled to the field with Kate Bowler, Pamela Escobar, and Stacey Vanderhurst, and it has been a privilege being part of their respective research and education trajectories. Most importantly, my research would not be possible without the assistance, kindness, and generosity, of Halima Ben Umar, Khadijah Ibrahim Nuhu, Rashida Abdullahi, and their families. There are many women who I cannot name here that have taught me everything I know in this dissertation. I am so fortunate to have had their companionship and patience throughout this challenging project. Thank you.

Finally, I would like to acknowledge the support of my parents, Rose and Dave Rhine, along with Patrick, Shawn, and Andy, and my two nieces, Erin and Nora.

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INTRODUCTION

THE EVIDENCE OF THINGS NOT SEEN

Now faith is the substance of things hoped for. The evidence of things not seen.
Hebrews 11:11

This is the Book.
In it is guidance, sure, without doubt
To those who fear Allah:
Who believe in the Unseen,
Are steadfast in prayer,
And spend out of what
We have provided for them
Qur'an 2:2-3

2. The Unseen Things

> Hope is in the tender hands that hold you.
> Hope is in the embrace of the loving.
> Hope is in the flesh touching flesh
> to remind us of our human selves.
> Hope is in the gentle nod of recognition,
> hope is in the limping body still pushing
> against the pain, the discomfort, still
> laughing from so deep down it feels
> like the rush of alcohol in the head
> the full abandonment of all fear.
> Hope is in the freedom to say
> I long to be touched by a lover,
> I long to feel the rush of desire
> satisfied; hope is to embrace hunger
> and find comfort in the sharing of needs.
> Hope is in the hands we grasp,
> the prayers we whisper,
> the Amen, the Amen, the Amen.

Excerpt taken from *Faith*, Kwame Dawes (2008)

In the spring of 2003, I met with a young, widowed woman in the middle-belt city of Jos, Nigeria. It was a difficult interview, filled with many tearful pauses as she recounted her relationship history. I was anxious. New to the country, I had no idea how to comfort her. Should I stop the interview? Nigerians would say simply, “I’m sorry” and wait for the crying to stop. Apart from the hospital staff, I was the only person who knew she was infected with HIV. The woman wanted to continue. Her narrative jumped back and forth over time. It was hard to follow. She too was anxious and interrupted her answers numerous times to ask me questions: about America, about her health, about the tape recorder. As she warmed up to me, more questions followed: Did I have a boyfriend? When would I marry? I stammered through my answer trying to bridge our seemingly incommensurable social worlds. Yet another interruption: “Katie,” she said, “I want your advice,” she paused. “Can I get married?” Again, I did not know what to say. She continued – her doctor warned her about spreading the virus. Her pastor encouraged HIV-positive couples to marry, but she was afraid to tell him about her HIV status. Her family, also unaware of her status, was perpetually inquiring about her boyfriends and would introduce her to an array of admirers, hopeful that she would remarry. She also had a boyfriend. I soon came to learn that many of the women I interviewed both in Jos and in the in the northern Nigerian city of Kano had boyfriends, both HIV-positive and HIV-negative, and were concerned about marriage.

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This is a dissertation about the lived experience of HIV as it is interwoven in the recent history of global health intervention in Nigeria. I explore the aspirations, dilemmas, and everyday lives of women participating in the world that HIV prevention and treatment campaigns have opened up. Across sub-Saharan Africa, a positive diagnosis has widely been considered a death sentence, presumed to jeopardize not only one's health, but also her education, work, family, and social reputation. Once an undetectable disease whose sufferers lived and died of a sickness with an unspeakable cause, HIV-positive persons collecting antiretroviral therapies in Nigeria now number in the hundreds of thousands, with as many as a million more awaiting treatment. Physicians and counselors no long emphasize to their patients the pathology of HIV or the forms its progression takes; instead, they focus upon the life-prolonging effects of medications. Individuals are assured that they would remain healthy if they adhered to their medications. Within one of the clinics where I worked, an HIV-positive counselor was called upon to offer advice to a distressed patient. She said to this woman: "See my face? Do you know if I am positive or negative?" The woman said she thought she was negative. My friend continued, "How do you know this?" The woman responded that it was because she was so fat. "In fact," this counselor countered, "I am positive…So you see you can live healthy just like everyone. So long as you take your medicines everyday."

Most women living with HIV in northern Nigeria acknowledge the distress they felt at the time they learned their status. "At the time," one of my informants described, "I felt I would die. But later, I discovered that other healthy people get sick and die and I am still alive. In fact, I have become healthier than before and now do things a negative person is not able to do." Most of the members of her support group concurred. Another woman stated, "For me, since I became aware of my status, I have never thought that the disease would kill me. Before [my diagnosis], I had grown thin and everybody looked at me like an AIDS patient. I went to the hospital and I learned of my status, but I never considered the thought of dying. I just gave everything to God and up until today I do not think that this infection will kill me. Because, I know there are different diseases that can be responsible for my death…or even an accident." How is it that these women have come to reject the physiological death sentence a positive diagnosis confers? Are they rejecting biomedical knowledge entirely in favor of prognoses offered by other explanatory systems? Are they simply reproducing the discourses of global health policymakers that celebrate the "emancipatory" possibilities with which these therapies are imbued? Most of the women with whom I worked are highly invested in biomedical regimes of care and have witnessed the chronic, degenerative trajectory of the virus – both left untreated and treated. Many have been caretakers for and have lost partners and children. These women are not unaware of the ways in which HIV-infected persons suffer the virus's devastating consequences.

In epidemiological terms, to be categorized "at risk" of an illness is to suggest that an individual is pre-disposed (through a genetic, biological, environmental, or behavioral condition) to a possible physical or psychological injury. In this dissertation, I want to understand the social forces that shape HIV-positive women's dispositions toward the threats HIV potentially pose to their futures. In order to interpret the disjuncture between the "death sentence" of HIV that the women above have seemingly been handed and their response to this prognosis, it is important to understand the ways in which risks are also characterized in their popular representations and everyday conversations among Nigerians. As locally defined, categories of "at risk" of HIV are rarely described in terms of their biological or ecological determinants. Rather, representations of risks are enmeshed with understandings and fears of broader social threats, not just HIV *per se*. Those who are considered most at risk are either marginal, powerless, passive recipients of the dangers that social threats pose; or they are regarded as those who are agents in bringing danger upon themselves, as well as upon Nigerian society writ large. HIV-positive persons, consequently, have been discredited as irresponsible, promiscuous, and deserving of their misfortune. These women struggle not with the virus's association with death so much as they struggle with its social stigma.

HIV is undoubtedly the most visible of public health challenges in Nigeria – not only in terms of prevalence rates, but also in public awareness and the capital devoted to infrastructure, technologies, and treatment. Political and public concerns over the spread of the virus are everywhere: on billboards and radio programs, in primary school lessons and church sermons, in employment opportunities and economic development schemes. The need to address "issues of culture and traditional roles" that contribute to increased [HIV] vulnerability – especially the cultural practices that shape the "status of women and girls" in local contexts – are core emphases of all global HIV interventions. Photographs of dying women and orphaned children are published alongside of epidemiological statistics in health and development program overviews, annual reports, and the popular press. Married women, epidemiologists have found, are at even greater risk of contracting HIV than their sexually active unmarried counterparts. They do not, however, fit neatly into the behavioral risk categories and behavioral change strategies emphasizing abstinence, fidelity, and condom-use outlined by these health and development agencies. The moral valences of risk outlined above mask these epidemiological dynamics and thus limit the scope and efficacy of interventions. What, then, are the consequences of this disjuncture?

It has been argued that the HIV epidemic has increased the rates of marriage dissolutions across sub-Saharan Africa. In northern Nigeria, it is not uncommon for women to marry multiple times, and consequently circulate through numerous partners over the life course. The reasons behind widowhood and divorce apply broadly to Muslims and Christians alike in the overall poor health of families, and the large age differentials between husbands and wives. Divorce is more frequent among Muslims because of the ease with which Islamic doctrines can be employed to dissolve marriages, although it is not unusual for Christian men to abandon their wives in a similar fashion: they separate from their wives and move out, provide them no means of support, and find partners elsewhere. Larger structural inequalities within Nigeria manifest themselves in marital conflicts, particularly concerning those surrounding the circumstances through which HIV is spread between husbands and wives. Further, because husbands are often the first to contract the virus, they are therefore commonly the first to fall sick and die, leaving increasing numbers of HIV-positive widows across the country. Marriage dissolutions, however, are only seen as problematic if the time between marriages lasts too long. The women with whom I worked feared calling attention to their HIV status not because of their illness trajectories, but because they lacked husbands. Beyond masking the stigma of HIV, I ask why it is that marriages and families matter so much to HIV-positive women.

This dissertation explores broadly the intersections between global health agendas, biomedicine, kinship, and gender relations in northern Nigeria. What are the cultural values, assumptions, and practices that inform global and local interventions to understand and curtail the epidemic in Nigeria? How do the moral evaluations that accompany these political, medical, and popular assumptions grant credibility to certain forms of knowledge surrounding HIV and its effects upon the body? How do HIV-positive women, in turn, respond to and navigate these social, ethical, and moral challenges surrounding testing, care, and treatment? What is the role of the family in these pursuits? How do local political economic dynamics and inequalities shape women's social and illness trajectories in resource-poor settings? What is it, precisely, that prevents women from reproducing the expectations of health citizenship encouraged by these global health campaigns?

Structures of Uncertainty

I begin this dissertation by orienting my research with theoretical questions surrounding risk and uncertainty. Far from being the product of contemporary global political and economic transformations and disintegration, which scholars have termed a "risk society," uncertainty is a universal human experience. While the term risk designates a useful category to describe something in a place to be gained or lost, the range of human stances toward contingency and what is at stake in these social actions extend well beyond this (Malaby 2002). Whyte (2002) proposes that scholars should approach investigations of subjectivities in terms of individuals' *situated* concerns; that is, "the specific uncertainty that particular actors experience as they try something that matters to them – as they undertake to deal with a problem" (175). These concerns are always intertwined with those of other social actors, both known and unknown.

Uncertainty is not merely a characteristic of an individual's anxious interior state. It is also structured symbolically, socially, politically, and materially, and it possesses infinite modes of expression. The relationship aspirations of HIV-positive women and their expectations for future support – and consequently the everyday social encounters where these aspirations and expectations manifest -- are not necessarily human universals, but rather depend upon the structures that uncertainty take in a given context. The Nigerian experience of living with HIV, which I seek to describe, will elucidate these points in important ways. In particular, I will emphasize the role of technological interventions in mediating social trajectories and life chances.

Virological Contingencies

Second, I am guided by literature that asks how biomedical technologies have reconfigured notions of gender and the family across cultures. Anthropologists have shown the ways in which new genetic and reproductive technologies, in particular, have the capacity to reinforce local and global forms of social inequality (see Inhorn and Birenbaum-Carmeli 2008). While these technologies may be tools used to commodify the body and regulate populations, men and women are also seeking and rejecting diagnoses and justifying their decisions with different logics than those envisioned by political and biomedical authorities. The "emancipatory" possibilities that diagnoses are purported to embody – by linking patients to treatment options – are weighed against the socially stigmatizing effects of marked difference. Patients may seek diagnoses even when treatment options do not exist, such as among sickle cell carriers in Senegal (Fullwiley 2004), or reject diagnoses when they pose threats to social relationships, such as a shared genetic condition between a mother and a child (Konrad 2003). In this dissertation, I describe how HIV-positive women adopt particular understandings of physiological and virological processes, and appropriate technologies and therapies in their pursuit of social goals. I will show how some women's aspirations will be fulfilled, and others' will be thwarted, not so much by the technologies and therapies themselves, but by the social relations within which they are embedded.

Vital Continuities

Third, I align this dissertation with scholarly work on processual, constructivist approaches to kinship. Focusing upon marriage in sub-Saharan Africa, anthropologists have called attention to the heterogeneity of the institution across both space and time, and the ways it reveals innovative perspectives on a diverse array of issues including gender, agency, and political economy (e.g., Parkin and Nyamwaya 1987, Bledsoe and Pison 1994). Individuals seek marriage and reproduction as they strategize to gain access to resources, to improve their status and secure other aspects of wellbeing. Marriage is not only a process of becoming, but also a process of "unbecoming." Divorces, for example, are not "clean breaks" that reveal broader social processes of disruption, fragmentation, and endings; rather, they reflect a "complex tangle of ongoing and disputed ties, obligations and dependencies…[generative of] *vital continuities* in the way that one generation passes on its status, property, identity and accumulated wisdom and folly to the next" (Simpson 1998:2, emphasis mine). These continuities take place between generations, and as women proceed from one marriage to the next. In this dissertation I want to understand the characteristics and dynamics of a woman's marriage that continue to influence her social life even after the marriage dissolves. I will focus on the "vital" dimensions of household economies, reproductive experiences, and healthcare to illustrate these trends. If HIV-positive women's kin are central to the ways in which they navigate these virological contingencies, then it is critical to understand the forces that nullify, establish, and prolong the virtues and discords of marriage.

"Going Private"

And fourth, I aim to explore the tensions and conflicts that emerge when global health projects seeking to promote the liberal virtues of enlightenment, empowerment, and activism are initiated in a context within which the gendered virtues of modesty, privacy, and family life are prized, and the threats of HIV's stigma are realized in the forms of overt discrimination, violence, and social abandonment. I want to understand the conjuncture between these global economies and the local moral economies driving HIV-positive women's goals of respectability and responsibility. Strikingly, one of the ways women seek to defy processes of ascription and abandonment is by joining a support group. Unlike the Western "self-help" rationales that motivate the formation of these organizations, the purpose for women's participation was often to find new husbands. Just as support groups may propel particular forms of public engagement, they may also encourage certain forms of sociality and domesticity not captured by these political expectations. While support groups' efforts to forge relationships between its members appear to be a thoroughly novel development driven by the complications of HIV infection, numerous elements of this process unfolding within these groups resemble those that characterize kinship processes throughout northern Nigeria. Women "go public" by joining these groups with the hope that they will be able to ensure their privacy and secure the support of families who can make claims for them on their behalf. This dissertation will thus evaluate contemporary theories of biological citizenship and juxtapose them with the patterned forms of claim making and belonging that occur within the context of the domestic sphere (Rose and Novas 2005; cf. Das 2001).

From Invisibility to Ubiquity: A History of HIV in Nigeria

According to the 2005 HIV/Syphilis Sentinel Survey, there are currently 2.86 million persons living with HIV in Nigeria, the third highest number in the world, behind only South Africa and India. There were close to three hundred thousand new adult HIV infections in 2005 alone. These findings suggest a national prevalence rate of 4.4 percent out of a population that surpasses 140 million. Nigeria -- "Africa's Giant" -- is the ninth most populous country in the world. With close to ten million persons, Kano, one of the focal contexts of this dissertation, is the country's most populous state. It is roughly the same size as Chad, Rwanda, or Guinea, making it larger than nearly 25 other countries in Africa. In the city of Kano -- the largest urban center in the northwest zone of Nigeria -- the sero-prevalence rate matches the national figure at 4.3 percent (HSS 2005). In terms of sheer numbers of persons infected, this could represent as many as two or three hundred thousand cases of HIV. The second focal context of this study is the urban center, Jos, which is the capital of Plateau State located in the north central zone of Nigeria. Jos has a population of approximately 3.2 million with a sero prevalence rate of 5.0 percent (HSS 2005). Nigeria's current prominence among affected countries, however, masks the fact that the nation's policymakers and global health and development institutions alike largely disregarded the epidemic until the late 1990s. Further, while these rates are now widely circulated among these agencies, HIV-positive persons continue to be hidden – and continue to hide – from political attention.

The first two Nigerian cases of HIV were diagnosed in Lagos and were reported in 1986 at the International Conference of AIDS in Paris (Nasidi et al. 1986). Nigeria's initial efforts to address the spread of HIV are widely acknowledged to be tepid at best (Kanki and Adeyi 2006). Following this report, the National AIDS and STD Control Program (NASCP) and its predecessor, the National Expert Advisory Committee on AIDS (NEACA), were convened in the late 1980s with a charge of supporting monitoring and surveillance of the epidemic, and establishing voluntary counseling and testing centers, prevention of mother-to-child transmission of HIV programs, and health facilities with the capacity to administer antiretrovirals and treat opportunistic infections. While surveillance reports revealed a dramatic increase in prevalence from 1.8 percent to 4.5 percent between 1991 and 1997, advances in health infrastructure to support prevention, treatment, and care were minimal.

It was not until 1999 that policy and programmatic aims began to shift -- largely initiated by democratically elected President Olusegun Obasanjo, who inherited a national prevalence of 5.4 percent when he entered office. NASCAP was replaced with both the Presidential Committee on AIDS and the multi-sectoral National Action Committee on AIDS (NACA) in 2000. Committees were also established at the state and local levels (SACAs and LACAs). NACA was responsible for both the development and implementation of the three-year HIV/AIDS Emergency Action Plan (HEAP), which sought the "removal of socio-cultural, informational and systemic barriers to community-based responses, prevention, care and support," with an emphasis on the behavior change program now known as the ABCs (abstinence, mutual fidelity, and condom use). With the establishment of the Civil Society Consultative Group on HIV/AIDS in Nigeria, groups including the National Association of Persons Living with HIV in Nigeria (NEPWHAN) and the Armed Forces Program on AIDS Control were mobilized with support coming from the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria.

While bi-annual surveillance reports at this time documented increasing numbers of HIV-positive persons throughout Nigeria, few individuals – even among those who participated in these studies – actually knew of their HIV status and even fewer sought treatment. This began to change slowly in 2001 with the initiations of the Nigerian National ART Program, which purchased antiretroviral treatment for 10,000 adults and 5,000 children. The federal government spent $3.5 million in importing drugs from India, to be offered to patients at a subsidized cost of $7 per month. Far more patients, however, were enrolled than could be supported by this program leading to extensive waiting lists, and – in many cases – the halting of treatment for up to three months for patients already collecting drugs. At that time, there were only 25 treatment centers across the country receiving federal support. Only 2.3 percent of the estimated number of persons in need of medications was receiving them (Kanki and Adeyi 2006).

As HIV began to reach pandemic proportions across the country, Nigeria finally attracted the attention of global health and development agencies. In 2002, the World Bank loaned Nigeria $90.3 million to support the HIV/AIDS Emergency Action Plan. And in that same year, Nigeria was identified by the National Intelligence Council as one of five countries comprising the "next wave" of HIV/AIDS, along with Ethiopia, China, India, and Russia. According to this report, the epidemics in these countries have been deemed strategically important to the United States because of the size of their populations; the fact that each are in the early-to-mid stage of the epidemic; and because, they argue, there has not been sustained high-priority attention paid by these governments to the course of the epidemic and the measures needed to be taken to curtail it. While they acknowledge that Nigeria has been the most active of these countries to promote HIV awareness, it has been undermined by political instability and the rapidly deteriorating public sector. At the end of 2003, there were officially 100,000 cases of AIDS reported in the country, which represented only a fraction of the estimated 1.5 million cases of AIDS and 3.2 to 3.8 million estimated cases of HIV. It was predicted that there would be 10 to 15 million cases of HIV by 2010 (NIC 2002). Nigeria's epidemic was visible primarily because of its ties to global concerns surrounding political stability, *not* because of the illness courses of its infected population. HIV-positive persons continued to exist only in the aggregate.

In the early 2000s, the United States government received global criticism for its recalcitrance in intervening in global development and HIV/AIDS concerns. National security reports and projects such as these were instrumental in the development of the President's Emergency Plan for AIDS Relief (PEPFAR) – America's initiative to combat the global HIV/AIDS epidemic. In 2003, President Bush requested Congress to devote $15 billion over five years to stemming the HIV epidemic in sub-Saharan Africa and the Caribbean. The goal of the original PEPFAR initiative was known as the "2-7-10 plan;" that is, provide two million persons with ARVs; prevent seven million new HIV infections; and provide 10 million persons HIV care. Broadly, their programs center around treatment, care, and prevention activities, as well as the collection of Strategic Information. Nigeria was among the first to be recognized by PEPFAR and one of the most funded of the focus countries. The first $350 million was dispersed to focus countries in January 2004, and full implementation began in June of that year. Nigeria's initial grant from PEPFAR was approximately $71 million in 2004 and has increased exponentially each year. By September 2004, 13,579 persons were receiving treatment. This figure doubled to 28,500 in September 2005, climbed to over 67,000 in September 2006. There were 126,400 recipients in September 2007, and 211,500 as of September 2008, which falls well short of its goal to treat 350,000 persons. Over half a million patients currently in need of treatment remain without medications. The current PEPFAR budget approved for 2009 surpassed $440 million.

Research Methods

Exploring the tensions that arise between the public visibility of technologies and projects of public health and the virtues of privacy, modesty, and family life in northern Nigeria have proven to be a far more complicated methodological endeavor than I anticipated. "The Evidence of Things Not Seen" is perhaps a fitting characterization of the improvisations that have characterized my work with this population. To some extent, these difficulties and the various ways scholars evolve and improvise their methods over the course of their ethnographic projects characterize the discipline of anthropology. But mine began with a more basic concern: *where do you meet HIV-positive people?*

In 2002, I first began my research in the middle-belt city of Jos in Plateau State. While few patients had access to the government-subsidized treatment program during the time I was there, Jos was quickly becoming one of the epicenters of HIV research in Nigeria. In 2000, the Harvard School of Public Health was awarded $25 million from the Bill and Melinda Gates Foundation – at that time the largest grant in HSPH's history -- to initiate the APIN (AIDS Prevention Initiative in Nigeria) Project. In Jos, this project was forged in collaboration with the Institute of Human Virology World Laboratory, the Jos University Teaching Hospital and other agencies. Their work included the collection and management of epidemiological information, including "real-time surveillance" of high risk populations and the spread of sexually transmitted diseases. I was given an affiliation with the Institute for Human Virology, who had recently carried out a large survey with a population of (illegal) miners on the Plateau. These ties enabled me to design and carry out a series of interviews with these men. While I learned much about the informal social organization of mining operations and the sexual networks of these individuals, none were aware of their HIV status and few knew anything about the virus.

In early 2003, I was introduced to a small free clinic in Jos, which had just begun a support group for their HIV-positive patients. At that time, the group was comprised of 25 or 30 men and women, both Muslim and Christian, many of whom spoke Hausa and English and were native to northern and north-central Nigeria. In addition to collecting life histories from each of these members, we spent much time traveling in small groups to Evangelical and Pentecostal churches in the city, giving presentations about HIV. One or two individuals would tell their "testimony" of how they contracted the virus and they would lead the church in prayers. The members of the church would give the support group members money, which would be shared with the members. Those who gave testimonies would be given more money than the rest. In many cases, these testimonies differed in both subtle and obvious ways from the narratives I collected. Several prominent themes emerged from these interviews and observations. The first, described in the introductory paragraph, was the dilemmas men and women had over marriage. Most of the members of this group were, in fact, widows and widowers. Many had contracted HIV not from pre-marital sex but from their marriage partners. While now there are numerous public health and anthropological accounts of the ways in which marriage shapes HIV risk, to me this came as a complete surprise. A common theme brought up in my interviews was the ways in which the range of questions employed by counselors to assess risk did not map onto the life experiences of these individuals. Patients felt stigmatized by counselors and physicians often in glances, gestures, and tones, as well as explicit judgments or actions. I have drawn from the stories and thoughts of several of these individuals in this dissertation, particularly in the chapters on "Prevention with Positives" and "Dilemmas of Diagnoses and Disclosure."

I spent a week in the northern Nigerian city of Kano in 2003 and was particularly intrigued by the religious and political transformations, in the wake of Nigeria's transition into democratic governance, and the northern state's introduction of *Shari'a* law. Given the emergence of these strict religious, political, and social norms about promiscuity and infidelity, I was told repeatedly that there was not an "AIDS problem" in Kano. Interested particularly in the role of gender as a lens through which to examine this nascent epidemic, I returned to Kano in 2004 for three months to interview female members of a support group. Like the support group in Jos, this group was small and sponsored by a prominent NGO that focused on women's health and development issues. The majority of the women I met were Hausa-speaking Muslims, and they spent much of their lives living in northern states, and ranged in age from 18 to mid-40s. I met weekly with a group of these women and conducted a number of focused interviews with 12 of them. I expected to find HIV-positive women in this group actively engaged in public projects, similar to their Jos counterparts. While they seemed to be happy to take part in my study, they were ambivalent about their group's public outreach activities and seemed to be reluctant participants in them, at best. They were, however, most eager to talk about marriage – both their past relationships *and* the relationships that were being arranged within the support group. These conversations are highlighted, in particular, in the chapter, "Support Groups, Marriage, and the Management of Ambiguity."

Beginning in 2005, with the expansion of treatment options in both Kano and Jos, enrollments of HIV-positive persons in support groups, NGOs and hospitals increased exponentially. The small clinic where I worked in 2003 was selected as one of Nigeria's first PEPFAR sites, and free medication began to be offered to all patients. The number of HIV-positive persons who collected treatment there went from a few dozen to over two thousand within just a couple of years. Virtually everyone who collected ARVs at area hospitals was referred to support groups. In 2005, this small clinic had 800 persons enrolled in their support group, with approximately 150 in attendance at their weekly meetings. In Kano, I witnessed a similar pattern of growth. In 2006, the number of support groups across the city increased from two to seven, and five hospitals managed the cases of thousands of patients collecting treatment. Dozens of tertiary hospitals and clinics were testing and counseling HIV-positive persons and referring them to these treatment centers. There were over 26 organizations within the city of Kano receiving support from PEPFAR for HIV prevention efforts, counseling, and other support services for persons living with HIV.

Given the expansion of testing and treatment programs in both urban and rural settings across northern Nigeria, I could have accessed HIV-positive persons in any number of sites. Instead I focused predominantly upon the relationships I built in those first two years. The in-depth interviews that I conducted with HIV-positive people in 2005-2008 were all based upon introductions I received from persons I knew from those first two visits. The eight months I spent in Kano between 2006 and 2007, and the four months I spent in Jos, Kano, and Abuja in 2008, was, in some respects, quite different from my earlier visits. First, I devoted much of my time to observing and spending time with families in Kano. I lived in two different residential neighborhoods with Hausa-speaking Muslim families. I spent the majority of this period in the suburban neighborhood of Hotoro and a shorter period of time inside the "old city" of Kano in the neighborhood, Chedi.

In Hotoro, there were multiple large houses and apartments in this walled compound where I lived. The household was occupied by the mother-in-law of my close friend, two of her grown children, and the children of her late co-wives. In addition to the families who lived there permanently, there was a steady stream of visiting guests, other family members, and children, who stayed for both short and long periods of time. Much of my day-to-day life in Kano centered on the activities of this family. I would make "my rounds" among these individuals: waking up to greet 'Mama' and having tea or breakfast with her, to moving to another apartment where I would sit in the kitchen while my friends were preparing meals; in their parlors I would meet with their husbands, friends, and other visitors. Being both (relatively) young and non-married, conversations of courtship, marriage plans, and weddings, were common, and I was given many lessons on the proper behavior of young women, wives and parents. Knowing I was interested in medicine – and having suffered through numerous maladies while living there – I also spent countless hours discussing matters of health and healing.

Through these individuals I forged many of my lasting friendships and social networks throughout the city. I would accompany them to their workplaces, markets, schools, relatives' and friends' homes, parties, weddings, condolences visits, and other formal occasions. In these settings, I paid attention to issues such as how marital status shapes routine activities. I examined differences among and between widowed and divorced women, and took note of their exchanges with other men and women, including their parents, former in-laws, other family members, and friends. I was especially interested in conversations surrounding pregnancy and parenting, polygamy, infidelity, marriage conflicts, divorces, aging and health. At places such as weddings and other family events, I watched how men and women interacted with each other, what they talked about, and how individuals participating in the weddings described the process of courtship and marriage more broadly.

In Chedi, I lived in an apartment above a small family of four. The house belonged to the wife, who had inherited it from her late husband. She had remarried and they had two small children. The research I conducted here was also quite different than work in previous years. I was introduced to a "matchmaker" in the neighborhood, who introduced me to a number of widows and divorcees in Chedi and the surrounding neighborhoods of Sharifai, Yola, Alkantara, and Darma, most of whom were her clients and friends. With these individuals, I conducted approximately 50 semi-structured interviews on an array of issues related to their family life and marriage dissolutions. While their cases are not featured in this dissertation, my interviews with these women were instrumental in helping me to make my argument on the ways in which reproduction, healthcare, and the economic instability of households shape the transitions HIV-positive women experience into and out of marriages.

During the time I spent in Kano between 2006 and 2007, I also observed the day-to-day operations of an HIV treatment center, where approximately 250 men and women collected antiretroviral therapies. I attended staff meetings, pre-test and post-test counseling sessions, training workshops, and informally spent time with doctors, nurses, laboratory technicians, pharmacists, and other persons involved in the clinical management of HIV-positive persons. Within the counseling sessions, I listened to the advice patients were given regarding their changes in health, treatment, adherence, sexuality, fertility, and preventive behaviors, and the questions and concerns patients, in turn, raised. I was particularly interested in how patients reflected upon HIV-related illnesses, fatalities, and the influence ARVs and their side effects had on their daily life activities. I observed how patients were recruited into this treatment program and the efforts the hospital staff took to encourage patients to return for follow up care and medications. One of the HIV-positive women whom I had interviewed in 2004 – and perhaps my closest friend and key informant – was a counselor whom I "shadowed" not only at the hospital, but also through much of her daily life. More than any other individual, her case has informed and is featured in most of the arguments I make in this dissertation.

In 2008, I spent a number of weeks in Abuja, where I met with American and Nigerian policymakers, program implementers, physicians, and epidemiologists involved in carrying out the PEPFAR-sponsored programs in Nigeria. Through my interviews, I wanted to learn more about the collaborative dynamics between international, national, and local governmental, health, and social institutions and the individuals involved in HIV treatment and care. I discussed with these persons their priorities and experiences with these prevention and treatment initiatives and I sought to understand their evaluations of social problems surrounding gendered inequalities, poverty, stigma, and more focused critical thoughts on the problems of adherence, drug resistance, and secondary prevention of HIV (including their concerns over sero-discordant partnerships and "super infections"). I also collected narratives on their day-to-day routines and the ways in which their career trajectories have evolved over time. In a number of chapters, I contrast the priorities of global health policies and programs with the actual experiences of northern Nigerian women living with HIV, and these interviews helped me in contextualizing these initiatives.

Between 2006 and 2008, I collected case studies of ten additional HIV-positive women. These women had been married at least once and were currently residing in Kano. Hausa was their native language and all but one was raised in a Muslim family. These conversations covered much of the same ground that I focused upon in my earlier interviews in Jos and Kano. I began with their descriptions of childhood, families, and schooling, followed by adolescence, relationships, marriage and childbirths. I asked questions about marriage conflicts and broader family conflicts, sicknesses, and the dissolutions of marriages. I reviewed with them their relationship and marriage ideals and how one goes about remarrying. Polygyny and infidelity were also examined as elements of the remarriage process, as well as sources of marital conflict. We often focused on the social significance of childbirth and children, as well as the importance of family relations in influencing men and women's relationship trajectories. Finally, we discussed issues related to HIV and the life course: their HIV knowledge, experiences in knowing or caring for HIV-positive persons, prevention efforts, potential exposure(s) to the virus, social stigma, HIV's complications with sexual functions and fertility, treatment, and HIV-related morbidity and mortality.

Equally important during this period was the time I spent with the HIV-positive women with whom I had interviewed between 2003 and 2005 in Jos and Kano. I no longer concentrated on formal, tape-recorded interviews with these individuals; instead, our interactions were much more informal. I spent time with them as they cooked and cared for their children. We would shop and visit their relatives. But mostly, we would gossip, or "jist" [to use a Nigerian expression]: we would talk about boyfriends and marriages, the news about people we knew in common, and our own critical thoughts on the position of women, the abuses of family members, and our misgivings about treatment programs and support groups. My interest in support group politics and dynamics waned in these more recent visits. In part, it was because these meetings had become so large that they resembled lectures or church services, and lacked the participatory dynamics I had come to appreciate in the different groups I attended in Jos and Kano when I first began this study. More significantly, many of the women I first met in these groups themselves lost interest in attending these meetings. They maintained their relationships with the leaders of these groups and NGOs and could call upon them if they had urgent needs. They would occasionally agree to participate in programs that might give them money or other resources. They also had close friends they had made in these groups – including boyfriends. But mostly, they had other work and social obligations to which they had to attend. Consequently, I followed them as they moved beyond their support groups.

All of the HIV-positive women I interviewed were at some point associated with a support group. This meant they had a number of things in common that likely differentiated them from other populations of HIV-positive persons unaffiliated with a support group. They all lived in an urban setting and had access to healthcare, and currently, HIV medications. Most women I knew joined these groups in search of new partners and economic assistance, which means they were more likely to be poor and non-married. Issues of access limited my ability to explore these issues in depth from other perspectives. At the time when I commenced this work in 2003, I was fortunate to have developed the relationships that I did within this burgeoning support group in Jos. HIV-positive persons, as I argued, were largely invisible within the population. The following year in Kano, I learned that once HIV-positive persons remarried, they often disappeared from support groups entirely and would have no interest in being part of a research study. I found out much of what I know about HIV and marriage from the perspective of non-married women. In the wake of expanding treatment options, however, there are now numerous ways in which a researcher can locate HIV-positive persons. In any given hospital in Kano, for example, there are hundreds of persons who go to hospitals to collect medications each month. Thus, it is possible to have a much more diverse sample of women than that with whom I worked, accounting for the nuances of ethnicity, class, education, place of birth, age, and other health criteria. Rather than refocus my study to expand upon these different social positions and perspectives, however, I prioritized the relationships I have cultivated over time with these particular women in Jos and Kano. What makes my study unique from others is the very fact that I have made long-term commitments to these two populations of women.

None of the women I know, for example, are newly diagnosed with HIV. Given that my study first began in 2003, most of these women have known their status far longer than the majority of HIV-positive persons across Nigeria. Some have "lived positively" for a decade or more. This allows me to make arguments about women's marriage experiences that would perhaps be less convincing among persons who have known their status for only a couple of years. Many of the non-married women I first met subsequently got married and had children. Even more significantly, because I have spent such a long time between these two particular communities, my relationship with these women and their organizations has changed in a way that I think is critical to the points I seek to advance in this dissertation. I would like to think women's initial distrust of me has shifted to a more general comfort with my presence. These women know all I really like to talk about are boyfriends, marriage, and families – and that, not coincidentally, is often all they would like to share with me. I acknowledge, in particular, that there are many differences between women who live in Jos and Kano, between those who are Muslim and Christian, between urban and rural dwellers, and between old women and young women, to which I do not do justice when I gloss my observations as "northern Nigerian society." In response to this, I rely heavily upon the many relationships I have built and experiences I have had over my two and a half years living in northern Nigeria, to make these arguments – not all of which are easily captured in ethnographic writing. Further, I concentrate on the detailed narratives women have offered me over more generalized summaries, which I believe are provocative and present important social questions, though not necessarily definitive answers.

Chapter Organization

Chapter One, "Prevention with Positives," focuses upon biomedical and popular depictions of HIV risks and the death sentences accompanying HIV-positive diagnoses. I contrast these representations with HIV-positive women's own understandings and experiences of risk and the threats the virus poses to their physiological and social trajectories. Second, I examine the circulations of virological knowledge as it is intertwined with these understandings of risk. These "virological contingencies" – the various social pursuits that virological dynamics are believed to make possible – are grounded in reproductive intentions and outcomes, matters of kinship obligations, and larger critiques of social inequalities. Third, I elucidate the social contingencies that emerge and unfold as HIV-positive women seek access to antiretroviral therapies. These efforts can serve as lenses onto both gendered inequalities and the broader political economic context that constrains patients from accessing the resources necessary to intervene in their illnesses.

Chapter Two, "Dilemmas of Diagnoses and Disclosure," asks why ordinary Nigerians would want to know their status and why they might not want to know. What specifically is at stake when one receives a positive result? I contextualize fears of HIV-positive results within the larger moral economies of marriage and family life. Women's partnerships and sexual behaviors are thoroughly enmeshed in their marriage aspirations as well as their material livelihood. The risks of remaining unmarried and economically unstable (the latter of which reinforces the possibility of not marrying a respectable husband) often outweigh the risks of HIV. I argue that *from whom* one is informed of their diagnosis *to whom* that individual, in turn, chooses to disclose, and *when* this person learns of her status all illuminate – and shape – central dimensions of social ties.

Chapter Three, "Support Groups, Marriage, and the Management of Ambiguity," argues that, in the context of the African HIV epidemic, support groups are not simply "emancipatory" spaces for discussions of social and health well-being; neither are they institutions functioning solely to cultivate self-responsible and economically empowered patients. In this chapter, I describe how HIV-positive women in northern Nigeria have appropriated a support group to facilitate their marriage arrangements. In the group I observed, women negotiate threats of stigma and the promises of respectable marriage through what I call the "management of ambiguity" surrounding the HIV status. This practice captures the conjuncture between these global economies of HIV intervention and the local moral economies driving women's goals of respectability and responsibility in the face of HIV/AIDS. Marriage aspirations are windows onto the symbolic importance of families to Nigerian women, the local gendered power dynamics that shape social and illness trajectories in resource-poor settings, and the overarching constraints that prevent women from reproducing these global expectations of health citizenship.

Chapter Four, “Vital Continuities: Sequential Marriages and HIV,” points out that the symbolic importance of marriage among Nigerians misleadingly suggests partnerships are static, stable entities over time, when in fact they are highly fluid for both men and women. Even the point at which a marriage ends is ambiguous. Northern Nigerian women will move out of and back into a single marriage, as well as will likely transition into and out of a series of marriages over their life course. Through the cases of three HIV-positive women who have been married multiple times, this chapter traces the lasting effects of household economic instability, the significance of reproduction and its disruptions, and the affective and material exchanges between husbands and wives and their broader kinship networks. I focus in particular on the exchanges that take place over issues related to women’s health. HIV infection, I will show, is a concern that accompanies these larger social issues and magnifies their consequences for subsequent marriages.

CHAPTER ONE

PREVENTION WITH POSITIVES

Introduction

Popular fears of geopolitical instability have been tied to an array of forces, including financial market crises, climate change, terrorism, and most recently HIV/AIDS. The epidemic, policymakers have argued, magnifies a crisis in the development of social and health infrastructure in Nigeria. The "crippled nation-state" offers a powerful symbol for mobilizing the need for global health interventions. Nigerian leaders welcome this assistance, embracing a trend across sub-Saharan Africa of outsourcing infrastructural services as endemic political corruption and the debt accrued through structural adjustment programs have depleted the capital needed to address these deficits. Current political efforts targeting HIV control, consequently, have operated through assemblages of financial agencies, non-governmental organizations, corporations, and other social institutions. HIV prevention and treatment campaigns, funded and organized by these global assemblages, have mobilized new paradigms of risk management worldwide. They seek to reduce the spread of the virus through the dissemination of epidemiological information, and investments in cadres of experts, surveillance tools, biotechnologies and laboratories, and most recently, antiretroviral therapies. These biopolitical projects have included the classification of "at risk" populations and targeted behavioral change programs, the focused monitoring of virological dynamics and measurements of infectiousness in HIV-positive populations, and the universal provision of HIV treatments. In Nigeria, the efforts of these agencies offer compelling illustrations of the ways in which ideas, objects, and capital oriented toward particular responses to the HIV epidemic circulate globally. In a closer examination, however, it becomes evident that these biopolitical projects are being challenged in both direct and indirect ways in different local contexts. Nigerians are interpreting, appropriating, and reconfiguring these projects through particular political, social and moral agendas.

In this chapter, I first consider the multiple levels through which the risk of HIV is imagined and problematized. I focus in particular on how an apparatus of risk management is mobilized and reproduced in Nigerian popular commentaries. Epidemiologically, to be categorized "at risk" of an illness is to suggest that an individual is pre-disposed (through a genetic, biological, environmental, or behavioral condition) to a possible or psychological injury. Rarely, however, in Nigerian commentaries and interventions are "at risk" categories of persons classified strictly following this biomedical logic. The unknowable threats of broad political economic changes in Nigeria are rendered into problems through particular forms of political analyses, moral reflections, and technoscientific practices. "At risk" populations, I have observed, tend to be clustered dichotomously: there exist those who are marginal, powerless, passive recipients of the dangers that social threats pose; and those who are agents in bringing danger upon themselves (as well as upon society writ large). Both categories are inextricably intertwined with labels of moral and immoral. I juxtapose these epidemiological and social categories with the ways Nigerians living under the description of risk (whether those who are "at risk" or those "doing risk") negotiate and subvert these authoritative voices. Specifically, I center this analysis on women living with HIV and how they respond to these physiological and social "death sentences," as well as the claims to risk they deny.

Second, I examine the circulations of virological knowledge as it is intertwined with these understandings of risk. I concentrate on the monitoring of physiological dynamics and measurements of infectiousness in HIV-positive populations as a lens onto which we can understand these developments as social processes. In Nigeria, biomedical authorities and families alike may consider this information as something that must be withheld if it has the potential to motivate immoral and unhealthy behaviors. Alternatively, it can be used to reinforce judgments that a person is indeed acting morally. In this section, I explore the ways in which Nigerian counselors and patients themselves evaluate the credibility of virological data. The process through which credibility is granted is contingent upon moral evaluations and aspirations, and the efficacy through which "evidence" can be transformed into meeting particular social goals. I refer to the possible futures HIV-positive women imagine as "virological contingencies." Unlike the policy debates that view the significance of these findings in terms of broad societal impacts, measurements of (non) infectiousness among Nigerians are grounded in reproductive intentions and outcomes, matters of kinship obligations, and larger critiques of social inequalities.

And third, I elucidate the social contingencies that emerge and unfold as HIV-positive women seek access to antiretroviral therapies. Human rights activists, as I stated, have expressed their unconditional support of universal HIV treatment programs because of the possibilities these efforts present for reversing the exclusionary dynamics associated with the virus's deadly prognosis. Public health practitioners identify the risks that ARVs pose through measures of individuals' attitudes and behaviors, and their virtues through measures of their physiological effects on individuals' bodies, population level effects on life expectancies, and epidemiological prevalence rates. Largely taken for granted are the virtues of therapies for patients' social lives. In this section I ask why it is that these actually *matter* to women? That is, what do these therapies do for patients beyond their physiological effects? And how do social relations, in turn, affect the course of illnesses that women experience? I show how HIV-positive women make claims upon numerous authorities to acquire assistance for their healthcare needs. Not all patients are able to secure the leverage needed to receive treatment and care equally, however. For some women, this quest for therapy goes unnoticed or unattended to, until the point at which their bodies have virtually deteriorated. Both the toll of the virus and their neglect is plainly visible, perpetuating the cycle of fear and stigma that HIV-positive women desperately seek to avoid. As they seek to be unseen, I argue, women must first obtain recognition in their efforts to get and stay well.

Threats, Risks, and Uncertainty

In their book, *The Normal Chaos of Love*, Beck and Beck-Gernsheim (1995) have argued that in the conditions of reflexive modernity – that is, a society characterized by increasing individualization freeing men and women from traditional gender roles – love has become more important to individuals at the same time as it has become more elusive. They write that men and women "are driven into seeking happiness in a close relationship because other bonds seem too tenuous or unreliable" (24). Ulrich Beck, known best for his theory of "risk society," describes how processes of modernization have resulted in the increasing unknowability of the risks industrial and technological developments have produced (Beck 1992, cf. Giddens 1991). The erosion of social relations and obligations is a symbol of contemporary times, social problems, and ethical dilemmas. Mitchell Dean (1996), in summarizing the consequences of Beck's risk society for example, writes:

> Residual traditional, communal or regional bonds are undone by the relentless surge of globalization; solidarities of class, family and nation give way to a multiplicity of forms of life and the conscious adoption of lifestyles…The net product of the forces constituting the present epoch make it one in which identities are either de-centered, dislocated, fragmented and placed in crisis (Hall 1992:274-275) or, more subtly, subject to processes that, while offering opportunities for self-actualization, can also lead to fragmentation, insecurity and powerlessness (Giddens 1991: 187-201). (213)

Epidemiological analyses are part and parcel of larger biopolitical projects that seek to enumerate and assess the state of human relations and social behaviors. In the face of the unknowable, danger and menace are increasingly being categorized and expressed by epidemiologists through the idiom of risk (Trostle and Sommerfeld 1996). Collier, Lakoff, and Rabinow (2004) refer to these efforts as a process that enables present acts to be made responsible – a process reflecting a much deeper preoccupation with order, certitude, and accountability in the West. The efforts to classify and categorize risks extend well beyond that of epidemiologists. According to Malaby (2002), this preoccupation is driven in part from the Western preeminence of statistical reasoning (Hacking 1991, 1992) and the control of this information by experts (e.g. Latour 1987, Beck 1992).

The tendency of social theorists – and popular journalists -- to suggest sweeping relationships between processes of globalization and modernization and the disintegration of solidarities of class, family, and nations is highly problematic. For one, class, family, and nation cannot be examined as autonomous social units. Second, their statements often suggest that these are static, primordial categories of sociality, subject only to fragmentation and dissolution, and selfhood is, consequently, a constructed category in reference only to crisis. Both subjectivities and socialities, in fact, are formed and reformed continually in dynamic, culturally specific processes. I would argue that people's anxieties, distrust, and discord might actually be indicative of just how important these relations are in modern times. In evaluating this work, Dean (1996), too, acknowledges the problems of theoretical meta-narratives of modernity and post-modernity, and suggests that the work on self or identity – and I would add on social relations – should be analyzed through "the specifically conceived topography of the person it employs, the questions it puts to aspects of conduct, the techniques it encourages, the "practices of the self" framing it, the population it targets, the goals it seeks and the social struggles and hierarchies in which it occurs" (215). Foucault would argue that the "practices of the self" described by Beck are not, in fact, specific to post-modernity, but are in fact part of a much older, longer, and complex trajectory (Dean 1996:215).

Far from being the product of contemporary global political and economic transformations and disintegration that Beck, Giddens, and others describe, uncertainty or the unpredictable, is a universal human experience. Malaby (2002) illuminates the ways that the literature in medical anthropology on both epidemiological critique and narratives, both fall victim to this presumption – that human beings seek to minimize the chanceful, and therefore dangerous, nature of their lives (290). While the term risk, Malaby suggests, designates a useful category to describe something in a place to be gained or lost, the range of human stances toward contingency and what is at stake in these social actions extend well beyond this. Among the multiple domains of indeterminacies Malaby outlines, I find his conceptualization of *cosmological indeterminacies* to be most useful. By cosmological indeterminacy, he refers to "the ever-present possibility for any explanatory system (any cosmology, or way of making sense of the world) to be called into doubt (293). This thread, in particular, is informed by the work of Thomas Csordas (1993) who also privileges indeterminacy as an essential element of human existence.

Susan Reynolds Whyte (2002) proposes that scholars should approach investigations of subjectivities in terms of individuals' *situated* concerns; that is, "the specific uncertainty that particular actors experience as they try something that matters to them – as they undertake to deal with a problem" (175). These concerns are always intertwined with those of other social actors, both known and unknown. In the context of particular uncertainties, the forms these social encounters take are predicated on the desire for continuity in personal relationships and, as Whyte suggests, the strengthening of the possibility of mutuality to come (183). But, toward what ends do individuals' imagine that these virtues of mutuality ultimately serve? Uncertainty is not merely characteristic of an individual's anxious interior state. It is also structured symbolically, socially, politically, and materially, and it possesses infinite modes of expression. Relationship aspirations and the expectations for future support – and consequently the everyday social encounters where HIV-positive women's aspirations and expectations are manifest -- are *not* necessarily human universals, but rather depend upon the structures that uncertainties take in a given context, which – in and of themselves -- are neither threats nor virtues. Political and technological interventions are the tools with which authorities seek to mitigate risks. The Nigerian experience of living with HIV elucidates these points in important ways: it reveals both the prospects and limitations of these interventions in mediating uncertainty as well as social and health trajectories.

"At Risk" in Nigeria

In contemporary Nigerian society, there has been a consciously conceived and concentrated effort by leaders to employ particular narratives of the sexual lives of its citizens in both their formulations and justifications of social agendas. Accompanying these narratives are continual references to "at risk" populations. From the perspective of physicians and epidemiologists, individuals who are categorized as "at risk" are pre-disposed in some way to a possible physiological or psychological injury, often through exposure to biological, genetic, or behavioral conditions. Rarely, however, in popular political and social commentaries and interventions are "at risk" categories of persons classified strictly following biomedical logic. At risk populations tend to be clustered dichotomously: there exist those who are marginal, powerless, passive recipients of the dangers that social threats pose; and then those who are agents in bringing danger upon themselves (as well as upon society writ large). Both categories are inextricably intertwined with labels of moral and immoral. Underemphasized in these narratives, however, are the overlaps: namely, those who are labeled at risk also pose risks. By troubling the "neat" categories of moral and immoral, the justifications for and efficacy of interventions are disrupted. In the following section, I emphasize the subjective ways in which authorities define the processes that shape dispositions and tie threats to effects. The ways in which these processes are positioned and elaborated upon speak directly to what is at stake for authorities and the strategic aims they take.

Morally laden depictions of social and health risks are expressed in virtually every public forum in Nigeria, and are perhaps most common in the popular press. In any given month, one could find dozens, if not hundreds, of stories framed similarly. The sexual behaviors of adolescents and pre-adolescents, for example, are caught up in debates over "street children." A Nigeriaworld feature entitled, "Street Children: The Agony of a Nation," describes the forces driving this "epidemic":

> The Street Children phenomenon in Nigeria is gradually assuming alarming proportions, particularly in urban areas. The immediate cause of this challenge appears to be deeply entrenched in poverty, which defines lives of the vast majority of the Nigerian people. Invariably, broken homes and families who find it difficult to provide the basic needs equally end up at some point on the streets and the phenomenon very much alarmingly resulting in: child labour, child trafficking, child prostitution and a host of others…The government has a lot to do to address the problems which are largely social, economical, health-wise which are in the ambit of the state. In fact the menace can be reduced through strategies towards reduction of poverty, mass-literacy, preventive health programmes, and other social services.
>
> [Atinuke, 9/2/08]

To "problematize" the Street Children phenomenon, the journalist first calls attention to the trajectories of economic processes that drive poverty and threaten to destabilize urban households. In the face of this unfolding demise, child labor, child trafficking, and child prostitution are these trajectories' predicted outcome. Children are indeed presented as victims of these unfolding threats, falling subject to these occupations. The language of illness epidemics employed to present this case is not coincidental: the supposedly "natural" course of epidemics grants further power and persuasiveness to this association between poverty and labor, which, though compelling, is not rooted at all in nature (and neither, for that matter, are illness epidemics). As it reads, contemporary social conditions foster epidemics of "social illnesses" among children. Children are "at risk" of suffering these presumed fates. Less explored in this article are potential ways that children's behaviors – that is, their occupations – could also be a force in destabilizing social structures. Situations portrayed as moral imperatives – such as that on behalf of innocent children – demand action. Claims to particular state actions, however, might perhaps be weakened if children were not simply innocent victims in the face of these processes. Certain moral claims are granted greater attention than others, depending upon whom these claims are made. In the case of the association between poverty and street children: if there were nothing to be done, would the category of "children at risk" exist?

Designations of victims shift to those at fault in other narratives. A series of articles, again published on the website, Nigeriaworld, explores the "malady" of prostitution, "left unchecked and…spreading like wild fire" in Nigerian universities. Remarking on this seeming paradox, Uzokwe (2008) writes, "By day, they masquerade as students, attending classes and going to the libraries like other students but by night, they shed their academic garbs and don that of the oldest profession in the world." Uzokwe proceeds to classify the range of approaches university women follow in soliciting men. Observing that women possess multiple phones, this writer pauses on their role in this apparently sinister business. He states:

> Ironically, these girls and their male accomplices are misusing cell phone technology in Nigeria. The advent and proliferation of cell phones, in the country, was a highly welcome development and was one of the few positive achievements attributable to the Obasanjo regime. It cut down on the need for traveling around the country. It may have reduced the number of car accidents in the nation because of reduced travel. There is also the possibility that it may be saving lives in emergency situations. However, campus prostitution seems to be one area that something good has been turned upside down and used to achieve sinister goals. Cell phones are unfortunately aiding the young girls in flawlessly executing their illicit trade.
>
> [Uzokwe, 7/21/08]

In this narrative, the journalist illustrates his fear of the ways that material benefits of development, such as universities, and the very objects that symbolize modernity, such as cell phones, can be exploited or spoiled. Uzokwe attempts to reinforce his recasting of threats as risks through his systematized descriptions of the illicit behaviors of young women. In this moral reflection, women are to be blamed for appropriating these benefits and deploying them in decidedly "non-modern" activities. Here, sexual behavior is classified as distinctly "non-modern" and therefore requires intervention. Like street children, women's patterns of sexual behavior are thought both to reflect and reproduce social instability.

I am not contesting here the existence – or importance – of these associations. My emphasis here has been to draw out how categories of risk are created and given meaning in their juxtapositions with larger global processes and locally embedded moralities. Sexual behaviors, I argue, are inflections of other potentially socially destabilizing risk behaviors. Likewise, the fearful threats of the HIV epidemic's trajectory in Nigeria are inflections of the fearful threats of these larger social processes.

The subjective and social experiences of HIV-infected women in Nigeria, consequently, are situated within a local moral economy that unjustly and unevenly distributes both the burden of sexual and societal fears and accusations of sin onto those who test positive. These assertions, doubts, and anxieties surrounding HIV simultaneously engage local symbolic meanings, are caught up in complex social relations and interactions, and are propelled by political economic forces (e.g. Farmer 1992, Scheper-Hughes 1994, Jing 2006). They also take the forms of rumor, conspiracy, gossip, and blame, which by definition, are rooted in ambiguity, not fact. Rumors surrounding "the AIDS club," for example, where HIV-positive persons knowingly infect others, exist globally, but their particular expressions and interpretations reflect amalgams of the political, social, and cultural landscapes within which they circulate (Kroeger 2003, Leclerc-Madlalla 1997, Fine 1992). I center here on two particular cases that invoke associations between risk and HIV because of the sharp contrasts that are revealed when juxtaposed against the understandings and accounts of the moral basis of HIV transmission suggested by the women with whom I worked.

In an article situated prominently in the national newspaper, *This Day*, for example, the journalist identified Nigeria's position as the third highest "infected" country in the world and reported the release of a National Agency for the Control of AIDS [NACA] document entitled, *Basic Facts on HIV/AIDS*. Among its key "facts," this paper sought to:

> "[alert] the nation that there were increasing cases of Nigerian ladies who, in their desperate desire to get back at the society, especially because of the stigmatisation which is still very prevalent, dress up provocatively and seek for lift from men, only to end up raping them and gleefully taunt their victims: "Welcome to the club, you are now HIV-positive."
>
> [Ugeh, 9/20/07]

Rumors such as these, which blame the course of the epidemic on the promiscuous – and even vengeful – behaviors of women and men, circulate widely among Nigerians. I have heard them mentioned in passing among health workers and even in accusations by HIV-positive persons, despite the fact that epidemiological evidence incontrovertibly refutes these reports. I sat one afternoon in a clinic with a counselor and a member of an HIV support group – Rita – and they recounted to me a similar story they were told by a young university-aged woman at a workshop earlier that year. The woman had a professor who said he would not give her a passing grade unless she has sex with him. She begged and pleaded with him. She said she could pay him any amount of money he wanted, but he refused. Finally, the woman told him she was HIV-positive. He refused to believe her and finally she gave in and slept with him. At this workshop they discussed her case. Some of the women said he got what he deserved. Others said that she should have reported him. He could then infect the other young women from whom he demanded sex. Nigerians think with and through HIV-related rumors, gossip, and blame, and these undoubtedly reflect broader social inequalities of gender, as well as ethnicity and other economic divisions.

In a controversial series of editorials in *The Daily Trust*, another widely read national newspaper in the northern states, Idang Alibi (2007) unapologetically pronounces his disgust for Nigerian AIDS sufferers, their immoral behaviors, and the corrupt society within which they live:

> There are some who have contracted HIV/AIDS innocently; a greater majority did so willfully, so to say. What I expect from HIV/AIDS sufferers and victims is not to dwell on how they got it, but to show genuine repentance and ask for God's mercy. They infuriate God and man when they proceed to act as if God and we owe them apologies. It is true it is God who created sex for man's enjoyment. But

> being the manufacturer, He gave strict specification as to how it should be used. Anyone who violates the manufacturer's guidelines should not act as if he is an innocent victim.
>
> [Alibi, 9/27/07]

This journalist is reacting to the increasing presence of HIV-positive persons in the media and in public health campaigns, whom he believes seek to justify and excuse their presumed sexual sins, rather than acknowledging that they were wrong. Like the NACA report, he too employs the victims/aggressor dichotomy, even as he argues for the distinction to be dismissed. HIV is a broad epidemic of immorality that can only be addressed through widespread behavioral and attitudinal change. He argues that patients must confess and apologize to God, but what he really wants are public acknowledgments of wrongdoing.

The Denial of Death Sentences

Having spent months observing counseling units, I was surprised to find explanations surrounding the pathology of HIV infection and its progression often absent in discussions between counselors and their clients. Instead, the life-prolonging effects of medications were stressed. Patients were assured that they would remain healthy if they adhered to their medications. One counselor stressed to all of her clients, “Before, typhoid fever killed many people and now there are medications that treat it…” An HIV-positive friend working as a counselor in one Kano hospital recounted to me a case where she was called upon to offer advice to a distressed patient. She said to this woman: “See my face? Do you know if I am positive or negative?” The woman said she thought she was negative. My friend continued, “How do you know this?” The woman said it was because she was so fat. “In fact,” this counselor, countered, “I am positive…So you see you can live healthy just like everyone. So long as you take your medicines everyday.”

Most women with HIV acknowledged the distress they felt at the time of their diagnosis, but stated repeatedly that all of these symptoms and thoughts about death had been relieved. In a conversation with women in a support group, one woman pointed out, “At the time, I felt I would die until later I discovered that other healthy people get sick and die and I am still alive. In fact, I have become healthier than before and do things a negative person is not able to do.” Most group members concurred. Another stated, “For me, since I became aware of my status, I have never thought that the disease would kill me. Before [my diagnosis], I had grown lean and everybody looked at me like an AIDS patient. I went to the hospital and I learned of my status, but I never considered the thought of dying. I just gave everything to God and up until today I do not think that this infection will kill me. Because, I know there are different diseases that can be responsible for my death or even an accident.” Similarly, a third woman emphasized, “When I found myself in this position, I became very thoughtful and worried so much I could not eat, would not bathe and stopped socializing. I also stopped paying attention to my prayers. But gradually, when I remembered that Allah has said that for every affliction there is a cure, I started praying more frequently. I would pray into water and drink *habbatussauda* [a medicinal plant, which is described in the Qur’an as a treatment that could cure all but death].”

A number of questions could be raised about why it is that patients’ discourses rarely dwell upon either the physiological “death sentences” or immoral pronouncements presumed to be handed to them. It could be that women are reproducing the biomedical knowledge provided to them by counselors or physicians. These authorities rarely articulate the details surrounding the prognosis for untreated HIV infection given their fervent desire to promote medication adherence. Unlike, perhaps, the broader population of Nigerians, however, most of the HIV-positive women with whom I worked *have* witnessed the chronic trajectory of the virus – both left untreated and treated. HIV, by its definition, is a shared illness. Many have been caretakers for and have lost partners and children. These questions speak to a broader concern about the nature of health-related knowledge. In his essay, "The Importance of Knowing about Not Knowing," Last (1992) draws upon his observations in rural northern Nigeria and suggests that there exists in Hausa society a "layered," uneven distribution of health knowledge. Patients rarely possess complete comprehension of any particular medical system even as they actively seek treatment from it. That is, they may not be interested in knowing how healing works, so long as it works. "People in practice," Last writes, "do not so much "switch codes" as simply switch off" (403). Such forms of denial, disinterest, and "switching off," scholars have argued, may serve broader psychological and social purposes.

One could make the case that HIV-positive women are (re) imagining their histories through particular social lenses to minimize fears surrounding the fatal consequences of the virus. Stanley Cohen (2001), for example, poses a series of questions that guide the psychoanalytic framing of denial: "Is [denial] the normal suppression of background noise – allowing attention to be paid to more important matters – or a defense against a personally threatening perception? [Is] denial malignant (as with high HIV risk groups denying their vulnerability) or benign (like the false hope that allow terminally ill cancer patients to go on living) (5)?" Though compelling, these questions are both overly functionalist and morally prescriptive. Sobo (1995) complicates these renderings in her influential text, *Choosing Unsafe Sex*, which seeks to reveal the disembodied nature of AIDS knowledge possessed by African American women. Despite their high levels of understanding, Sobo's informants denied that their behavior places them at risk of HIV infection, pinning the label "at risk" instead, upon unknown, immoral Others. In pursuit of cultural ideals surrounding, love, trust, and monogamy, which are highlighted, paradoxically in prevention messages, women engage in unsafe (condomless) sex to build and to maintain this denial. Their narratives do not, in other words, present a distortion in their thinking, but rather, the ways in which risk perceptions are imbued with cultural and contingent meanings. HIV risks and their denial, consequently, may be classified as malignant, benign, or irrelevant, in different social contexts and historical moments (e.g. Biehl 2001, Smith 2003, Allen 2004).

Health beliefs and behaviors, anthropologists have argued, index attempts by patients to conjure up a sense of relative order in the midst of chronic physiological, social, and economic uncertainty (Desjarlais 1997, Lock and Kaufert 1998, Whyte 1997, cf. Jenkins et al. 2005). No singular, discernable local or global framing of dis/order could predict or translate these diverse responses, as Last (1992) had suggested. Individuals interpret and act in a myriad of ways upon being diagnosed with a terminal illness, not easily unified in a single sociological or psychological model. The distinction made in global health practice between "indigenous beliefs" and "biomedically grounded public health prescriptions," assumes a static, hierarchical structure grounded in the highly problematic language of cultural difference (Pigg 2001, cf. Abu-Lughod 1991).

Scientific and officially sanctioned knowledge and "subjugated knowledges" always co-exist (Foucault 2003, cf. Boellstorff 2009).

From God We Came: Diseases of Destiny

I argue that the futures HIV-positive women in northern Nigeria contemplate and the ways in which they navigate being in the world cannot be located solely within those outlined in biomedical symptomatology taxonomies. They are not "switching off" or disinterested in overarching theories and systems of health knowledge. Rather, they describe the etiologies of their illnesses and their prognoses through religious discourses of predestination. My interviews with HIV-positive women often turned to the inevitability of HIV infection, regardless of their husbands' or their own sexual histories. Women often rejected outright the immoral accusations described above without any probing. Northern Nigerian Muslims, for example, focused on how individuals "strengthen their faith" in light of a positive diagnosis.

The explanations women apply to the cause of their HIV infection are *not* in fact a novel development in light of these morally laden popular sentiments. They reflect the ways in which women make sense of array of illnesses and misfortunes. Hassana's case is illustrative:

> During my wedding, I was fourteen and my husband was thirty-two...I became pregnant after four months…We had a girl. We did not go to the hospital and I did not have any complications or tears. After two days she died without any fever or observed illness. Truly, I was sad but then I remembered that Allah giveth and He taketh whatsoever He wishes...I spent one year before getting pregnant [again] and had a boy… [Soon after his birth], my husband started with intensive diarrhea and cough, so we went to [the hospital] and tests were run and drugs administered while he was told he was HIV-positive. When he came back I accused him of infecting me and almost hated him for being on my own and him infecting me. This went on for days. Then later on, I thought: "Allah destined for

> this to happen to me, otherwise I would not have gotten it"…I only told my mother, who told my dad, and so I was taken to the hospital. My father went back for the result and later told me, preached, and advised me. Before my husband fell ill I had heard from people and on the radio about HIV and had heard people say, once you are infected then you die. So, when I learned of my status I said, "That's it. I am also going to die" and I spent the night crying and could not eat. At the time I never met an infected person before but just knew people called the disease "*kabari kusa*" ["grave site brought close"]…After some time I accepted my fate and believe that Allah has said that every affliction has a cure.

In considering the sexual behaviors of their husbands and partners, women also complicated these understandings of risk and fate. Most women understood that their husbands might have had numerous partners -- and indeed, numerous wives. Some were critical of their husbands' relationships, but many accepted that these men had numerous partners, and they had nothing to do with immorality. What mattered in terms of their moral character was how they cared for their wives. In my meetings with the HIV support group, one woman argued:

> What bothers me about these accusations of immorality is that people assume that it is sexual immorality that causes HIV. That is, you get it from your husband's house. When I had it, I never brought it to my mind that I got it as a result of sexual immorality. I know that it was my husband that infected me. Most of our men bring this disease to us because they travel a lot. And if they got infected, they would not even show that they have it – in order for one to help them to carry on with their lives. Instead, they would keep quiet. It has never come to my mind that immoral sex causes it.

Even when women suspected that their husbands had acted immorally, what mattered most was forgiveness. Ladi said, "If a woman finds herself in a situation where her husband is responsible for infecting her, she should leave everything to Allah. Both of them should believe Allah brings down diseases as He wills." Jummai spoke of her husband, who infected her and then later died:

> My husband would never have given me this disease if he had known because he loved me immensely. I do not think of my husband as responsible for infecting me. I have simply accepted it as my fate and from Allah…Because he loved me so much and never wanted anything to happen to me. When he was ill, he kept praying for me, and asking for Allah's blessings for me. He asked that I find someone to care for me at my own time.

Another woman in the support group agreed:

> When we go to the hospital, some women would be insulting their husbands. But I know if my husband knew he had this disease, he would not infect me because I know how he loved me. Up till tomorrow, I don't think he was the one that infected me…If a man loves his wife very well, then there is no way he will allow something to hurt her. And she also will not want anything to hurt him. If it were not God that said I would get this disease, even if I am with him. I would not get it. So that is my faith. It is only God that gave me this disease.

Talatu, a newly married HIV-positive woman, explained this point further: "All diseases are destiny. God gave you the disease in order to forgive you. God says he has never given you trouble without taking away another from you. If God gave people this disease, there is another thing he will relieve them of. Even if you lost your money and you say, *Inna lilahi wa ina alahi raju'un* [from God we came, to him we shall return], God will give you what is more than that money." Women's emphases upon continuity amid the multiple threats to their health and social status that are posed by HIV are striking. If *all* diseases are destiny, HIV is seemingly indistinguishable from other possible illness threats. Another conversation focused upon God's protection. Talatu continued:

> Apart from praying to Him, what will I do? Any time I pray, I beg God to forgive me, to forgive Muslims and to forgive those that are not Muslims. Since it is a sickness. If you pray to God, you tell God to protect you from getting another disease. You see, our disease is a simple one, since it cannot be spread except from sharp objects. We take care of ourselves. Whatever the type of job we do, we make sure we do not have a cut [which could accidentally infect someone]. If you do it intentionally and infect someone, you have sinned. You see we don't

> have hypertension, diabetes, asthma… If you did not say it, nobody will know you are healthier than a person who is healthy.

Health outcomes, according to Talatu, are largely outside of individuals' control. The physiological threats HIV presents can, at best, be mediated by everyday practices of hygiene. Even more importantly, no one will know HIV is present unless you were to state it explicitly. As a physiological condition HIV is thus "a simple one" in that, if one takes care of himself or herself, one cannot infect someone. Hygiene, itself, is a practice of inscribing moral virtue upon the body. I reinforce this point in the next section, where I suggest that, in fact, the physiological effects of HIV and the everyday practices of virtuous living among HIV-positive women are co-dependent upon and co-produce each other.

Virological Contingencies

Immunologists have used the analogy of a train on a track to illustrate the independent contributions of CD4 counts (white blood cells) and viral loads in an individual. Hale (2006) writes, "If the infected individual is imagined as being on that train traveling toward a clinical event – such as acquiring an [opportunistic infection] or dying from AIDS – the CD4 count provides information on the distance of the train from that destination, whereas the viral load provides information on the speed of the train in reaching the destination." Anthropologists and social theorists have identified an array of metaphors located within the discourses of immunology – what Haraway (1991) refers to as a "potent and polymorphous object of belief, knowledge and practice" (204, cf. Martin 1994, Waldby 1996). Drawing upon these diverse immuno-iconographies, Waldby

(1996) argues, “the immune system provides biomedicine with a kind of corporeal nanotheater, or perhaps a nanocinema, where the sexual relations and sexual identities understood to participate at the social level in HIV infection can be rendered into scenarios and played out at a microscopic level” (64). These scholars question, more broadly, the cultural assumptions biomedicine makes in its determinations of organism boundaries, the relationships between self and other, normal and pathological, purity and contagion. Less understood are the ways in which patients themselves imagine their virological capacities and trajectories.

In this section, I explore the ways in which Nigerian counselors and patients themselves engage in evaluating the credibility of virological information. The process in which credibility is granted, I describe, is contingent upon moral evaluations and social aspirations, and the efficacy through which “evidence” can be transformed into meeting particular social goals. I refer to these possible futures as *virological contingencies*. Scientific knowledge can be considered something that must be withheld if it has the potential to motivate immoral and unhealthy behaviors; on the other hand, it can be used to reinforce judgments that a person is indeed acting morally. In some cases, patients view biomedicine itself as a body of knowledge proscribing their social aspirations. This evidence can symbolize larger inequalities in infrastructure that grant some persons access to healthy families and routinely expose others to illness and death. And still in other cases, immunological data – namely CD4 counts – are appropriated by patients themselves in determining their ability to pursue these social aims. Unlike policy debates that view the significance of these findings in terms of broad societal impacts, measurements of (non) infectiousness among Nigerians are grounded in reproductive intentions and outcomes, matters of kinship obligations, and larger critiques of social inequalities.

In the summer of 2008, I met with one HIV counselor in the middle belt city of Jos, Nigeria, and she explained to me her reluctance to discuss the probability of HIV transmission without condom use to her clients. She knew that many of the women she counseled were having unprotected sex with their partners, despite her guidance to abstain or use protection. Further, most women who had attended the clinic knew of sero-discordant couples who had been having unprotected sex for many years without contracting HIV. Even so, she remained adamant that these details should not be shared. If patients believed that ARVs were also pills for prevention, it would most certainly encourage "reckless" behavior.

I discussed the case of one of my friends in a sero-discordant marriage with Fatima, a married HIV-positive woman who was a volunteer in the HIV clinic. She stated:

> Ah! She [an HIV-positive woman with an uninfected partner] should not get pregnant. Like I have some cases in here. There is a woman that the husband is not infected and she wants to get pregnant. I was kind of asking how do you do it? Because if you don't use condoms your husband will get infected. She says no, God just protects the husband. I don't know how they do it….Once you are infected if your husband is uninfected if you make love to him, definitely the man will become infected.

Another counselor explained to me:

> This is an environment where family wealth is measured by the number of children that you have. [Even among sero-concordant couples], you want them to continue to use a condom because…when they are positive, they still don't understand that, "look we are at high risk of increasing the different cell type that you pass along to each other." They think, "I'm positive, she's positive, so we can just forget about it and not use a condom" which is not really what you want. [Regarding sero-discordant couples:] In fact just two days ago, a client just

> walked in and said, "oh I have a friend and his wife is positive, but the man just kept testing negative. They have actually gone to the facility [the testing center] and they have been counseled on using a condom. So he is sleeping with his wife, but the wife is actually the one who is angry. The wife is like, "Why are you using a condom? You just want this to be only my own [problem]." The point of my message to both of them is, he is not only trying to protect himself, but he is also protecting her because of the different exposures, and you are not sure of what is coming around. The challenges come up when they want to become pregnant. That is where the dilemma is. Scientifically, it is a challenge here.

In this case, the efficacy of condom use in protecting a wife from infecting her husband is contested not on a scientific basis, but on a social basis. The wife interprets the husband's desire to use a condom as indicative of his reluctance to share the burden of her illness. It reflects her fear that her husband will rescind his obligations toward her social and medical wellbeing. The counselor attempts to employ other scientific information – protection from "the different exposures" – to argue that the husband is in fact acting responsibly on her behalf.

I probed the counselor further: So, what can you do? What are your priorities in terms of programming to address some of these reproductive dilemmas?

> What can you do? These technologies are way too expensive. Well, basically it means balancing the scientific evidence with the reality of people living their lives as humanly as possible … with the concept of "do no harm". I think that the major direction is, at the end of the day, how can you help them achieve the maximum within their life? So, it is really looking at what is the scientific evidence, and asking how can you help them achieve pregnancy?

In other words, this counselor knows that her clients desire children and she feels limited in how much assistance she can provide. The scientific evidence supporting heightened HIV risk during unprotected sex is weighed against the reality of her facility not having access to assisted fertility technologies. Her counseling unit addresses this compromise in their resignation to care for the woman the best they can, following a virological contingency that involves investing their concern and care in the health of pregnancies. They attempt to ensure that the child is healthy and free of the virus. Also, they encourage HIV-positive partners who desire children to employ a version of the calendar method – having unprotected sex only during the times when a woman is ovulating. While the latter of these suggestions is perhaps an innovative public health model of harm reduction, the efforts to provide optimal antenatal care in health settings reflects a broader infrastructural investment across Nigeria that is accessed by pregnant women, regardless of sero-status. While family planning counseling continues to be a taboo conversation for many, antenatal guidance is widely discussed and valued. This makes sense in a country with one of the highest fertility rates and infant mortality rates in the world. The virological contingencies that HIV-positive women face reflect and reproduce larger social contingencies in Nigerian society.

Patients themselves have become highly invested in "researching" viral dynamics when it comes to the question of whether they could have children. In 2003, a number of years before I began to hear of counseling units employing these harm reduction techniques to address patients' reproductive intentions, HIV-positive patients debated at length the appropriate measures one needed to take to become pregnant. This advice has come not from doctors or counselors so much as it has circulated among patients in waiting rooms and support groups. Fascinatingly, CD4 counts, a numeric measure of the strength of the body's immune system, were a central calculation used by HIV-positive women in deciding when they can become pregnant. Fatima's dilemma is exemplary:

> Fatima grew up in a traditional Muslim household. She married young and never used any family planning. She had several miscarriages and believes she contracted HIV from a blood transfusion she received after a miscarriage. She learned of her HIV status 3 years ago when her sickly baby died after only a few

> months; her husband, however, is not HIV positive. No one else in their family knows of "her problem," as her husband is afraid they will hurt her if they find out. When she tested positive, the clinic advised her to use condoms. They use condoms, but it was hard in the beginning. They did not always remember or have them around. After a few months Fatima became pregnant, to her husband's delight. When she delivered she took Nevirapine at the clinic and the baby is HIV free. Since the baby is healthy and Fatima is doing well on ARV drugs, her husband wants to have more children, "Because my husband, he is desperate to have children. Because he is the only one his mother gave birth to. So that time I gave birth to my first, my mother was saying I should give birth, again I should give birth. She wants more children." Fatima says that she "would like [to have more children] … When I started the ARVs my CD4 count was very low. I did the test last week and I collected the results today. My CD4 count was four times as high. So maybe when I am strong."

CD4 counts, like other biological markers used by physicians in treatment decision-making, are deemed vital indicators of a person's physiological functioning. To patients, however, they are perceived to be precision instruments enabling a new sphere of physiological activity – namely, pregnancy. Undoubtedly, the notion that a CD4 count affects pregnancy outcomes came from a medical authority and was likely derived from the circulation of virological research, similar to the studies outlined above. Credibility, however, was granted as HIV-positive women inserted themselves into their own informal "clinical trials." Collectively, women questioned what the *threshold* must be in terms of one's CD4 count (greater than 250? 300? 500?); they deliberated the *sample size,* or how many women became knowingly pregnant after testing positive -- and they followed up on the health status of a woman, her husband, and their baby over time; they sat uncomfortably knowing that there could never be *proof* over the "non-occurrence of an improbable event;" and they debated the behavioral and biomedical variables that might have influenced a particular outcome: Was this one woman simply too old to have another pregnancy? Or was this that woman's first pregnancy? Did she have fertility issues prior to her HIV diagnosis? Was she with the same partner she had before her HIV diagnosis, or a new one?

What lie at stake in these controversial negotiations are more subjective assumptions about *what these measurements enable socially.* Among Nigerian counselors and patients, investigations into the lessening of sexual infectiousness are inextricably intertwined with the aspirations and obligations tied to the social roles of wives and husbands. Also suggested in these narratives are the larger structural forces that prevent individuals from fulfilling social expectations. Why is it that some women have access to assisted fertility options while others do not? What economic constraints might fuel a woman's fear of being abandoned by her husband or a mother-in-law's fear of having few grandchildren? These forms and processes of social inequalities are especially pronounced when examined through the lens of patients' narratives surrounding their efforts to secure care and treatment.

Pharmaceuticals and Power

Differential access to HIV treatment has been one of the most potent symbols of global social inequalities in contemporary times. Paul Farmer (1999) recalls an encounter he had with a priest in Central Haiti who was eager to show him the latrines they had built since he had last visited. Observing the incongruity between the new latrines and the crumbling edifices within which the villagers lived, Farmer asked him whether he thought these latrines were really "appropriate technology" for such a poor village. Furious, the priest retorted, do you know what "appropriate technology" means? It means, "good things for rich people and shit for the poor" (21). In what follows, Farmer argues that concepts such as "appropriate technology," "sustainable development," and "cost effectiveness models," reveal culturalist rationales deployed to justify the differential valuation of human lives, and reinforce the impoverished social positions that led to these patterns of illness in the first place. Through these analytics, attention is drawn away from global patterns of health and inequality and onto the actions and attitudes of patients who are presumed to lack the knowledge, discipline, or capacity to comply with treatment regimens.

The coexistence of effective life-extending technologies and "lost life chances" in local contexts (Petryna and Kleinman 2006), such as that which Farmer assesses, and the technical, political, and ethical practices that constitute this paradox, are underscored in the recent global movements to provide universal access to HIV treatment in developing countries. Susan Reynolds Whyte and her colleagues (2006) suggest that, "As global pharmaceuticals, ARV's have captured the social and political imagination more powerfully than almost any other kind of medicine. At the same time, they are caught up in a process of fetishization that is the fate of any *thing* that so effectively objectifies a possibility" (260). This is a nod to Appadurai's The Social Lives of Things, upon which their own text, The Social Lives of Medicines is based. Commodities, according to Marx, are fetishized when value is inhered upon the object itself, not in the labor that produced it, nor the social relations that lie behind its exchange. In other words, in examining the social forces that shape "whose illness is worth treating?" and "whose life is worth saving?" the dominance of the "thing" – in this case the drug -- is taken for granted at the expense of the consideration of the social relations embodied in, and symbolized by those objects.

To understand, however, where to locate patients' agency and the forms of power that shape particular social and health trajectories, scholars must extend their questions beyond the boundaries of clinical interventions. In this section, I center my analysis on a single case study of an HIV-positive widow in her 40's, from whom I collected a personal illness narrative. It reveals, broadly, how she came to contract HIV, how it was diagnosed, and how she obtained treatment. Maimuna's story indexes the ways in which interventions have unevenly unfolded at the same time that it complicates depictions of passive, ignorant patients.

Maimuna begins:

> At first I was not told by any of my family that I was not healthy. It was my husband that was sick and was on admission at the hospital for a long time. He was given an HIV test, but I was never told…I have known about my status for ten years now. Then, people stigmatized persons living with HIV. Even the drugs had to be bought. My husband's relatives were buying his drugs for 40,000 naira [approximately $300]. I did not know that the family was buying and giving him these drugs. They would just tell me to give him these drugs at a particular hour. He was sick for nine months before he died.

Maimuna commences her account by remarking upon her husband's family withholding information about her husband's status. She served as her husband's caretaker without knowing the cause of his illness; neither was she expected to know that HIV is a virus that has been potentially shared between them. As she later points out, they did so to protect her from worrying about her shortened life span – a secret in which her doctor was also complicit.

> Forty days after he died, I had a rash. When he was sick, I was very healthy and did not think I had this virus. I was the one taking care of him. I went to the hospital because of that rash. Then, I knew everything [about HIV] because I listened to the radio and watched the television. I was suspecting it was what killed my husband, even though I was not told. Seeing those rashes, I said to

> myself, “Since it happened to him, please do not allow something like that to happen to me.”
>
> I went to the hospital. When I was there, I was given some drugs and was told I would be given an injection. I said I did not like it. Because when my husband was on admission, two months before his death, he was given an injection. When he was given this injection, his entire body became swollen. His body became rotten and greenish in color. The doctor that was treating him was angry, asking who came to give him that injection? So I was afraid and refused to receive an injection. I was not tested or given drugs. His family did not know I was sick. Only my parents knew and they said it was a fungal infection.

Maimuna notes the circulation of information surrounding HIV that has accompanied Nigerian prevention campaigns, which raise her suspicions and inform her pleas – her prayers – for her to be protected from the virus. She listens closely to conflicts doctors themselves have over the appropriate therapeutic actions to be taken to treat her husband, which inform her future decisions over the measures she seeks and rejects in the course of her own treatment.

Nancy Scheper-Hughes (1992) in her ethnography, Death Without Weeping: The Violence of Everyday Life in Brazil, argues that poverty, hunger, and worry are medicalized through pharmaceuticals: “If hunger cannot be satisfied, it can at least be tranquilized, so that medicine, even more than religion, comes to actualize the Marxist platitude on the drugging of the masses” (202-203). She illustrates the “bad faith” of pharmacists, health workers, and patients themselves in supplying and consuming drugs that perhaps may “fortify bodies” but do nothing to transform the unequal social relations and poverty that has wrought ill bodies in the first place. Whyte’s (2006, 2002) concern surrounding the “fetishism” of pharmaceuticals draws upon the arguments of Nichter (Nichter and Nordstrom 1989; Nichter and Nichter 1996), who emphasizes the false consciousness involved in consuming medications as convenient, cost-effective “quick fixes" for those without the time or means to live a truly healthy life. The "inflated claims of medicines" foster this false sense of health security (Nichter 1989:235). Medications serve to individualize health and wellbeing, masking the social roots of illness etiologies, and "undermin[ing] the impetus to participate in ecological-environmental based popular health movements in a social context where they are of crucial and immediate importance" (Nichter 1989:235 in Whyte et al. 2002). Less is clear in Maimuna's narrative about the everyday material and affective exchanges she had with her husband or her in-laws prior to her diagnosis. Could we have better understood Maimuna's patterns of illness through her in-laws vacillation of support than through the different regimens of treatment she received?

Commoditization of health through pharmaceuticals, however, cannot be explained simply by an invasion by drug companies or a deception perpetrated by the politically powerful; indeed, people use and disregard medications for their own ends – which are not limited to addressing their health. Why, for example, might Maimuna have refused an injection when she suspected her sickness was related to HIV? Her fears driving this resistance were intertwined with the course of her husband's illness, as she projected his experience onto her own possible future course. In this case, the potential "fix" this injection offered did not individualize Maimuna's illness trajectory; in fact, quite the opposite. It built a new subjective sense of social connection, not only elaborating upon exchanges of experience and affect characteristic of spouses and caretakers, but also between the living and the dead.

Maimuna continues:

> But I knew that it was HIV. I used to have a constant fever, and whenever I had a headache, I would go to the hospital. I suspected the virus because people would say that HIV-positive people will be having fevers, diarrhea and cough. Whenever I fell sick, it was that same doctor – the one who treated my husband – that I would go to see in this other hospital. You know, then, there were no drugs. You would only be given Panadol [Acetomeniphine] and others. There was a time when an Islamic foundation – which sponsored another clinic in Kano -- asked doctors at this hospital to send them people to be tested for HIV. Seeing that the fever refused to stop, my doctor said they should go and do the type of test that they did for my husband for me. So when the test was carried out, they showed me that I had it too.
>
> I would usually go to the doctor at this particular time for a check-up. Any time I went there, no matter the number of people I met, I would be the one he would see first. He would attend to me and then I would leave for home. He called me and said, "Hajiya ["Madam"], come in," and he prescribed drugs for me. One day, he said there were some men from this same Islamic foundation that came to test the herbs they were selling. He said, "Maybe you should try it and see if it will work for you." Then I said, "Okay, if it will work for me…but people told me that [the virus] did not have a cure." The doctor just took pity on me. That was the reason why he introduced me to this foundation. He said that it was only patients that agreed who would be given the herbs. I said I agreed and he allowed me to meet with the people. I went back the following day. I was introduced to the person that was giving the herbs. He came and met me at my home, and instructed me on how I would take it. When I returned to the foundation's clinic, I was a bit better. I stopped having diarrhea and all those things disturbing me stopped. So long as I continued to take these, I would not be having other problems. But when fever or other things occur, I should go to the hospital. They said these treatments would cure the disease.

The person who matters most to her in guiding her treatment course is a particular physician who privileges her concerns over those of his other patients and uses his leverage to grant her access to a "clinical trial" of herbal treatments being conducted by an Islamic foundation. This treatment regimen coexisted with the care offered by Western hospitals.

Scholars of contemporary Western democracies have described the ways in which free market logics have been deployed as a technique of governing (e.g. Brown 2005). Guided by the belief that the market is better than the state at distributing public resources, political policies encouraging corporatization, privatization, and economic efficiency are furthered and advanced through expectations surrounding the individual internalization of neoliberal traits (Ong 2006). Anthropologists have begun to pose questions surrounding the intersection of neoliberal governmentality and global processes (e.g. Ferguson and Gupta 2002, Comaroff and Comaroff 2000; see also Perry and Maurer 2003; Ong and Collier 2004). In that they are projects unfolding in tumultuous post-colonial states and polities, the notion of a "homogenous nation-state as the essential form of modern power" is a misleading construct (see Geertz 2004). Indeed, the very need for *global* efforts to rollout HIV treatment programs in sub-Saharan Africa is often premised upon the fact that nation-states have lost the power they once had over their populations and citizens, failing to ensure their basic rights to health.

Sweeping statements such as these mask, however, the vast heterogeneity of health and social infrastructure, and the unevenness of the epidemic itself in Nigeria. Religious centers in Kano conduct "clinical trials," at the same time as state-employed conduct them. Physicians at teaching hospitals are simultaneously private consultants who attend to their patients in their own houses. Whyte (2002) comments on healthcare in Uganda: "'It's not just a matter of medical *know-how*,' I have heard people say, 'but also of *know-who*.' Connections are important when you need the knowledge, drugs and procedures that are widely available if not widely accessible" (184). Whyte continues, "In the 'do-it-yourself' bureaucracy (Mbembe and Roitman 1995:343) of contemporary government health care, admission to hospital requires a caretaker, food, supplies, and money" (185). These interactions may reflect conscious effort to secure and maintain the support of medical and social authoritative figures that can ensure these requirements are met.

However, there are other more mundane ways in which health seekers ensure this support. Being a regular customer at a local pharmacy or a private clinic, for example, might provide greater steerage or negotiating power in determining how one will be treated (and how much it will cost) than being a patient at a large state hospital. This practice could be read as an example of the ways in which these market-driven projects of neoliberalism have infiltrated the rationales and routines of patients-consumers. Such local accounts, in any case, vastly complicate the question of how to identify "culpable" authorities. Power is indeed diffused throughout the population of caregivers and recipients. Still, we confront Maimuna's central dilemma: not all patients are able to secure the leverage necessary to receive treatment equally. Uneven health outcomes are visible both on the individual and the population level. Maimuna's concerns over her family's and community's response toward the perceived social cause of her illness limited both her movements (her visits to the hospital) and the forms of communication among them. We proceed in our conversation:

> At that time, I was not able to buy ARVs. Where would I find the money? I was referred by my hospital to another NGO that offers support to women. Then the support group I attend was founded. It was during the Obasanjo government that ARV's began to be distributed. We [positive people] said to him that people were dying and there were no drugs. So he said they should bring it. When it was brought we were called to go to the teaching hospital where these drugs were first distributed. They held a meeting and we patients were told to bring 25,000 naira [approximately $200] for the test, CD4 counts, and others. We told them we had no money. It was rich people that were going there. In the meantime, I was just taking care of myself.
>
> When my husband was alive, my in-laws were the ones taking care of us, bringing us food items, and giving us money to spend. When I fell sick, my brother-in-law would come home to pick me up and take me to the hospital. He told his other

> relatives they should bring me here to the hospital because they were giving out drugs to HIV-positive persons. He came and told me and I said, "since when? I knew about this for the past two years, but you need to pay 25,000 naira." He now said all those fees have changed. You only pay 7,000 naira [$60] and can start taking the drugs. He paid this money, and they did all the tests for me. But still they said there were no drugs. They said that currently they were only recruiting 100 people to try the drug and to see if it would work in our body.

Much of Maimuna's case took place prior to the PEPFAR-sponsored projects, but even during this time, there emerged innovative assemblages such as that represented by the Islamic foundation's clinical trial of medicinal herbs. Moreover, professional groupings of physicians, pharmacists, and other health workers emerged as actors mediating these initiatives both at the level of the population and in the routine lives of Nigerians. Most emphasized in Maimuna's account, however, was the array of family members whose resources and larger social ties shaped their ability to make claims for and benefit from treatment. This reveals a break from Foucault's de-emphasis of the family as a sovereign power – a distinction that has long been questioned by feminist scholars as it reinforces dominant patriarchal social structures. Critical to the above narrative, however, is that Maimuna engaged directly and indirectly with *all* levels of formal and informal circuits of care. Even with this landscape outlined in such detail, it is impossible to discern from this vantage point how it is that these various authorities actually enact power in such a way that some are thoroughly protected and others are neglected. Scholars thus must examine closely the techniques of power being exercised as a window onto these uneven terrains.

Ong (2000) draws out the ways in which state power has ceded to conglomerates in order to remain competitive in global market economies. She terms this concept "graduated sovereignty." She suggests that this dynamic has resulted in different sectors of the population becoming “subjected to different technologies of regulation and nurturance and in the process, assigned different social fates” (Ong 2005:86). Thus, while some populations are afforded rights and resources, others are rejected – an enactment of “variegated citizenship.” While there exist populations who are thoroughly neglected by the state – for example, African populations afflicted by disease, starvation, and war – their claims for “biological welfare” may be addressed by non-state actors (Ong 2006:24). Central to this thesis in Ong’s framing are the “neoliberal calculations” that determine the categorical designations of inclusion and exclusion (214).

While Ong does little to ground these arguments in ethnographic observations, they have been taken up in fascinating ways by scholars of biosociality in the context of HIV. Specifically, this work has centered upon the role of support groups. Paul Rabinow (1992, 1996) has argued that biotechnological developments and the dissemination of biological knowledge, in particular, have influenced (and have been influenced by) the formation of associational communities whose memberships are based upon biomedically- and genetically-defined conditions (cf. Ginsburg 1989, Rapp 2000, Rapp and Ginsburg 2001, Rose and Novas 2005). The significance of these biosocial groupings, scholars have suggested, lies particularly in their political projects involving claims of recognition and inclusion based upon a particular illness, or what has been called, their “politicized biology” (Petryna 2002, Biehl 2004). Novel biosocial groupings have emerged in the forms of support groups, which have been important structures in shaping both HIV-positive subjectivities and specific ethical claims. Maimuna speaks explicitly about the functions of support groups in speaking out for political policies directed toward the provision of treatment. Further, she counts herself among the positive persons who made claims upon the Obasanjo presidential administration for ARVs. Aligned with a support group, she assumed a voice (Whether it was just one she took on for this narrative alone or one she actually expressed in a public political forum is a different, but critical question addressed in this dissertation.) that enabled her to explicitly voice her discontent with the injustices of treatment access.

In his account of the genealogy of the Brazilian AIDS treatment program, Joao Biehl (2007) in his monograph, Will to Live: AIDS Therapies and the Politics of Survival makes a pointed critique, arguing that while all-encompassing sovereignties are not easily located; states do not necessarily weaken amid economic globalization. Rather, the Brazilian state itself embodies a dynamic market authority: “a state open to civil society, decentralized, fostering partnerships for the delivery of services, efficient, ethical, and, if activated, with a universal reach” (10). Biehl focuses upon an HIV support group, Caasah, as one window onto the ways politico-medicalized subjectivities are cultivated and the processes through which those unable to conform and contribute to a “more vigorous and productive citizenry” are left to die a social death. Within this institution, politicized bioscientific knowledge becomes inscribed onto physical bodies (the practices of the self where treatment regimens and other practices of self-care), social bodies (where patients monitor the self-practices of one another) and political bodies (where Caasah itself becomes institutionally recognized).

In the same breath that Maimuna acknowledges the breakthrough she and the support group within which she participated made in demanding drugs from the Nigerian government, she critiques the government’s gesture by pointing out the unevenness through which population-level treatment campaigns were being carried out – they were programs for the rich. When Maimuna was finally able to secure the support of her in-laws, there were simply not enough drugs to go around. Her intense, repeated efforts to gain the attention of program administrators were unsuccessful.

> When I would go to request ARV's, I would meet the woman who takes files to the doctor who prescribes the drugs. She would look up and say, "So you've come again?" And I would tell her yes. She would reply that there was no place in the program and that I should go to another place. There I was introduced to the person who hands out the drugs. It was on weekends, every Friday, that they would be given to us. Whenever I went and was not able to collect the drugs, I would go and tell him that I had yet to receive them. He would tell me to be patient and come back the following week. Each week, I would feel as if I should not go, but I just made myself do it. I spent three months going to the hospital asking for drugs. Then there was a day the pharmacist asked me, have you gotten drugs yet? I said no. Exasperated, he went in and told the doctor my story. He said, "Look at this woman's body. Whoever sees her knows she needed drugs and you did not give it to her. Instead you give them to people who are healthy." After that, they now asked me to come and collect drugs. When I was finally given them, I felt like I had been cured. They cost 1,000 naira [$8] each month.

It was not until a pharmacist recognized the extreme deterioration of her physical condition that she was presented to the program as a candidate for treatment.

It was, ultimately, Maimuna's deteriorating bodily integrity that secured her the attention of program administrators: the revealing of her "bare life." This claim, as social theorists would argue, embodies the definitive characteristic of sovereign power: "the power to let live and make die" (Agamben 1998). It elucidates a precise moment where the question of whose life is to be enhanced and whose is not worth saving emerges – the very definition of the two sides of biopower.

But to stop here – at the cusp of Maimuna's death in the hands of a hospital physician -- is again to de-contextualize it from the larger narrative. In this statement, she acknowledges the mediating role of the pharmacist and perhaps, indirectly, is reaffirming her sense of value and worth as she is socially recognized *despite* her bodily condition. Returning to Whyte's argument above, the reasons for asserting the importance of the "know who" over the "know how" might also illuminate a sense of discontent with these larger unequal political structures. Didier Fassin (2007) reflects upon a similar biographic account he collected from a young HIV-positive woman in South Africa, also on the cusp of death. He suggests that she attempts to inscribe upon this narrative – and consequently upon her self – a sense of collective life beyond her physiological condition (*zoe*). Fassin speculates on her account as I do with Maimuna:

> In recounting her life Puleng wanted to express a sense of the injustice over her condition…It is not intended to produce tears for her suffering that she knows will end soon. It demands truth of the anthropologist and those to whom he will repeat it later. It is not only the fact of dying at twenty-nine from a disease reputed to be incurable that is an affront to the young woman; it is also and above all the accumulation of social violence that has made her existence what it is. AIDS is taking her life, but what life has it been? Her protest is not against a biological fate but against a political fact.
>
> [2007:24]

The dichotomy of "the protected" and "the neglected" thus demands further interrogation. Even as Joao Biehl advances this argument about the social and economic terrain of pharmaceutical governance, the strength of his analysis also extends to the ways in which he privileges the experiences of AIDS survivors negotiating these "economies of salvation" through and beyond the support group, Caasah. These include those whose self-practices oriented around survival do not necessarily map onto the optimization of health and those who refuse to or are unable to conform to particular social categories necessary to make claims for treatment and support. He elucidates the lived experience of these individuals in local moral worlds, seeking to "understand the afflicted in their own terms" (405). In doing so, he complicates notions of structural violence, marginalization, victimhood, and resistance, privileging instead the "affective entanglements" associated with individuals' resilience.

It is with the latter of these emphases that I orient the political analyses and implications of my work. As I proceed through the following chapters, I ask how it is that individuals attempt to recast their futures in the face of social death: What is the substance of things hoped for? Why do some individuals seek to be unseen? And why do others remain invisible -- despite their public aspirations, needs, and demands?

CHAPTER TWO

DILEMMAS OF DIAGNOSIS

Introduction

Much of what is known about the prevalence and presence of HIV in Nigeria is based upon aggregate estimations and projections. Without confirmatory tests, most individuals infected with the virus are merely sick, or – more likely – are *not* sick, but have been married to sick partners. HIV dwells in the body without symptoms for an unknown period of time. Further, the illnesses that accompany HIV infection resemble those of any of a number of diseases present throughout sub-Saharan Africa. An HIV screening, consequently, is often an afterthought for patients, one considered only after a range of biomedical and traditional treatments for typhoid, malaria, or other parasitic infections have failed. Even the most severe symptoms associated with advanced stages of HIV are so prevalent in Nigeria that patients do not necessarily suspect that the virus is at fault. HIV-related deaths are not remarkable in a country with an average life expectancy of under 50 years. There is more, however, to be understood about the invisibility of HIV in Nigeria than that which can be concluded by these epidemiological and demographic trends. The virus's immoral connotations entrench fears of stigmatization and abandonment among HIV-positive persons and individuals sever themselves from all potential associations with the disease. Political-economic forces contribute to the social invisibility of the virus: patients, for example, lack the resources for repeated visits to the hospital; health care providers are unable to follow the course of a patient's recovery; and infected persons often die in their homes without autopsies.

An HIV test, consequently, is at the center of interventions that seek to render the threat of HIV into defined, quantified, and manageable risks. I begin this chapter with a review of the anthropological literature on diagnoses in cross-cultural perspective. Social science researchers have contrasted the ways in which the act of labeling an illness leads to efficacious social and health benefits (e.g. Rhodes et al. 1999, Coulehan 1985, Safran and Muran 2003), against the ways in which they fashion new forms of marginalization, stigmatization, and social control (e.g. Parsons 1951, Goffman 1961, Horwitz 1982, Hahn and Kleinman 1983). Anthropologists have examined the ways in which the organization of diagnostic categories and performance of diagnostic procedures are culturally constructed, and the ways in which these categories and performances are interpreted, enacted, and resisted by patients who have received these particular diagnoses (e.g. Good 1992, Kleinman 1988, Martin 2007). This work has been further enriched by studies of new genetic and reproductive technologies, and the ways in which they have contributed to reconfigurations of gender and the family cross-culturally (Inhorn and Birenbaum-Carmeli 2008, Fullwiley 2004, Konrad 2003). . These studies have revealed both how diagnostic technologies reinforce local and global forms of social inequality, and how these technologies are appropriated by individuals in asserting their agency, employing their own local moral and ethical compasses to navigate the challenges of living with chronic illness.

Following this review, I evaluate a contemporary global debate surrounding a shift in the modality of HIV testing from one in which patients themselves seek an HIV test through a voluntary counseling and testing center (VCT) to one in which HIV testing is offered routinely to patients in all healthcare settings, regardless of whether a patient is deemed "at risk." I contextualize the initiation of VCT and the case that is made for its designation of "exceptional" in the realm of American research and activism. I then look to the data and claims to credibility that have been made by those argue for the "end of exceptionalism" in testing modalities. An analytical framing that juxtaposes individuals' rights to privacy and autonomy against the communal interests of prevention and treatment, I will argue, masks the ways in which these interventions' virtues, harms, and the risks they imagine and present are underscored by diverse political and cultural assumptions.

In turning to my own ethnographic work with Nigerian men and women living with HIV, I ask why it is that ordinary Nigerians would opt to receive a test and why might one not want to know? The virtues and fears embedded in the act of taking an HIV test, I suggest, are inextricably intertwined with questions of how families and relationships might be reconfigured in light of a positive test result. In other words, the autonomy and privacy that testing centers seek to protect are often undermined by the social relations and networks within which individuals are situated. Nigerian social and health institutions employ particular assumptions about family formation and the social roles and responsibilities of marital partners to encourage HIV testing. I argue that evaluations of benefits, harms, and risks can only be understood through the lens of the social expectations of kinship in efforts to promote testing and protect health, and the ways in which kinship is enacted in the decisions surrounding diagnoses and disclosure.

"Doing Diagnoses" in Anthropological Perspective

A classic tenet of personalistic ethnomedical models is the preeminent role of the healer in discerning the *who and why* of a disorder (Foster 1976). Byron Good (1994) summarizes: the naming of the source of suffering constitutes "a critical step in the remaking of the world, in the authoring of an integrated self' (128-129). For patients with chronic conditions, testing is a crucial element in the validation and legitimization of illness claims (Rhodes et al 1999, cf. Kleinman 1992). In exploring chronic back pain, for example, Rhodes and her colleagues (1999) write, "Thus while in other conditions a positive test may be feared, for back pain patients a positive result affirms a 'real' problem and allows their suffering to become "an acceptable illness, one that can be handled" (1190, citing Coulehan, 1985:370). In psychological terms, a correct diagnosis reveals the "emancipatory" potential of a correct label. It fosters the establishment of a "therapeutic alliance" between clinicians and patients, which is considered one of the cornerstones of the healing process in biomedicine. In the public health literature on HIV, clinicians are instructed that this relationship can facilitate patient education, improve medication compliance, and promote behavioral change among their patients. Patients, in turn, are assured they can rely upon this empathetic bond during times of crises (Safran and Muran 2003). Studies such as these assume that biomedical practitioners are the prevailing authorities in producing and enhancing the life chances of persons infected with HIV. I propose that, in fact, there exists an array of authoritative persons in patients' lives, not limited to health professionals, who contribute to the validation of disorders and disordered identities, and who foster the alliances upon which patients depend in times of critical need.

Social theorists have also conceptualized illness diagnoses as the foundation upon which patients are enculturated into a "sick role:" one characterized by a process of accepting the terms, prescriptions, and limitations of a condition, with an aim of getting well (Parsons 1951, cf. Arluke 1988, Gallagher 1976, Levine and Kozloff 1978, Meile 1986, Segall 1976). The latter of these expectations, however, present distinct challenges for those with chronic illnesses, pain, and disabilities, who cannot entirely be healed (Hahn and Kleinman 1983, cf. Murphy 1990). As physicians and patients act according to expectations surrounding these social roles, they reproduce the setting and the rules that govern their environs. "Total institutions," such as hospitals or asylums, argues Goffman (1961), strip a patient of the social context from which she comes, reinforcing her "essential" deviance, thereby creating the conditions not only for her stigmatization, but also for larger processes of social control. Specific diagnoses propel patients through particular health institutions, revealing a spectrum of forms of control, ranging from the more custodial and coercive to the more supportive and therapeutic (Sadowsky 1999, cf. Horwitz 1982). Green and Sobo (2000) write, "A positive HIV antibody test can shatter a previously crafted sense of self, and it can mean that an individual will incorporate a new facet into his or her identity – that of being HIV positive" (2). While these scholars have explored the relationship between social identities and the interpersonal management of HIV stigma, less clear are the ways in which other social institutions – besides medical establishments – intervene in these processes. I thus emphasize not only processes of identity formation (and disintegration), but also the kinship and religious norms that shape these dynamics.

Anthropologists have complicated biomedical notions of the "strength" and "efficacy" of diagnoses, by demonstrating the ways in which diagnostic categories or labels are thoroughly embedded with cultural assumptions. Exemplary of this research are anthropological interrogations of psychiatric diagnoses in American biomedicine, revealing the ways in which these assumptions differ both across space *and* over time (e.g. Good 1992, Kleinman 1988). Lakoff (2005), employing the term *diagnostic liquidity*, argues that taxonomies of behavioral pathologies are not necessarily transferable across professional domains. He illustrates these barriers and their consequences through the documentation of the failures encountered by a Western research project seeking to extract the genetic material of bipolar patients in Argentina – a context within which the American diagnostic infrastructure of bipolar disorder does not exist.

Martin (2007) elucidates the ways in which, even among American patients "living under the description of manic depression," individuals are actively wrestling with the terms used to define them by psychiatrists. While some patients refuse to perform tasks in front of doctors that they know might reveal bipolar symptoms, others consciously caricaturize biomedical definitions of mania, revealing the "rationality" beneath the presumption of manic irrationality. Through these performances, patients express not only a sense of discontent with medical categories, but also the ways in which psychological conditions *do not* encompass their personhood entirely. Advances in biopsychiatric research informing diagnoses of emotional and behavioral dysfunction, which are optimized in certain contexts, hidden in others, and laden with moral judgments, thus provide an important window onto the tensions that result when novel classificatory technologies become inextricably intertwined with social relations and subjectivities.

Anthropologists have questioned how societies are reconfigured when biomedical tools, diagnostic protocols, and other forms of technical knowledge “travel” across diverse locales. These studies have elucidated the intimate ties that technologies forge with global power configurations (e.g. Inhorn and Birenbaum-Carmeli 2008). Recent developments in genetic and reproductive diagnostic screening have demonstrated the ways in which technologies are capable of complicating conventional definitions of families and gender (e.g. Bonaccorso 2004, Edwards 2000, Franklin 1997, Konrad 2005, Thompson 2005), as well as both restructuring and reinforcing pre-existing social inequalities (e.g. Rapp and Ginsburg 1995). The scientific developments that led to in-vitro fertilization (IVF) have occurred concurrently with the development of genetic tests, such as pre-implantation genetic diagnosis (PGD). Though ostensibly to be used to screen for heritable diseases, PGD has been appropriated and commoditized for an array of uses including: a tool of sex selection, a gauge of “success” for IVF, and a mechanism for the cultivation of embryos with a particular genetic makeup to be used for donation purposes (Inhorn and Birenbaum-Carmeli 2008, cf. Franklin and Roberts 2008, Hashiloni-Dolev and Shkedi 2007, Lock 2009, Van Balen and Inhorn 2003). As apparent in the proliferation of this research, concerns surrounding the *geneticization* of human bodies and suffering are at the fore of social analyses (Lippman 1992). Far from reducing a person to his or her biological essence, however, these studies have revealed the ways in which processes of geneticization dynamically elaborate in profound ways concepts of relatedness and the political economic contexts through which these concepts are reproduced.

Most important to the larger aims of the chapter are the ways in which patients themselves contemplate diagnoses in reference to their sense of social identity as well as notions of family aspirations and obligations. Fullwiley (2004), for example, considers the paradoxical ways in which carriers of sickle cell traits in Senegal enlist "traditional" Islamic and Wolof interpretations of the pregnant body and the family to justify the need for the "modern" techniques of prenatal screening and the possibility of selective abortions. In other words, patients rationalize and enact their own *personal biopolitics* in managing the risk of sickle cell. For example, life "enters" the fetus 40 days after its conception, according to the Hadith. While the specificities of this Hadith might have been unclear to some individuals, the logic of "before-and-after ensoulment" makes it possible to consider selective abortion to prevent having a baby that would knowingly face an inordinate amount of suffering in its life. Sickle cell specialists, on the other hand, presumed these religious traditions and cultural ethics to inhibit such considerations among patients. In a context where sickle cell anemia lacks political investment or attention (an effect, Fullwiley terms, *discriminate biopower*), biomedical practitioners were ambivalent or reluctant to promote sickle cell screening, opting instead to advocate for larger political projects involving improving institutional and laboratory infrastructure for treatment.

Similar arguments have been made in ethnographic studies of HIV activism. Scholars have illustrated the role HIV-positive persons have played in making public claims for the protection of human rights and the provision of antiretroviral therapies.[14]

Framings of agency – especially gendered forms of agency in Africa – are often conceptualized as the ways individual interests are realized against structures of political power. Such framings risk exaggerating individual autonomy and reifying state-subject relationships. In this paper, I ground the dilemmas women face over HIV tests within hierarchies of kinship and gender relations. In other words, the expressions of and constraints upon women's agency that I have observed are not oriented so much around the issue of whether or not to seek an HIV test, but instead are intertwined with larger questions over the ways individuals negotiate power relations in their sexual and social lives (e.g. Epstein 1996, Rose and Novas 2005, Nguyen 2005, Fassin 2007, Biehl 2007).

Like Fullwiley, Konrad (2003) too focuses upon the everyday dilemmas of patients in defining and negotiating their own constructions of moral 'value' in the context of predictive genetic testing. Working with women who have sought IVF by anonymous ova donation and those who have been identified as a "pre-symptomatic" to Huntington's Disease, a genetic disorder, Konrad traces the process whereby individuals determine what knowledge is "good" and what knowledge is "bad" to know and be known. For example, the child of a couple who received IVF through the assistance of an anonymous donor complicates the norms of a shared blood lineage, adding to a genealogical grid both a child *and* this stranger – as it shapes a mother's concern of whether and when to tell others this conception secret. For those diagnosed with Huntingdon's, a genealogical norm would suggest that this "information" be passed down from parents to children; however, in many cases, children might must contemplate sharing this information "up" to their parent's generation – exposing the difficult morality of a mother unknowingly passing on a genetic illness. Physicians and caretakers, as well as technologies and physiologies thus mediate decisions surrounding disclosure.

Konrad challenges the traditional biological understandings of genealogy based upon consanguinal relationships, as well as its social premises expanding the definitions of relatedness (cf. Carsten 2000; Franklin & Ragoné 1998). She subsumes the novel social, moral, and affective ‘anatomies’ created in these negotiations of relatedness under the more inclusive term ‘genealogical ethics.’ This larger sense of relatedness and the moral complexities that underscore acts of disclosure overtly disputes the conceptual premises of individual autonomy that are employed in the bioethical debates surrounding the “right to know” informing disclosure policies in Britain.

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This review of the literature presents a number of important points relevant to the dilemmas encountered by patients who contemplate HIV testing. The emancipatory potential of a label, for example, is weighed against the socially stigmatizing effects of marked difference. Local moralities infuse these trajectories. An “alliance” with one’s physician reflects a highly valued social bond for patients chronically afflicted with illnesses of unknown durations and trajectories. By contrast, illnesses imbued with immoral connotations are deeply feared and intensely surveilled by the public. They potentially alter one’s sense of self and sever social relations, as treatment for these conditions are institutionalized both medically and politically. An HIV diagnosis could be seen as profoundly emancipatory in that it links HIV-positive patients to treatment options and encourages those who are HIV-negative to change their behaviors. For patients in resource-limited contexts, a diagnosis can potentially provides opportunities for economic advancement, as HIV treatment programs are among the few venues for the provision of social welfare. On the other hand, HIV is a highly stigmatized condition, characterized by severe social suffering and trajectories of treatment and care that are erratic at best.

Considering the process of diagnosing a condition, we see that the very taxonomies informing differential diagnoses are culturally constructed. When scrutinized cross-culturally, these “objective” categories crumble, as certain symptoms are visible and others go unnoticed or remain hidden. While this is most obvious in behavioral and mood abnormalities, some physiological symptoms are socially recognized while others are seen as insignificant in certain contexts. While a simple diagnostic technique reveals one’s HIV status, its behavioral and physiological “symptoms” in Nigeria are quite complex: unprotected marital sex is in no way considered a behavioral anomaly in this pronatalist country, nor are fevers, aches, or stomach pains considered unusual in places where high rates of malaria, typhoid, and other infectious and parasitic diseases affect virtually everyone. The ways in which patients engage with the terms of their diagnosis are worthy of attention as well. How HIV-positive patients live their daily lives “under” the terms of particular diagnoses reveal their attempts to resist its social and physiological taxonomy, as well as live beyond it – for example, as I demonstrate, through attention not only to their health, but also their beauty, through marriage, and through children.

Ethnographic research on the ways in which genetic and new reproductive technologies have reconfigured notions of gender and the family across cultures also has important significance for studies of HIV diagnoses. While diagnostic technologies may be tools used to commodify the body, creating and reinforcing both local and global forms of inequality, men and women also rationalize and justify their use by drawing upon different forms of knowledge that defy traditional/modern categorization. Employing both local understandings of physiological processes and social responsibility, individuals are capable of making difficult ethical decisions that defy the simplistic assumptions their doctors assert. Moreover, upon close examination of the decisions of individuals who have sought genetic and reproductive technologies and received "positive" diagnoses, it becomes evident that they too rely upon local moralities in their decisions surrounding disclosure. Not only do technologies and diagnoses themselves complicate the traditional configurations of families, the decisions made surrounding disclosure further reveal the ways these novel social, moral, and affective 'anatomies' justify a rethinking of theoretical understandings and pragmatic applications of relatedness.

A close reading of individuals who seek diagnoses and live with HIV-positive results will elucidate further these complexities, and will challenge the assumptions embedded in human rights and bioethical discourses. In the section that follows, I begin with one of these bioethical debates in the context of the HIV epidemic surrounding the efficacy of HIV antibody tests in reducing population-level patterns of risk, morbidity, and mortality. Turning to the everyday experiences of Nigerians in negotiating HIV testing, it will become evident, once again, that global assumptions surrounding HIV risk and its management are interpreted, appropriated, and reconfigured in illuminating ways, complicating not only the framing of these global debates, but also the aims and effects of their proposed policies.

The Right to Know

In 2003, the World Health Organization issued a document entitled, "The Right to Know: New Approaches to HIV Testing and Counseling." It begins:

> People have a right to know their HIV status, and testing and counseling should be widely accessible through innovative, ethical and practical models of delivery. HIV testing and counseling are entry points to HIV-related care and prevention services, and provide opportunities for people to reduce their risk of acquiring or transmitting HIV. High priority should be given to scaling-up HIV testing and counseling to maximize the opportunities to reach those with HIV infection or at high risk.

The report outlines the benefits of HIV testing both on the individual level and the community level. HIV tests, according to the WHO, enable individuals to change their behaviors to protect themselves as well as their partners; gain early access to treatment and care, including PMTCT services; "better cope with HIV infection;" and "plan for the future." On the community level, HIV testing decreases stigma and discrimination and mobilizes support for "appropriate responses."

Soon after the publication of this report, the WHO announced that 2006 was to be the "Year of Acceleration of HIV Prevention in the African Region," with increasing the uptake of HIV testing as its centerpiece. To accelerate prevention, strategies included not only expanding access to and the availability of test kits and centers for counseling and testing, but also included rethinking the larger role of and modalities for HIV diagnostic testing. Human rights activists have advanced a global movement toward "provider-initiated" or "routine opt-out testing." In such a practice, an HIV test would be offered at all clinical visits, with the option for the patient to "opt out" if she or he does not desire a test. This differs from the current model of client-initiated voluntary counseling and testing (VCT), which often is offered at centers outside of healthcare facilities, and involves detailed pre-test counseling protocols. These protocols focus upon providing patient education and ascertaining whether the individual falls into a particular risk group category, with the expectation that a plan can be generated for a patient to reduce his or her risk exposure. Discussions surrounding the feasibility of implementing provider-initiated testing are taking place globally. I emphasize here the history of this shift as it originated in U.S. policy debates.

While the protection of the rights to patient privacy and autonomy are clearly stipulated in codes of medical ethics and are defined in major human rights conventions and protocols, in the context of the American HIV epidemic, advocates defend these rights on the basis of decades of overt discrimination, neglect, and violence upon marginalized HIV-infected populations. Policies mandating HIV testing, named reporting, and partner notification, in efforts to quell the trajectory of the epidemic at the population level, they argued, threaten to undermine the rights to privacy and personal autonomy among infected persons.

Activists struggled for a political voice and gained an audience of government leaders, researchers, journalists, caregivers, and pharmaceutical companies. To those contesting the reform of HIV screening protocols, written consent reflects not merely accordance to biomedical protocol; it is emblematic of the larger socio-political challenges and advances of these actors. While the modalities for HIV testing appeared to be “exceptional” to diagnostic procedures for other illnesses, the forms of advocacy for HIV-positive persons were not, in fact, exceptional in the slightest. HIV activists joined larger social movements that sought to advance issues of equality in race, gender and sexuality, and disability.

Furthermore, the significance of informed consent, confidentiality, and disclosure has a history that extends beyond the HIV epidemic to the Tuskegee Study where 400 African Americans infected with syphilis were enrolled in a research project without consent and went untreated for 40 years, despite the availability of effective medications. Given the disproportionate number of African Americans infected with HIV, written consent is not an abstract principle of ethics, but a symbol of the historically embedded inequalities in American healthcare. And while the vast advances in technology and treatment for HIV have unquestionably altered the natural history of the disease these same institutionalized social inequalities also complicate the relationship between testing and access to healthcare.

In this case, for those advocating the routinization of HIV antibody screening, a test represents a powerful technology that enables the threat of HIV transmission to be harnessed and managed through a discreet set of priorities and actions taken by public health authorities. The threat of HIV, in other words, is no longer a hidden misfortune inexplicably striking its victims, but rather a social problem of service accessibility and behavior modification. In an article entitled, "Changing the Paradigm of HIV Testing: The End of Exceptionalism," Bayer and Fairchild (2006) trace the numerous biomedical, epidemiological, and social developments supporting the shift to universal HIV screening. Epidemiological data has shown 50 to 75 percent of new infections in the United States occur among persons unaware of their status. Undiagnosed or late-diagnosed cases, health policy-makers argue, represent "lost opportunities" to link individuals to medical care, reducing infectiousness, and encouraging safer behavior (2024). Rapid HIV testing eliminated the time delay that presumably had deterred some patients from returning to collect results. Antiretroviral therapies have transformed HIV infection into a chronic condition that can be managed. HIV advocates have made significant progress in advancing anti-discrimination and privacy laws. And the most persuasive evidence, according to the advocates for this policy change, has been the large-scale epidemiological shifts that have accompanied prevention of mother to child transmission (PMTCT) counseling initiatives, which offer provider-initiated testing.

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The narratives of this debate in the United States, as shown in the examples above, are cast in a human rights framing, emphasizing the tensions between individuals' rights to privacy and autonomy, and the communal interests of prevention and treatment – taking into consideration the benefits and harms of each. Debates over the appropriate modality of delivery, however, reveal the ways in which these risks, too, are underscored by political and cultural assumptions surrounding the meanings of autonomy, privacy, consent, access, and the relationship between knowledge and behavioral change. They are shaped both discursively and pragmatically and reflect particular social agendas. Using examples from Nigerian men and women who have tested HIV-positive, I will complicate the above assumptions, and also will reveal limitations to the human rights framing used to legitimate these policies.

Secrecy, Privacy, and Power

In sub-Saharan Africa, HIV is most commonly transmitted through heterosexual sex between husbands and wives. An HIV diagnosis is thus intertwined with the social and sexual lives of Nigerian couples, families, and kin groups. The two customary ways one obtains an HIV test in Nigeria are through VCT centers and through prenatal (PMTCT) screening. I have also outlined in the previous chapter the political developments that have led to the establishment of VCT and PMTCT centers, which are now found throughout Nigeria. In line with the global priorities of the WHO, UNAIDS, the CDC, and other major global donors, Nigerian health ministries have made pre-test counseling, informed, written consent, and post-test counseling standard protocols in all of these facilities. While these policies stress the individual and population health benefits of receiving an HIV test, question remains: why is it the ordinary Nigerians would opt to receive a test? Why might one not want to know? In other words, how do these proposed benefits resonate with the lives of those who consider taking a test?

Talatu

In the negotiations leading up to marriage in northern Nigeria, many things remain secret. The families and friends of the couple are responsible for the "research" that must be done on the potential spouses: What were the social reputations of the man's family members? Are his senior relatives financially stable? Did the woman have any difficulties with pregnancies in the past? Is there any history of mental illness or other condition believed to be potentially harmful to their children? And yet despite this extensive investigation, secrets often remain or are covered-up by family members who fear the dissolution of the marriage plans. Although, again, individuals are increasingly educated about the behavioral risks for and the symptoms potentially indicative of HIV infection, there exist numerous social concerns that prevail over these fears. Women, as individuals, are often unable to demand an HIV test of their partners. When married, it is impossible to abstain from sex with their husbands for lengthy periods. And they possess little power in preventing their relationships from dissolving.

I met Talatu, a twice-divorced Muslim woman in a support group for HIV-positive persons in the northern Nigerian city of Kano. Shortly after her first divorce, she told me, there was a man who had courted her. Although he was much older than her, Talatu felt that he could help support her children and she accepted his proposal for marriage. She noticed he was very thin and attempted to persuade him to take an HIV test before they married. He insisted on a quick marriage and paid her dowry. They set a date for the wedding, but when her persistence for screening grew, he stopped visiting her. Afraid that she would lose him, Talatu asked his friends why he was avoiding her. They told her that he was unhappy about the HIV test. Her behavior implied that she did not trust him. She sent him an apology, and they were married. Talatu expected that once they married, she would possess greater authority and would be able to convince him to be tested. For two months, she resisted moving in with her husband and refused his sexual advances. Her friends began to lecture her about a husband's right to have sex with his wife, and she ultimately relented.

Talatu knew her husband had had a number of partners before her, since friends had said they had seen him with other girlfriends. In spite of this reputation, they expected now that he was married, he would stop pursuing other women. A few months later, she began to have stomach cramps, which would not go away. Her illness became serious and she went to the hospital. Her husband then gave her divorce papers, because he could not cope with her always being sick. After the divorce, Talatu's parents took her to the hospital to have her blood tested. They knew her status then, but would not tell her. Her daughter from her first husband, whom she was still breastfeeding, soon became sick and started to lose weight. She suspected that her baby might also be sick with HIV, though her mother told her that she should not “call sickness” upon to the child. Later, her baby died. She then learned that her first husband died of AIDS, as well. Talatu returned to the hospital for an HIV test and confirmed she was positive.

As HIV is most commonly transmitted through heterosexual sex between husbands and wives, a diagnosis is intertwined with the sexual and social lives of Nigerian couples and their families. Community reputations, financial stability, and health histories are all part of the calculus employed by kin in contracting marriages. Individuals and their families – particularly those with limited resources – maneuver in strategic ways to ensure that partnerships are forged or dissolved. Despite the fact that most Nigerian women are aware of the ways HIV is transmitted, few are able to demand an HIV test of their partners. Following marriage, they are unable to abstain from sex, even if they suspect that their partner is infected. And finally, most do not possess the power to prevent their relationship from dissolving, if their husbands seek to divorce or abandon them. There are limitations to women’s autonomy both in their relationships and their decisions over their health. Ultimately, the social risk of losing a partner outweighs the risk of HIV transmission.

Perceptions of Promiscuity

The women with whom I worked in a support group in Kano had much to say about the problems of adultery among men and the relationship between extramarital affairs and the HIV epidemic. One of our meetings together focused on this concern.

Adultery, they argued, was unambiguously immoral. Hafsat, for example, explained, "Islam has made provision for cheating men. According to *shari'a*, death is the penalty one pays for adultery. Religion also provides for punishment in the hereafter, if [adulterers] are not caught. Also, there are repercussions on society because adultery leads to the spread of sexually transmitted diseases, as infections are transferred to women. Men are indebted to whosoever they infect and their punishment is certain."

"But is promiscuity only a problem among men?" I asked. The women of the support group agreed. "Hausa women," Hauwa pointed out, "are 99% shy, while men are only 1% shy. So men's desire overwhelms them, and that is what gets them into the trouble." Another responded to her, "Because men get more desires, God has made provision for them to marry four wives, is that not so? But some men have four wives and still seek other women outside. Women, on the other hand, once married love and honor their husbands. Its not possible to seek another man except yours." Most of the women concurred, "We [women] could see a neat, good-looking man but not be moved. Men, however, would not hesitate to follow a well-dressed woman, even though he is knowledgeable, informed, and might have just finished preaching in the mosque. He will see and follow a woman, and that's why we keep seeing all sorts of problems. It is because we digress from God's teachings." Statements such as these naturalize sexual drive, attraction, performance, and satisfaction into defined gender roles. Men innately need more sex than women.

At fault, women suggested, was "Hausa culture," which propagates women's ignorance and feelings of shame about sex. Lami commented: "We know men are more knowledgeable in Islam and we assume men are the unfaithful ones but let us why is this so? We women do not do what men want -- that's why." Hausa culture makes women shy and so they do not do what the women "outside" do to men. "So you see, the man who tastes what is outside will never return. We have this problem and should seek solutions…For example, if a man has wives who are well behaved, clean, neat and do the things he gets from outsiders then it will be very difficult for him to pursue these other women." I asked Lami to elaborate and she said that it is due to wives being "dirty, unfaithful, and not looking after herself properly":

> If the man comes to her and finds her smelly and the bed un-welcoming, he tends to be drawn to someone else who is neat, looks and smells nice. There still exist men with beautiful, neat, cultured, obedient and sensible wives, but because they are like goats, they will seek others. Especially there is a problem if a woman cannot sexually satisfy her husband. That will lead him to seek a second or a third wife, or sex workers. Some women do not know the art of love making, so by mistake, or stroke of fate, the husband finds himself in the company of an experienced woman, and that's it. He would prefer going to that one. Usually infidelity in men is because the woman is not good in bed.

In order to meet these virtuous ideals, however, women must possess material resources, which – not coincidentally – men were responsible for providing. Men neglect their wives and thus have the justification for pursuing new girlfriends. At the same time, women blame themselves for their lack of culture, when it is larger social inequalities driving patterns of sexual behavior.

Asama'u

While misdirected accusations of promiscuity drive women's fears of learning their status, most Nigerian women have had multiple sexual partners over their life course. Premarital and extramarital sex is common among women, as well as among men. Adolescent women, particularly those in the north, are pursued by older men and often marry at a young age. Sexual relationships in the interstitial period between first and second marriages are particularly common, as well. One of the support group members I met, Asama'u, was 26 years old and had never married. She transitioned into and out of a number of relationships before she tested positive. In her narrative, she paused on the description of her first boyfriend, the first man she loved and with whom she had sex:

> As soon as I began to have feelings for [my boyfriend], I started hating school…He sent his relatives to our house to ask for my hand in marriage. My parents told his people that it was not possible -- that I would finish school. At the time, he was 25 and I was 13. My parents told him they did not like him and he should stop coming to see me. After his second attempt and failure to get my parents permission…we went to the mallam who promised us help. What I fail to understand until today is, how come after that visit the love we felt for each other became so intense? Of course we were taking portions from the mallam and there were items he ordered to be buried. My boyfriend took care of that, being the man. After that, things changed. Whereas in the past I did not spend much time visiting with him, I would now stay at his house until after 11 in the night talking. At the time, he was much wiser and would say let me adjust your head tie, or some other excuse to hold my hand or he would buy me a ring and put it on my finger. We were meeting whenever I go out to watching movies at a friend's house…

Asama'u was 26 at the time I first met her. When she was a child, social attitudes were shifting toward the importance of "girl child education" in northern Nigeria. Her parents' insistence on her remaining in school was, at least in part, a reflection of this shift. Even with this change, early marriage is extremely common and Asama'u resented the fact that she was not permitted to marry when other friends were. Likely, however, this confrontation was less about education and more about the character of her boyfriend. Love potions, perfumes, and other charms used to seduce girlfriends are almost always part of stories of women's sexual experiences, just as they are prevalent across Nigerian films and literature. Essential also to these relationships are gifts of jewelry, clothes and other gifts. As further evidence of his wealth and attractive qualities, she marveled at his house, which had a "TV, video, stereo, speakers and light effects." Though she was fearful at first of visiting him in his room, this soon gave way:

> We continued to meet after my lessons, and then one day he fell ill. When I told my friend, she advised that I visit him and take oranges with us. He was seriously sick. After that, I continued to check on him until he became well. I would meet him in his room and we would chat. Gradually he deceived me into having sex. For example, we would watch American movies and I would ask him questions about what couples were doing -- Why is he touching and holding her, and so on. And he would explain. So things went on until I became totally infatuated and we had sex. I did not know what was happening…I knew he was playing with my senses, telling me if I had sex with him my relatives would allow us marry so with that I continued to have sex with him. I do not know what his thoughts were -- I just knew I loved him and him me. I also knew by now that sex is what obtains in marriage…So we kept up the relationship and I would tell my friend what we were up to. She would teach me new things to do whenever I was with him. He used to give pills to me everyday, and when leaving for school he would buy me a term's supply.

Though most women assured me that they had never had sex before marriage – whether it was true or not – given that Asama'u had HIV and had never married, it would have been difficult to lie about her sexual experience. She stressed, however, that she was "tricked" into having sex the first time, and it was because she loved him and expected to marry him that she continued to have sex with him.

> My parents still insisted they did not want him to marry me, and they sent me away for a few months. As soon as I got back I went straight to his place only to be met by a friend of his -- He asked me "Have you not been around?" Your boyfriend has gotten married. I could not believe it so I went back home and cried…Afterwards, he returned proclaiming love for me but I no longer felt anything for him. I blamed him and my parents, but I do not blame myself because if my parents had let us marry none of this would have happened…. Anyway, before we had separated, I had suitors whom I never paid any attention to, so I simply moved on with one of them. Although this new boyfriend was no match for my first, I simply forgot my previous and moved on. This time, I was wiser and did not love like I did before. I thought about my carelessness and scolded myself. With this boyfriend, we were together for a year. We had a good relationship and were in fact in love. But I discovered he was not interested in

> marrying me so I ended it. During the second relationship, I never used contraceptive and never got pregnant. I never really thought about pregnancy, although I would be a little scared if I was a few days or a week late. It was when I was with my third boyfriend – and about to marry – that he began to fall sick. When he did not get better, I went to a counseling center and that was where I learned I had HIV. Before I could tell him, he had died.

In northern Nigeria, relationships often are both formed and dissolved quickly. In many cases, women themselves described not knowing the reasons behind their dissolution. Women look for evidence of a man's sincerity in his marriage intentions, though this is often difficult to initially see. In addition, many women and men both have numerous concurrent relationships – some sexual and some not – as they evaluate one another's intentions. With her first boyfriend, Asama'u was not aware of any of her boyfriends other relationships, but in her subsequent relationships, she knew. She claimed to be protecting herself from "falling in love" with these suitors, but rarely are relationships without the material and affective exchanges that would indicate love.

Asama'u's case reveals not only the dynamics of many adolescent relationships in northern Nigeria, it also provides an important example of how women reflect back on their past partners – a required component of HIV screening. Unlike the formal global health protocols that involve identifying the behaviors that place individuals at risk of infection and devising a plan for changing these behaviors. These evaluations are in fact laden with questions of moral values and uncertainty.

Protecting Privacy

The biomedically-guarded right to privacy enforced (or expected to be enforced) in HIV counseling centers is quickly complicated by these relationship dynamics. Mercy, a Christian widow with two young daughters, had suspected her husband was HIV-positive for a number of years before he passed away. These suspicions were raised, in part, from "the way [she] married him," as she described. Soon after they married, he had found employment with UniPetrol in the urban center, Lagos, while she remained in her village in Plateau State. He told her that once he found a place to live, he would come and get her. Over a year passed, and she began to hear from her family that he was living with another woman. They had suggested it was because she did not give birth to a son. "If I don't have a male child in the house, forget it." Her mother-in-law told her that she was nothing and they were advising him to marry another woman.

Mercy's husband came home one weekend and she became pregnant again. But then to her surprise, he denied the baby was his and wanted her to abort it. They fought and he left her. Finally, she went to Lagos on her own. He tried to divorce her, but she said, "It cannot work. I married you when you had nothing. Now you are something, you want me to leave. Where do you want me to go? I cannot go back to my parents' house. I'll stay even if you want to remarry. I'll stay." He found her a room, but gave her no money to pay for her to attend antenatal clinic or even food. Her husband had packed up his things from her house and was living with a girlfriend. She delivered her baby at home with the help of a relative. The baby was constantly falling sick. Soon after, her husband returned to her apartment. He too was severely ill. It was at this point that he was admitted to the hospital.

She began:

> When [my husband] started his job, his illness became serious. He was then admitted in one hospital called Abimbola Hospital in Lagos. The way I looked at him, I began to suspect what was wrong. I was thinking of the way I married him.

> I had never seen him sick. I saw him with tuberculosis medicine and I asked him why he was taking the drug. He said he did not know -- that they just gave it to him. So I went and met the doctor and asked him, "What is the problem with my husband?" He said that there was nothing wrong -- that he will soon be ok. "Just tell me, I insisted, "I am a medical personnel. No matter how serious the case is." So he said, "You are a medical personnel?" I told him, "Yes we do work on these cases. That is why I came to ask." So I told him I am going to leave my husband with him. If anything happened to him, he should contact his family and tell them. "…Because I don't want to try to answer questions that I don't know anything about. If he dies, his family will ask me questions. If he dies, don't ever look for me because I'll sue you." The doctor was scared. He said, "Madam, I am sorry but your husband is HIV-positive. Don't tell him I told you. He warned me that I should never tell you; he didn't know how you'd take it."

Mercy's case elucidates an array of social structures and inequalities that constrain the norms and forms of information and resources shared between husbands and wives in Nigeria. Most broadly, these include the economic forces that push men to migrate and travel for work. These occupations and the unstable sources of income affect both the amount and the motivation men have for sending money to their wives, and the frequency of their visits. As Mercy explained, her husband and his co-workers all sought girlfriends and had affairs with other women when they traveled. The more wealth her husband possessed, the more she had to fear. This motivated her not to leave the relationship, but to fight to secure both her husband's economic support and his affective commitment to their marriage. As his income fluctuated, so too did this relationship. All Nigerians espouse to value children as a crucial component of marriage. Reproduction may serve as a means through which a woman obtains respect and stability within her family. A man's rejection of his parental role, as shown here, is not merely a form of economic abandonment, but also a mechanism for social abandonment. Mercy found other ways of generating income and assistance from her family and ultimately became her husband's only source of support when he fell sick.

Mercy's biggest fear was not the trajectory of his – or her – illness, but rather the questions his family would ask of her if he died. Despite the fact that her husband's infidelity was widely known, HIV would cast into doubt her own reputation and could provide his family yet another reason to justify her neglect. At stake when one receives an HIV test result is thus not only the question of whether or not one is infected, but also, who caught the virus first? Who is to blame? Even when a woman's virtuous reputation is well established among her in-laws, the suspicion of being responsible for infecting one's partner with HIV is grounds for her abandonment.

Mary

At a hospital in Jos, I interviewed another Christian HIV-positive widow – Mary – also with a young child infected with the virus, who offered a similar story to Mercy's:

K: Did you know anything about this HIV before you found out about your husband?
M: No. I was hearing of it, but I didn't know how it was…
K: You heard of it from where? How did you hear of it?
M: You know I work in printing press…So the place that they print [HIV materials], I work there. So I now read it. As I read it now, I bring it home. I showed it to my husband and said, "All what you are complaining of that is disturbing you, it's what is right here. Are you sure that you didn't have AIDS?" My husband says no. He denied it, he said, "No."
K: Do you think he knew?
M: He himself he knew that this was the problem.
K: He had a test?
M: Yes. He knew, but he hid it from me.
K: He had one but he didn't tell you?
M: He didn't tell me because I am very, very honest to him. I didn't keep men, I didn't follow men, but he did [had girlfriends]. So that's how we keep secrets.
K: You suspected then when you asked him, "You have this thing?" You suspected this was his problem?
M: Yes I suspected it. I even called his relatives so that they should help me to ask him to say the truth. If it's really it, there's nothing God cannot do. I believe it. God is a merciful God. He can forgive that. Actually [my

> husband] will die, but God may forgive him. I call many people to plead with my husband that he should tell me the truth. But he refused. He wouldn't tell me.

Information about HIV is ubiquitous in Nigeria and can easily be used to encourage individuals to recognize their symptoms and potential exposures. The public health-defined virtues of a test are couched in language that states, "knowledge is power." *Not* knowing one's status, however, is not always a sign of one's ignorance, nor is it necessarily *dis*empowering. To understand why it was that Mary's husband hid his status from her and why she insisted upon his disclosure requires a consideration of power in Nigerian gendered roles and expectations -- and specifically the dynamics of power within sexual partnerships and families, kin groups, and community relations.

Like the case of Mercy, Mary's interview also illuminates the ambivalence many Nigerians possess toward infidelity. Mary was certain that her husband had girlfriends, even though they did not speak about it. During the interview, she sought to reassure me that her desire for learning his status was not malicious – that is, she did not intend to dissolve the relationship or to seek some form of retribution. For women, these intentions would be widely considered highly immoral. Mary believed that, regardless of what his HIV status was, disclosure would not spoil their relationship. Religiously, she felt obligated to know his status so that she too could pray for his forgiveness, thus reinforcing her virtuous reputation. Her efforts to enlist her family to persuade him reflects a common way in which a woman confronts her husband when he fails to meet his social obligations.

We continued the interview:

K: You think maybe you have the same sickness then?

M: Back then?
K: Yes. When did you first think that maybe you have the sickness?
M: Actually since he had it, I knew that there's the possibility that me myself, I have it. The second reason again, the baby that I was carrying is not healthy as others. He's not very healthy as the other one. That's how I knew.
K: So at this time, you think when your husband, when he was down, you thought you might have a test? Were you thinking about going to get a test for yourself?
M: No, I didn't want.
K: Why not?
M: Because my husband was very, very, very sick. Very, very sick. So I didn't want… Back then, he has no energy again to do anything. He's very very sick. Very down.
K: But you yourself, you were not feeling down?
M: No, I was very healthy.

Despite the possibility that she might have HIV as well, it was critical to Mary that she learn the status of her husband first. She was *not*, in fact, interested in learning her own status. Without Mary's husband's sero-status first confirmed, for example, she opened herself up to the risk of being accused by her in-laws and others of *causing* her husband's illness. She risked having her children being taken away by her in-laws, or be abandoned without the means to support them. Mary, like most HIV-positive men and women, was most concerned with the potential reconfigurations of their family and social relationships that a diagnosis poses.

K: So did you want to go to get a test then, just to know your status?
M: Actually, I was so disturbed. I was so worried. So we now go to hospital. They admitted him [to the hospital] back then. So when they admitted him, I asked the doctor that they should please help me. I want to know this also, my husband's sickness. So they asked me, "Did my husband discuss anything with me?" I said, "No." So they now said, "He's supposed to discuss it with me now and the doctor refused to tell me. So later on, the nurses they plead with my husband. They said that they can't tell me. He's the person that's supposed to tell me. They plead with him.
K: The nurses they plead with him. But he wouldn't say?
M: No. He later told me that he had AIDS. So I now said to him, "Since all this while?" I would wake him in the midnight to plead with him that he

should tell me so that I will know how to handle myself with this little boy in the future. So the doctors told me, "There's nothing I can do." The nurse thinks that I should go for test to know maybe I'm positive or not. So I left the hospital that day. The following day, he has already died. So when the doctor came into the ward now, he gave me a letter that I should go for test. So I did the test. And then they told me that they are not sure of the result. So I went back to do another many tests to make sure. I did Western blood [Western blot]. So the test brought it out that I'm positive… Well, actually, they didn't tell me in [the hospital] that I'm positive. They didn't tell me. They just tell me that they would put me on drugs back then.

K: But you knew then?

M: Since they said that I should stop breastfeeding my baby, I knew that there is something wrong.

K: They test the baby also?

M: Yes, the baby is also positive.

K: But they wouldn't tell you then?

M: No, it's my baby. It's my baby. I know that. Since my baby is positive, then I, the mother, am positive also.

In this passage, physician and nurses are rigidly following the hospital policy that they keep the details of an HIV-positive patient's condition private. Unlike virtually any other illness treated in this hospital where family members would be fully informed about the patient's condition, an HIV diagnosis prevents any further discussion. Like Mercy, what ensued was a struggle between Mary and her husband's doctors and nurses to extract these details, when all of her previous attempts had failed. Her husband finally disclosed to her the day before he died. Mary's fight had little to do with the fear of the her husband's impending death – she knew her husband was dying of AIDS long before he or his doctors told her, nor was she particularly concerned with her own health. Rather, her struggle was a demand for recognition: recognition of a woman who was wronged in her marriage; recognition of a wife who cared deeply about her husband; recognition of the power of her faith in supporting him; recognition of her status as an important actor in making health-care decisions for her family.

While stories about the emotion breakdown of clients in the face of their diagnoses were common, I was surprised to hear of and witness so many cases of persons receiving a positive result with little emotion at all. They asked few, if any, questions, nodded their head at appropriate times, and would leave the offices with their referrals in hand. Mary likely proceeded through the testing procedure similarly, if she received any guidance at all. Though I was initially appalled that Mary was tested and could leave a hospital without knowing explicitly her diagnosis, she clearly knew not only her status, but also knew far more about the virus, its physiological effects, and appropriate courses of treatment than perhaps even the counselors. She too was aware that these doctors were not following the appropriate counseling protocol, but unlike me, she was more affronted by their *social* disregard. Medical negligence, in other words, was recast in terms of a doctor or nurse's ability to mediate relationships in the context of healthcare. Health care providers and counselors, on the other hand, often confided in me their fear of causing marital discord and relationship dissolutions following HIV-positive diagnoses. The emphasis on privacy was thus justified under the auspices of protecting the client's relationship.

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The rights to privacy, autonomy, and self-determination are indeed fundamental components of all major statements pertaining to the rights of persons living with HIV and the broader principles guiding bioethical and human rights tenets (e.g. UNAIDS 2006). Mary's case, for example, complicates common assumptions surrounding the right to privacy, while Talatu's reveals the social forces prohibiting autonomous decision-making. The virtues of privacy and autonomy are undermined not so much by the modality of testing as they are by the larger social structures and inequalities that characterize kinship relations in northern Nigeria. In the case of Talatu's husband, his promiscuous reputation was well known. She returned to her father's house and they took charge of her health. Though her parents and husband did not inform her of her own sero-status, she began to suspect HIV for both herself and her sick baby. The death of her baby and her former husband compelled her to go to the clinic herself to receive a test, where her suspicions were finally confirmed.

A woman has a greater chance of maintaining her reputation if she learns of her husband's status before he informs his family or he passes away. Without a husband's confirmation that she has been a respectable, faithful wife, a positive result in the hands of his kin and community jeopardizes more than her health. His family may take her children, or they may leave them without any support. They may also take away her possessions and deny her the inheritance she is due. Her relatives may broadcast her status to the larger community, potentially spoiling her chances of remarrying. *From whom* and *when* one receives an HIV test result are as consequential as what a screening actually reveals.

Protecting the Public

Public health and other social authorities in Nigeria have attempted to address some of these problematic issues exemplified in the above cases through community programs to encourage the uptake of HIV testing. Unlike the opt-out debates I have described circulating among Western health policy makers, these authorities address marriage and the family explicitly in their interventions. Religious institutions, for example, have been increasingly recommending – and often requiring – premarital HIV testing. I have suggested that the autonomy and confidentiality that testing centers seek to protect are often undermined by the social relations and networks within which individuals are situated. Here, I argue that religious authorities often undermine their own policies through a contingent logic that defines under what contexts privacy must be maintained and under what contexts must confrontation and disclosure be mandated. These rationales are informed by particular assumptions about gender roles and local moralities, and reflect the same unequal relations of power that exist with kin groups and communities.

Among most Orthodox and Pentecostal churches in Nigeria, compulsory HIV screening policies began to be implemented in the late 1990s (Uneke et al. 2007). For many of these churches, HIV education became part of the pastoral counseling that couples received before their marriage. These policies dictate that couples be referred to a testing center, accompanied by a representative of the marriage committee from their respective churches. Churches that require premarital testing commonly prohibit or discourage marriages between couples that are sero-discordant. And, as families are often involved in and informed of these matters, they are also among those who forbid these marriages from proceeding. Pre-marital HIV screening produces the very possibility of a sero-discordant couple, at the same time that their test results become the potential premise for the relationship's dissolution. Many Christians who know they are HIV-positive and want to marry, but fear that their marriage would either be forbidden by the church leaders, or worse – that their status would be revealed to the church members -- would simply switch churches. In a news article entitled, "With This HIV Test, I Thee

Wed," (2008), Pastor Solomon Olu Ajisafe of the Redeemed Christian Church of God, commented: "If you are a member ... you know what [the rules are], so if you want to marry [without taking an HIV test], marry outside the church. But if you marry within the ... church, you must subject yourselves to these rules. So I don't think it is an infringement on the rights of anybody. Like any organization, the church has its rules." These formal rules, however, are often challenged by other competing moral principles on family formations and the social roles and responsibilities of men and women.

Ann

Ann, a Christian, HIV-positive women from the middle belt of Nigeria, was a member of a Pentacostal church in the city of Jos. She had fallen in love with a widow from this church and they began to plan their marriage. She had heard rumors that his wife had died of HIV, but still, she said, "because of the love I had for him, and because of how far we had gone, I had never bothered to know if it is true. Actually, it was out of love that I did that because, I thought, "Since I loved him, I saw no reason that I'll turn away from him because of a sickness. So I just felt, ok, even if that is going on, let me just keep the relationship." She continued:

> All the people in my church knew him and they know about our relationship. Even my church pastor knows about the relationship. The elders know about it. They even cautioned us as of then that we should go find HIV screening before going into the relationship. Maybe it was because of what they had heard from other places pertaining the death of his wife, so they wanted us to go into a screening before we began dating. I thought, maybe before the wedding. Uh huh. They insisted, but we didn't do anything about it. We didn't go. Our pastor cautioned us, though. The church pastors and the elders called him to ask him if it was true that HIV was what killed his wife. But what he told us was that his wife died of hepatitis. That was what he said. It was a cover up. Even when the church pastors and the elders called him, he told them the same thing. I was just

> thinking people were saying it was HIV because they are jealous of the relationship or something or that nature.

Ann's church, like most, had a formal policy of pre-marital screening. In retrospect, it became clear to her that not only did her pastors suspect her boyfriend's HIV status, but the other members did as well. They could not convince her to seek a test, however. Even though she knew this risk, her marriage mattered more. Ann and her boyfriend had lived together initially and had been having sex since they met, when they began to make plans for their wedding, she moved backed to her parents' house to prove to them the respectability of this marriage. In her absence, he had met another girlfriend. She had gone to his house one day and saw this woman there. He introduced this woman to Ann as "his wife" implying that he was planning to, in fact, marry her. Though she had been warned about his reputation, Ann did not know of this other girlfriend. She explained,

> The next day [after I walked in on them together], I went to the hospital and I met a counselor there, whom I knew from my church. I told her I come for screening. She said, but why am I going? What do I want to do with it? I said I would like to do it because this is what I've been has happened with the man that I've been going out with and I would like this insecurity off my back. I have to be confirmed. So she now advised me and said, look, I should just stay put and wait and see what God will do about it. She gave me some bad advice. She was telling me that God was on my side, so I don't have to bother. The only problem was to make my ways right with God. I insisted that I receive the test. One thing I always thank God for is that he gave me the kind of heart that I was able to take this news. I was able to absolve everything from that moment I learned of my status. I wasn't bothered by it.

When Ann rushed for a test, it became even clearer that members of the church had known of his HIV status and did not tell her. The counselor she met had initially tried to dissuade her from screening because she suspected that the result would be positive. She feared that Ann would not be able to deal with the emotional shock of a positive diagnosis and might even retaliate against her partner, a common expectation that most Nigerians had about women and their emotional fragility. "To wait and see what God would do about it" – advice to all men and women who go to the church with dilemmas – directly conflicts with a policy of mandatory testing. This counselor prioritized the moral concern for protecting Ann from this shock and the danger she felt this could pose to her former partner. Ann, on the other hand, was motivated by the need to intervene in her boyfriend's new relationship and she went to her pastor to confront him. She continued:

> I now called my boyfriend to meet with his pastor and one of his colleagues at the church's office. We sat and we talked and I told him in their prayers -- I said look, what really I'm feeling is that I'm guilty of something and if I'm to keep it in myself, it will not work. So that is why I had to come out and tell them this is what was going on. I begged him to let that woman go ... When I begged, he said ok, he's going to talk to her. But really he didn't do anything. He went ahead and married her. My husband was excommunicated from the church. But instead of coming back to reconcile with his God and the church to take him back, he went to a different church and wed there.

In Pentecostal communities, in particular, church membership is highly fluid, with individuals moving to new churches for a myriad of reasons. Ann's boyfriend could easily evade the church's prohibition by joining another, unaware of his status. The church had sought to protect this man's privacy, and upon confrontation he fled.

Love Letters and Muslim Women

Among Muslims, the promotion of pre-marital counseling and testing for both first marriages and remarriages has been identified by the National Supreme Council for Islamic Affairs as an important priority in their larger effort to encourage the broader

Muslim community to respond to the effect of the HIV epidemic. I observed a group of religious scholars commence the drafting of a National Islamic HIV Policy where the Qur'an and the Hadith were drawn upon in support of these priorities. To justify the provision of pre-marital testing they found the quote: "The Prophet (SAW) advised a companion to have a proper look at a *madinah* woman who he proposed to marry to ascertain that she is free from a defect they are known to have" (Hadith). That this passage was highly gendered did not escape my attention, but it did theirs. A marriage would not proceed if a woman were to be found HIV-positive. Men were never discussed.

In one of the hospitals within which I worked, a visiting group of Americans from Catholic Relief Services came to tour the facility. In the discussion that followed, one woman asked the head of the hospital whether it would be feasible to offer premarital counseling and screening inside of a mosque. The director said that while Imams and other Islamic authorities might be able to encourage individuals to go for premarital HIV screening, the ability to counsel inside a mosque would be very difficult. In northern Nigeria, women do not attend mosques for prayer, and most Nigerian Muslims would consider the idea that a couple would discuss matters of sex and sexual indiscretions inside of a mosque an abomination. The majority of northern Nigerian women thus learn of their HIV status when they seek prenatal care. Like in the U.S., "opt out" models are common in most major hospitals in Nigeria, and HIV screening is conducted along with a range of other tests over the course of a woman's pregnancy. Although women are expected to be given the option to decline – and some do – many more are agreeable to a test while pregnant. PMTCT treatment has become standard in Nigeria, and physicians and nurses stress to patients that they will be able to prevent the child from transmitting HIV if they are screened.

Because women are far more likely to attend antenatal clinics and be offered an HIV test than men, however, they are also increasingly confronted with the burden of disclosure to spouses. As shown in the above examples, women face enormous challenges in persuading their partners to go for a test. To encourage partner notification, "love letters" have become part of the prevention efforts of a number of Nigerian hospitals. The counselors would offer to write notes to their clients' male partners, where they would be encouraged to come to the hospital for their partner's disclosure, couple counseling, and an HIV test. When I first heard of this program, I found the idea of a letter absurd, as did my HIV-positive interlocutors. Women fear abandonment, violence, and stigma regardless of how their husbands learn of their status. Moreover, because women are the first to be diagnosed, they risked being blamed for their husbands' status, regardless of how the couple was exposed. Though the partner might ultimately (if reluctantly) come for a test, it would do little to protect the woman socially.

At one antenatal clinic, however, I observed an unusual variation on the use of a "love letter." I asked the young counselor how she adapted to the predicament of Muslim women, who, in her words have a much harder time telling their husbands their status than Christian women. She told me:

> Well, the number one thing that can be done to ease this issue is the counseling. Start from the word go. When [women] start the counseling, [it goes] very well. And there is a different way that you will do for the man because, well, personally this is the way I do [it]: I will write a note to the husband, that I would like to see him in the hospital because I have one important issue to discuss about the baby, and that I would like the man to come. So the moment they see this note, they are very eager – that, "a medical personnel want to see me, let me come and know what is happening." And when the man comes, that will be the opportunity that I

> will have to even sit down and counsel the man talk to him; by the time I finish counseling, they will say, “Madam, I am ready to do the test. Let me do this test.”
>
> [Specifically] I tell them, “Okay, when women come during the process of delivery, they may need a blood transfusion. And because of the issue of HIV that is so rampant now, that is why we always want to do this screening for the husband. So, in case the woman falls into labour and there is a problem, we can know the blood group to do the transfusion.”
>
> We won’t even say it is HIV, we will say blood group; because, if you just tell them directly, they will not like it. But then, after that, you will tell them you will know the blood group, and you will know the genotype and so on. “Without this blood information,” we say, “your wife might get blood from somebody, and you don’t know whether the person is HIV positive.” They will say, “No! No! No! Madam, it is better if you can do my test for me so that I will know my status, just in case, so that you can prepare. Most of [the Muslim husbands], when you do that, well, it has really helped a lot.

What I found most striking about this particular approach to testing is that it stressed a man’s responsibility to his wife and children as the rationale for HIV screening. This stands in stark contrast with mandatory screening in churches and families, where tests were often used – if not explicitly, certainly implicitly -- as proof of a man’s or woman’s supposed immorality. In other words, an HIV test was demonstrative of men *and women* fulfilling their social role of protecting their children. Certainly, the biomedical and epidemiological developments in Nigeria, especially those tied to the prevention of mother to child transmission, have reinforced the public health benefits of this particular testing modality. The efficacy of these measures is a result of the ways in which the social significance of kinship relations and responsibilities are optimized in these decisions. However, even these approaches cannot always challenge the configurations of power embedded in relationships and broader kinship networks, which are determined in large part by conditions of poverty and social inequalities.

Laraba

Laraba, a Muslim divorcee from Kano, had remarried to a man who had a second wife and children. She had heard on the radio "about a disease that lacked a cure" and she began to worry that this disease was in her home. His wife, she observed, was never completely well and would constantly have diarrhea. Her husband would also be sick on and off and had rashes all over his body. She too was falling ill often. She insisted on going to the hospital and her husband told her, no. He denied her transport money, so she went to her parents' house and they gave her the money. At the hospital, she was tested for malaria and typhoid and was given malaria drugs, but she didn't improve. So she returned and they ordered another test.

> When I went back a week later to collect the result, I overheard the doctor telling the interpreter that some woman was HIV-positive. When I reached her table, I saw that the card in front of her had my name on it. She then asked me if I understood English and I said no. She wouldn't say what was wrong and told me to go back to the lab. At the lab, the technologist got me a chair and asked if I wanted some water. He made sure we would not be disturbed. He asked my name and if I had a husband. I told him yes and a son, also. He began to preach and said to understand that all that happens to humans is as God wishes. He asked me if I had heard about the incurable disease on the radio? I said yes. So, he said, that is what you have. He said to tell my husband that he was needed at the hospital but not to tell him my status or the reason why he was needed. Honestly, I did not feel much then. The doctor said that there was no drug, and that I should just continue to go to the clinic.

Like the above counselors, this technologist too feared the repercussions an HIV-positive diagnosis would have on couples' relationships, and it is clear that the technique these counselors use to bring husbands to the clinic is widely used. When Laraba got home, she said she did not show any anger or any signs that something was wrong. Like the counselor told her to say, she said to her husband he was requested at the hospital. He agreed, but then delayed. When she reminded him, he got angry and asked if she was told at the hospital that her sickness was caused by him? She said that she wasn't told anything. When they went to the hospital, she informed them discreetly that he didn't know she was aware of her status. The doctor told her husband that they needed to know both our problems because I had told them it was a long time now since I was last pregnant. So he agreed and his blood was taken. He wanted Laraba to leave, but they said to him they both should stay. The next day, the same technologist counseled us and told us there is no cure. He advised us to eat well and we would be able to live with the virus longer. Laraba described:

> When we got out I asked my husband what they had said was wrong. I told him I pretended to understand what the counselor was saying, but in reality did not. This, I did just to test him. He said it was not a problem and that he would buy the drugs. There is a woman who was taken to an herbalist and was cured, so he would go get us medication from him. So, our illness was nothing to worry about. Without him knowing, I told my parents what happened. My dad had heard about a traditional medicine and he bought it for me. By God's grace, I started getting better and regained my strength, even though I knew the disease was still there. I then offered it my husband. He was suspicious, but I told him that it was from my father. He began taking it. After a while, I told him that the herbalist said my mate [co-wife] should also take the medicine, but he said she was okay. I asked him, "What do you mean that this woman is okay?" Then he said, you know it is just fever. So I said fine. After finishing the medicine, my father asked me if all three of us were taking it. I said no. He said, talk to your husband because if she dies then you are at fault. You have cheated her. I spoke to him again he asked why I bothered him about the issue. I should just stay away from her.

Laraba took all of the measures she could to protect their health while avoiding confronting her husband about the source of their illness. She knew that the other wife needed treatment as well, but she was unable to convince him to give her the same medicine or take her to the hospital. Her husband likely wanted to avoid anyone becoming suspicious about the cause of their illness. After her mate's prolonged sickness, Laraba finally approached her and gave her their medication without telling her it was HIV that was making her sick. Laraba concluded:

> I gave her the medicine, but she was upset that her husband would be so hypocritical. I do not know whether she quarreled with him or what, but by the next day he stopped talking to me completely. This went on for three months. I just kept to myself. Whenever I ask him why he does not speak with me, he would deny that was angry. Next, he stopped giving me money to visit the clinic, and both he and his wife stopped taking the medication. Her illness became so bad that she could not get out of bed. When he returned from work, he would go and chat with her and that was it. I finally lost my patience and I told him I was tired of this business. He should just divorce me. My husband said, "Since you have said so, I will tell you your offence toward me: You are not trustworthy." And then he said I am also tired of being married to you, and he divorced me.

Conclusion

Analyses of stigma and HIV/AIDS have demonstrated how the epidemiological constructions of "risk group" categories have had profoundly stigmatizing effects on those diagnosed with HIV, in addition to its deleterious effects on prevention efforts (Glick Schiller 1992). Douglas (1991) has argued that the creation of alterity – realized conceptually through the act of diagnosing one HIV-positive – allows those in power (whether at the level of political leaders, medical practitioners, or family heads or husbands) to dehumanize, to scapegoat, to blame, and thus to avoid responsibility for sufferers (Schoepf 2001:339-340). Popular depictions of "excessive," "diseased," and "dirty" sexuality associated with definitions of risks groups have been the "words that kill" (Allen 1991), or the tools that those in power used to create alterity; that is, the need for the separation of the "pure" from the "impure" (Brandt 1986, Taylor 1990, Lyttleton 1996). Anthropologists thus have both stressed the social processes and experiences of stigmatization among persons living with HIV (i.e. Baylies and Bujra 1998, Yamba 1997, Farmer 1999), and the resistance of HIV-positive persons to this “othering” process (i.e. Parker 1987, Farmer 1988, Schoepf 1988).

Such forceful research findings would suggest that eliminating the pre-diagnostic ritual of counseling that seeks to place one into a risk category, and offering screening as part of the everyday practices of health monitoring should eliminate this violence. Those advocating “opt out” testing do so on the very premise that risk groups, as epidemiological categories, do not, in fact, exist any more. The most evident risk for contracting HIV – according to these arguments -- is *not knowing*. To make this point, however, is to abstract HIV knowledge and HIV “non-knowledge” out of context. While sexual partners have shared a virus, their relationships are characterized by larger material, symbolic, or affective exchanges. Heterosexual transmission between spouses is sub-Saharan Africa is an obvious example of the significance of these social dimensions; but scholars have also emphasized that even those infected with HIV through injection drug use have moral and social ties to those with whom they share needles (Bourgois 2003). These moral economies reflect not only the micro-political patterns of constraints limiting and shaping these exchanges of resources *and of knowledge itself*, they also intersect with larger unequal social structures. How, why, and what conflicts arise in the context of HIV diagnostic testing in Nigeria are questions underpinned by configurations of power determined in large part by conditions of poverty and social inequalities. These same conditions drive similar patterns of conflicts surrounding testing globally.

For the vast majority of my informants, at the time they finally obtained a test, they already knew or suspected they were infected. By its very definition, HIV is a shared disease. Most women have witnessed the illnesses of their partners and children. They know the virus's symptoms and they know that it is spread most commonly through sex. An HIV-positive test result reveals the social fact that both men and women have multiple partners over the life course – a fact that does not bode well in a moral economy where brides are valued for their chaste, virtuous dispositions. A positive diagnosis thus invites accusations of immorality, not only from one's partner, but also one's extended family. These accusations are the bases upon which marriages may be dissolved and social reputations may be destroyed. The social risk of losing this partner, I have argued, is often greater than the risk of contracting the virus. In their efforts to circumvent these threats, women seek to learn their husbands' status before their learn their own. Women have told me that the course of HIV is analogous to pregnancy: while one is able to hide their condition early on, it will inevitably show as it advances. That status of one's partner will ultimately be revealed to his family. Women maneuver strategically within this uncertain period of time in order to ensure that they can protect their reputations and social relations. Nevertheless, they often confront insurmountable challenges in their efforts to intervene in these relationship – and viral – trajectories.

CHAPTER THREE

SUPPORT GROUPS, MARRIAGE, AND THE MANAGEMENT OF AMBIGUITY

Introduction

On a hot, rainy day in 2004, I met with a group of non-married[1] HIV-positive women who were members of an HIV support group for men and women living in the northern Nigerian city of Kano.[2] In the non-governmental organization (NGO)[3] office where we assembled, a number of stiff, high-backed wooden chairs lined the perimeter of the room. I saw in an adjacent storage closet a dozen or so new sewing machines stacked high, ostensibly to be used in the women's skills acquisition program that the NGO sponsors. Several HIV prevention bumper stickers, along with a poster congratulating the organization's founder for being awarded a prestigious grant, decorated the walls of the office. In this formal space intended for job training, education workshops, and other HIV awareness projects, I conducted interviews and had many group discussions with these women that summer.[4] Working outside of the rigid structure of support group and NGO meetings held in that same room, the women and I spent much of our time together lounging on mats across the center of the floor gossiping about men: *What do women do to attract men's attention? What is the difference between a good boyfriend and a bad boyfriend? How do you please your partner? How do you relate to your co-wives?*[5] *What are the reasons behind the high rates of divorce in Kano? How has being HIV-positive impacted these expectations and experiences? Can HIV-positive women (re) marry and to whom?*

Sewing machines, congratulatory posters, and HIV prevention bumper stickers represent the currencies of enlightenment, empowerment, and activism that underscore the ways objectives of global health interventions shape particular social spaces in northern Nigeria. While support groups have emerged in contexts where most infected individuals maintain vigilant silence, these institutions are not simply emancipatory settings for discussions of sexual, social, and health well-being; neither do they function solely to cultivate self-responsible and economically autonomous patients. The women with whom I worked fear calling attention to their HIV status not by the trajectories of their illness, but by the fact that they lack husbands. In pursuit of new partners, HIV-positive women have appropriated a support group to facilitate their marriage arrangements. This practice captures the conjuncture between these global economies and the local moral economies driving women's goals of respectability and responsibility in the face of HIV/AIDS. Marriage aspirations are windows onto the symbolic importance of families to Nigerian women, the local political economic dynamics that shape social and illness trajectories in resource-poor settings, and the overarching constraints that prevent women from reproducing these global expectations of health citizenship.

The distribution of information, capital, and technologies from Western countries to developing countries has presented HIV-positive individuals with new sources for economic, social, and medical assistance. Moreover, new therapeutic options grant the potential for a period of life without or with few symptoms, enabling HIV-positive Nigerians to reconsider their life course aspirations. In spite of these new life chances, stigma continues to manifests itself in multiple ways across northern Nigeria. Even after gaining access to treatment, HIV-positive women often withhold their status from their families and social networks. Further, just as stigma is reflected and reinforced at the interpersonal level, it may also be reproduced through global health interventions in their efforts to encourage particular forms of public engagement among HIV-positive persons. In need of assistance, HIV-positive women make compromises, such as choosing to reveal their condition and participating in programs that place upon them unwanted, and potentially dangerous, public attention. The ways in which women negotiate stigma thus reveal the intersections and tensions between the symbolic, local, and global economies associated with Nigeria's HIV epidemic.

I make three major points in this chapter: first, I argue that the practices of support group matchmaking and the material, social, and symbolic exchanges that concretize these relationships draw upon courtship practices prevalent throughout northern Nigeria. Matchmaking is a social project not only unfolding in HIV support groups, but also within religious and kinship institutions. Further, just as marriage in northern Nigeria illuminates one of the central ways families manage the virtues and dangers of sexual behaviors, these support groups similarly attempt to promote a particular set of values surrounding moral and ethical sexual behavior.

Second, I elucidate the ways in which HIV-positive women's logics, motivations, constraints, and actions are thoroughly intertwined with those of their larger social and kinship networks. Far from autonomous actors attempting to maximize their gains and minimize their risks through their interactions with these global and local institutions, HIV-positive women prefer to obtain material, social, and symbolic resources from their husbands and families. Women hope that social networks will both protect their status and make claims upon these institutions for them. For example, *their kin* will confront individuals who maltreat them and demand that they be sanctioned. Further, they will accompany them to hospitals and ensure that they qualify for and receive appropriate treatment.

Finally, I suggest that women negotiate the threats of stigma and the promises of virtuous living through what I call the *management of ambiguity* surrounding their HIV status. Although undoubtedly HIV has the potential to confer a new and denigrated social status upon afflicted individuals, I observe here the ways in which women, in particular, attempt to defy processes of ascription and abandonment that often befall those whose pathological condition becomes publicly known. Women actively deliberate the questions of both to whom and when they should disclose their status. They employ silences and keep secret their HIV status among certain individuals, and cautiously reveal these "truths" to others. I have found that HIV-positive women, paradoxically, are motivated to join a support group to find husbands and reaffirm their kinship ties, but they do so with an ultimate aim of reestablishing privacy within their domestic affairs. "Going public" is thus a strategy for "going private."

Treatment Economies and Support Groups in Nigeria

In the early 2000s, global, state, and local funding for antiretroviral therapies (ARVs) was scarce. At that time, the men and women I knew who were able to collect ARVs paid as much as $200 or more each at state hospitals and private clinics. Hustlers peddling fake drugs and other "cures" were ubiquitous. Some of my friends from wealthier families paid the equivalent of thousands of dollars before realizing they had been scammed. Other who received subsidized drugs would sometimes sell them on the black market when they were in need of money.

Beginning in 2005, however, dramatic changes in the treatment economy were unfolding. A clinic in Plateau State, where I began my research, was selected as the first site for the PEPFAR (President's Emergency Fund for AIDS Relief) program, sponsored by the US government. PEPFAR, as initially conceived, promotes what they refer to as an integrated model of treatment, care, and prevention. A central objective of this program is the distribution of free ARVs to countries with the highest HIV prevalence rates. In the year 2007 alone, the US government allocated over $400 million to PEPFAR-funded projects in Nigeria, and that budget increases each year. As of January 2008 in Kano, there are now four major PEPFAR-funded hospitals, both public and private, that provide ARVs for thousands of HIV-positive patients, and 26 different organizations that receive support for other services and programs that promote treatment, care, and prevention. Nationally, PEPFAR funds close to 400 of these projects. Programs sponsored by international and national agencies including UNAIDS, WHO, the Global Fund, the Gates Foundation, and many others, cumulatively fund thousands of HIV-related projects, with annual investments that likely surpass a billion dollars

The provision of pharmaceuticals is not the only intervention targeted toward HIV-positive persons, however. Recognizing that stigma and denial produces barriers to treatment, care, and prevention, the 2004 PEPFAR guidelines stipulate the need to:

> Promote hope by highlighting the many important contributions of people living with HIV/AIDS, by providing ARV treatment to those who are medically eligible, and by involving those who are HIV positive in meaningful roles in all aspects of HIV/AIDS programming.
>
> [OGAC 2004:30]

The need to form support groups, as outlined in the PEPFAR guidelines is categorized under "palliative care." Drawing from definitions of palliative care employed in both global and national health organizations, they state:

> Palliative care and support goes beyond the medical management of infectious, neurological, or oncological complications of HIV/AIDS, and addresses symptoms and suffering directly. Building upon definitions of palliative care developed by the US Department of Health and Human Services' Health Resources and Services Administration (HRSA) and WHO, President Bush's Emergency Plan envisions expansion of *an intradisciplinary approach to palliative care and support making use of interventions to relieve physical, emotional, practical, and spiritual suffering*.
>
> [OGAC 2004:45, emphasis mine]

Support groups are more than venues for alleviating emotional and spiritual suffering, however. They are both centers where patients can be recruited for clinical interventions and research projects, and centers for projects that address "social care." PEPFAR defines this work as programs that support:

> [C]ommunity mobilization, leadership development for people living with HIV/AIDS, legal services, linkages to food support and income-generating programs, and other activities to strengthen the health and well-being of affected households and communities.
>
> [OGAC 2008:1]

Programs such as these are carried out by a wide array of predominantly local non-governmental organizations and are accessed by HIV-positive persons through their enrollment within support groups. International calls for greater involvement of persons living with HIV in local programs and the formation of support groups, have stemmed, in part, from the successful efforts of American HIV activist groups. These groups played fundamental roles in increasing awareness, publicly campaigning for their rights and the reduction of stigma of HIV-positive persons, and challenging the practices of researchers (Rose and Novas 2005, Nguyen 2005, see also Epstein 1996, Martin 1994). While alleviating emotional suffering, promoting economic productivity, and encouraging political engagement appear to be distinctly different and potentially conflicting agendas, they align neatly when framed with a Western, individualist paradigm valuing practices of "self-help" and "empowerment."

Because, in part, of the increasing investment in HIV treatment programs, the number of support groups across Nigeria has multiplied exponentially over the past decade.[6] In the city of Kano, there are now seven different support groups, comprised of several hundred men and women. Support groups and other associations of persons living with HIV/AIDS have been highly visible across the country, playing a key role in public campaigns for the rights of persons living with HIV. These awareness campaigns, for example, have sought to counter misunderstandings and stigma through interviews, testimonials, radio programs, dramas, rallies, and other projects. On the wall of one of the offices where I conducted interviews, there was a framed document outlining the "vision" of the support group. In line with the expectations of PEPFAR programs and those of other global agencies, it stated that the central mission of the support group was to contribute toward: promoting a "self-sufficient society," the alleviation of poverty, and the reduction of stigma.

The particular group with whom I worked was independent; that is, it was not sponsored by a single hospital or NGO. Again, reflective of the large political economic landscape of HIV interventions, this group receives funding from a series of grants awarded by different local, state, and global agencies. Given the proximity of this group to a number of hospitals with large treatment projects, their most recent activities have centered upon prevention and education programs targeted specifically toward the management of patient adherence to ARVs. Adherence programs intersect with issues that include nutrition, reproductive health, support of orphans and vulnerable children (OVC), and home-based and palliative care for its members. Support group members themselves have become "researchers," forming teams and carrying out large-scale surveys of their membership and communities. They have designated members responsible for "monitoring and evaluation," and are quick to mobilize when a visiting NGO representative, journalist, or anthropologist desires to meet with their group. In a field of competing support organizations, such measures are seemingly compulsory in order to obtain continuous sources of funding.

In this group, however, there was something strikingly different between the Western expectations of cultivating specific forms of coping, support, and knowledge found in the above statements, and the actual purposes this support group served. In my most recent visit with a woman in this group, she went to great lengths to explain to me the complexity of disclosure. I asked her, "If it is only Allah that has the right to tell people you have this disease, what is the essence of joining a support group and telling others you have this disease?" She replied, "Even in the support group, *you do not come* *out and say you have this disease.* You only do so when you have a job to do." I probed further, "What kind of job?" She said:

> Like the type of work we are doing with you. We are helping you because it is with this work that you will achieve your aims in school…even though we know you will not pay us. Some [other] people that want us to work for them, no matter the amount of money they will pay, we will not [disclose]. It is only because we are used to you – that is the reason we do this. For as long as this group has been in existence, we do not usually tell people -- even when we go out to work. There are other groups that do that. They will be showing themselves and begging for alms…You see some groups have governors or politicians that will give all of the women clothes during *sallah* festival, but they have never given us these things…[7]

In this group's meetings it is rare for men or women to state out loud that they have HIV. Members assume that one is either infected or affected, but it is rarely discussed. Business matters, rather than health concerns, dominate the group's discussions each month. Such an explanation, however, begs the question: Given this woman's intense dislike of the politics of support groups and her reluctance to share her status or her health or social concerns with other members, *why would she continue to come?* First, we must contextualize HIV-positive women's fears of disclosure.

HIV, Stigma, and Morality

In Nigeria, and in the northern states in particular, an HIV positive diagnosis has widely been considered an immediate death sentence. A number of forces have contributed to these popular perceptions. First, and most significant among Nigerians in their characterization of the epidemic, is the sheer number of persons living with the virus. In 2005, there were approximately 2.9 million Nigerians out of a population of close to 140 million living with HIV. And, in that same year, there were an estimated

220,000 deaths due to AIDS (UNAIDS 2006). Initial local responses were characterized by widespread denial and gross misunderstandings. In an attempt to counter suspicions of HIV as a fictitious disease, early public health campaigns employed pictures of skeletons, blood, and coffins to accompany awareness messages such as, "AIDS kills: Protect yourself," and "If you think you can't get AIDS, you're *dead* wrong." As a result, the Hausa terms for HIV/AIDS suggest an irreversible, near-death condition. *Kanjamau* refers to a lifeless body that is virtually skin-and-bones, and *kabari kusa* means literally "nearby grave," and figuratively, "one foot in the grave." These names and images reinforce the virus's fatal connotation, even as public health campaigns have altered their messages to demonstrate that *HIV does not show on one's face*.[8]

Although the stigma surrounding HIV stems in part from its association with death, even more damaging to those infected with the virus has been its association with immoral behaviors. HIV-positive persons have been discredited as irresponsible, promiscuous, and deserving of their misfortune. These individuals have lost jobs, houses, and even children, as a result of their families and communities learning of their sero-status. In Nigeria, political and religious leaders have used examples of HIV transmission in their larger projects and narratives inculcating particular morals surrounding sexual behavior. I have witnessed countless examples of the ways in which this occurs throughout Nigeria and how HIV-positive persons manage this stigma. The following case, in particular, reveals this point.

An HIV-positive friend of mine, Patience, asked me to go with her to a wedding held at an evangelical Protestant church just outside the city of Kano. She was previously a member of this church, but recently, she told me, she had stopped going. One of the central social projects of this church was to arrange marriages between its members. If a man desired to court a young woman in the church, he would approach a committee who would arrange the introduction and supervise their meetings, counseling the couple about the proper ways to behave in a relationship and preparing them for marriage. Patience had been widowed for nearly three years at the time and men in the church had begun to "admire" her. The committee approached her and told her that a particular man was interested in her. Much to their disappointment and consternation, she declined the introduction. In an earlier church service, the pastor disclosed the HIV status of one of their members to the congregation and Patience feared the same would happen to her. Despite this, the man continued to pursue her. A little while later, the committee approached Patience again, and she knew she could not continue to decline their requests, or they would become suspicious. She lied to the church leadership saying she was moving to another city.

Months later, one of her close friends was getting married in the church and Patience was obligated to attend. Having me to accompany her provided members of this church further evidence that she had moved to Jos, a city known for its large expatriate population of missionaries.[9] Patience did not disclose her status to her friend about to marry because, as she explained, her friend was not the type of person who could keep secrets. The theme of the sermon at the wedding centered upon the Biblical passage, "wives submit to your husbands."[10] In an interpretation I had not heard before, the pastor emphasized the numerous ways in which women behaved immorally in their marriages, defying and making excessive demands upon their husbands, such as pleading for expensive cloth, jewelry, and other extravagant items. Such requests, the pastor explained, drive men away from their wives and tempt them to pursue other women. "Women," he shouted, "you can then tie your Holland [cloth] with AIDS!"[11] According to this pastor, women's desire for these clothes drove husbands to affairs with other women, consequently making *wives* responsible for the transmission of HIV among couples, and the larger HIV epidemic.

I shifted uncomfortably in my seat, worrying about what Patience must be thinking. Used to these themes, however, my friend was undisturbed. I told her after the wedding that I thought her pastor was a misogynist. Why are only women to blame for marital problems, and why is it men's responsibility to simply forgive women's sins? Why not discuss men's roles in marital discord? And why did he feel it necessary to address these concerns at a *wedding*? Couldn't he have found some Biblical passage about love and happiness? She laughed, attributing my concerns to my own American ethnocentrism. Patience's case reveals the ways in which gender expectations surrounding relationships, local moralities, and stigma, are inextricably intertwined in Nigeria's HIV/AIDS epidemic.

(Re)Marriage Motivations and HIV

In examining the ways Patience navigated potentially stigmatizing encounters, it was clear that she could have avoided unwanted attention had she been married. To understand why relationships and marriage are the highest priority for HIV-positive women, we must first examine the social processes that inculcate women with these aspirations and intentions. Among Muslims in northern Nigeria, Callaway (1987) writes, "there is no acceptable place for non-married women of childbearing age…Adult Hausa society is essentially a totally married society" (35). In the past, if a woman chose to remain single, she was likely to be referred to as a *karuwa* [prostitute] (Smith 1959:244, cf. Pittin 1983, 2002). Religious doctrines stress the importance of marriage, while pragmatically, marriage offers women structures of economic and social support, in a country where there are few opportunities for poor women to generate income outside of kinship networks. *Mutunci* [respectability], a reflection of the stability of one's marriage and the moral authority she possesses, is revealed through her comportment within married life, particularly as she bears and raises children (Schildkrout 1983, Coles and Mack 1991, Callaway and Creevey 1994, Renne 2004). This observation applies both to Christian and Muslim Nigerian women.

Moral authority manifests itself in a number of ways. It reinforces a woman's own family's protection as well as the protection of her in-laws. Gaining this trust and maintaining this support is crucial for a woman to be able to make claims upon her larger family for her needs. Further, this support can be used to sanction her husband if he does not provide adequately for her. In many cases, women who remarry often do so to men with multiple wives. Moral authority helps to ensure that the love and support he might provide is equal to that of her co-wives. Moral authority also grants women greater decision-making power with the domestic affairs of the household, the support husbands provide for their children, and her freedom in pursuing work, education, and other interests. Its larger significance lies in protecting women from divorce. Though these expectations are formally outlined in *shari'a*,[12] women stress that these expectations cannot be taken for granted.

In addition to these expectations, marriage functions to ensure the symbolic need to protect men and women from the dangers of immoral sexual temptation. It has only been within this generation of reproductive age women that *kulle*, or wife seclusion in its strict sense, has not been a fundamental component of Hausa Muslim marriages in Kano city. The lasting effects of kulle are found in the expectations that married women possess good judgment and behave modestly when outside their homes.[13] Married women's separation from men, in this sense, is associated with reaffirming women's moral purity. Efforts to control women's sexuality are continually at the center of political and religious attention. In recent years, Kano state's government has attempted to address the separation of Muslim women and men in public spaces.[14] The increase in the prevalence of HIV/AIDS has provided these leaders further evidence of what has been defined as an "epidemic of immorality" across Kano. These sentiments directly contradict widespread public health research findings that suggest the most common route of HIV transmission for women in sub-Saharan Africa is through sex with their marital partners.[15] Most of the HIV-positive women I knew either received the virus from or transmitted the virus to their husbands.

And yet, a high percentage of HIV-positive women in northern Nigeria are currently non-married. While measures such as wife seclusion are put in place in an attempt to control women's sexual behavior, men, on the other hand, are presented with numerous opportunities to have multiple sexual partners over the life course – through institutions such as polygamy, divorce, and the widespread cultural practice of men's extramarital affairs. These are common despite, again, the fact that shari'a discourages the abuse of these institutions, and forbids extramarital affairs. Broad, gendered power differentials within marriage drive the high prevalence of HIV transmission among couples (Smith 2007, Hirsch et al. 2007, Parikh 2007, Wardlow 2007). Structural inequalities such as these manifest themselves in marital conflicts, particularly concerning those surrounding the circumstances through which HIV is spread between husbands and wives. They are often cited in women's explanations of the high rates of divorce among Muslim couples in northern Nigeria. Further, because husbands are often the first to contract the virus, they are therefore commonly the first to fall sick and die, leaving increasing numbers of HIV-positive widows across the country.

While demographers have argued that HIV has increased the prevalence of divorce and mortality across sub-Saharan Africa,[16] divorce-hood and widowhood [collectively termed *bazarawa* in Hausa] are, in fact, common experiences among all women of reproductive age in northern Nigeria. The reasons for this among Muslims include the ease with which Islamic doctrines can be invoked to proclaim a divorce, but also applies more broadly among Muslims and Christians alike in the everyday economic uncertainty within Nigerian households, the overall poor health among families, and the large age differentials between husbands and wives. Marriage dissolutions are only seen as problematic if the time between marriages lasts too long. Schildkrout (1986), for example, writes that widowhood is considered a ritual phase in most Hausa women's lives and a point where women, in fact, may have many options, including both the possibility of remarriage and routes through which they can improve their economic positions. Indeed, demographers lament their inability to calculate divorce rates because of the speed in which women remarry (Solivetti 1994).

Non-married northern Nigerian women often fear the stereotypes of promiscuity that characterize “independent” women who do not desire to marry again. This sentiment exists despite the fact that neither Islam nor Christianity mandate remarriage. The anxiety among women and their families has been, at least in part, informed by the advent of the HIV epidemic in Nigerian society and the ways in which it has coincided with the increasing religiosity of both Muslim and Christian communities. The efforts of Fundamentalist Islamic and Christian movements aimed at transforming the whole of Nigeria through their intensely public moral projects, center upon regulating family life. HIV-positive women are continually suspected of marital wrongdoings, witchcraft, and other transgressive behaviors that have led to their infection and the ultimate dissolution of their marriages.

Based, in part, on these accusations of immorality and the maltreatment of HIV-positive persons in their communities, many of my interlocutors were very careful not to let their families learn of their status. Asabe, an HIV-positive widow who is currently unmarried, has stated:

> Now I see that I am well and healthy and I think I can live positively if I find someone with the same status. So that is why I think of marriage…This sister-in-law of mine says also, “Asabe, you are now better. You should get married. You are always covering yourself and making a hard, unfriendly face, so how can any man be brave enough to approach you?” So, any man who wants to marry me would have to talk to my family or close friends. In my mind, I know what my problem is, so I do not tell [my sister-in-law] anything. I just laugh. I tell her, “My covering myself will not stop me getting a husband.” It has only been in the past months that I have thought about marriage and childbirth…I just pray for Allah to give me a responsible husband.

HIV-positive women, such as Asabe, are highly invested in finding new, *responsible* husbands, in part hoping that marriage would allay their families' anxieties, and perhaps even enable them to disclose to their families their HIV status.

Expectations of Courtship and Marriage

In a society within which most women's access to livelihood is so thoroughly intertwined with the resources of their husbands and families, it would be easy to overlook the symbolic transactions within relationships that designate value and virtue. As I left the wedding with my friend Patience, we ran into her admirer. She introduced me, and they had a brief conversation. She then told him we had to hurry back to Jos. Few Nigerian women I know ever reject a suitor up front. As a couple of my friend's younger sisters explained, you just never know if his situation might change. Regardless of whether *love* exists between a boyfriend and girlfriend, the importance of exchange during courtships is always emphasized my discussions with women. These exchanges both concretize and assign meaning to these social roles and the larger processes of social reproduction.

Kudin zance, literally meaning "discussion money," or the money or gifts that women would receive from suitors, is almost always expected in these visits. It might be a mineral (a bottle of soda), biscuits, candy, or other food item. It could also be a small amount of money, or other small token. Wealthier men might give larger items such as cloth, jewelry, or even cell phones. When I returned to Kano in 2006, a new mobile phone service arrived in Kano, which allowed for people on the same network to talk to each other for free. That year, Starcomms mobile lines were extremely popular.

Starcomms was different from services and required that one have a second handset (most Nigerians own a cellphone). These phones were often gifts between boyfriends and girlfriends or husbands and wives. As this service later began to restrict its free or discounted rates to very late evening and early morning hours, the conversations between boyfriends and girlfriends again took on a new layer of secrecy, as couples would speak to each other while the rest of their families were asleep. Text messages, too, fly back and forth between boyfriends and girlfriends as perhaps one of the most significant ways in which couples communicate.

Determined boyfriends come by women's homes hoping to greet them and talk, and women may or may not choose to acknowledge their presence. In some cases, this has to do with whether these gifts demonstrated the appropriate amount of respect for a woman of her status. Women might refuse to speak to a man if he did not come with a small token for her. They may send out another family member to tell him they do not have the time to speak. Men, in turn, seek other ways to pursue women, such as sending them cards or love letters, expressing their interest in marriage. They send friends and other relatives to meet with women's families and gain their approval. These meetings and negotiations are met with great formality as families intensely interview men and investigate their family's background.

According to Islamic tradition, it is expected that from the time a child is born, the father is responsible for education, marriage, and all financial costs related to child rearing. Mothers can contribute if they are able and wish to. I must state outright that there are vast differences between these Islamic ideals and the actual constraints families meet in marrying off their children. Marriage is a process in which the entire extended family is invested. Negotiations between the two families are long processes involving the details of the marriage gifts,[18] which are the responsibility of the families to contribute. These gifts are meant solely for the wife, and should the marriage dissolve, she carries these items with her. Everything, from who buys the bed to the television set, is dealt with in these negotiations. Among Christians, wedding negotiations and offerings, too, involve extravagant gifts and money. Like Muslims, however, there is enormous variability in the extent to which these items represent more of a symbolic exchange or the transfer of actual wealth. The religious persuasion of the families involved influences the degree to which weddings necessitate lavish gifts and vast amounts of wealth. Thus, wedding exchanges are not static components to be taken-for-granted, but rather are actively and continually negotiated.[18]

Far from an immoral, unacceptable practice resembling prostitution or other forms of gendered objectification, the webs of social significance attached to men's and women's expressions of love are intertwined with *both* material resources and symbolic gestures. Most importantly, these exchanges offer a woman and her family proof that a potential husband is capable of protecting her, providing for her, and treating her with respect. Men and women, therefore, are extensions of their broader kinship networks. The resources that men and women bring to marriage are not limited to their economic value and potential, but in fact, include the social and symbolic resources embedded in these networks of kin, as well.

HIV threatens women's material livelihoods in numerous direct and indirect ways. Healthcare costs are well beyond what most can afford, even when drugs are subsidized. As described above, fears of stigma may prevent some women from requesting assistance from their family members. Others who do request their families' assistance often find that they have reached the limits of what their families can offer them. Marriage, however, does not only function to remedy to women's economic concerns; indeed, if it only offered that, it would perhaps be less complicated for HIV-positive women just to enroll in their group's sewing school. I have used the example of courtship practices, engagements, and marriage transactions to reveal the ways in which designations of virtue are caught up in larger moral, social, and economic negotiations. The ties between these local moral economies and the marriage aspirations of HIV-positive women can be understood more clearly in looking at the ways in which support groups themselves, have attempted to reproduce these social relationships.

Support Group Matchmaking

While the explicit aims of the support group were to help promote a "self-sufficient society," the alleviation of poverty, and the reduction of stigma, I found that most women participate in this group with their own interests in mind – that is, to find husbands. In this group, there are many more women than men, and many more non-married women than married women. In part, these demographics may be a result of the fact that more women than men are tested and treated for HIV across the country. I suspect, however, that this imbalance is also suggestive of the pressures to marry that are faced by women without husbands, in particular. Moreover, most of these women come from poor families. It is widely acknowledged in the group that wealthier women from highly educated families have an easier time disclosing their status to others, and thus would not be limited to support groups to regain respectability.

Hausa is the lingua franca of the group, but given the reach of spoken Hausa across the northern and middle-belt states, members are from diverse ethnic backgrounds and are both Christian and Muslim. Unlike other NGOs and associations in shari'a states such as Kano, most of this city's support groups are comprised of both men and women. This mixing of religions and genders may be reflective of the fact that their major sources of support do not often come from Islamic religious foundations. Many of the Muslim men in the group have said that they joined because they see it as their Islamic duty to protect the women and children affected by the virus.

Despite their smaller numbers, men dominate the leadership positions in this group. While it is commonly understood that many of the economic opportunities and trainings offered to this group are meant to benefit women, men in leadership positions have access to even greater benefits. Apart from overtly corrupt opportunities to siphon money from projects sponsored by NGOs, leaders are also offered the chance to present their needs to a larger political audience through state and national organizations of persons living with HIV/AIDS. They are able to select the women with whom they would like to travel and support with these opportunities, and are therefore given significant leverage in forming relationships. Even men who do not hold these positions have enormous persuasion in obtaining girlfriends, given the large number of women seeking husbands in the group. In some cases even ethnicity and religion are not barriers to relationships, although it is still unusual to hear of these relationships ultimately resulting in marriage. To limit this analysis to the opportunistic behaviors of individuals in a "marriage market" characterized by a surplus of women and its relation to the potential gains in marriages, however, is to miss the larger social processes unfolding in these groups.

All group members take an active role in arranging relationships and marriages between themselves, their friends, and the group's female members. As women in the group tell others that they meet in the ARV clinic of the marriages taking place, this compels many to attend meetings. Marriage arrangements are formalized through the group's use of its dues and donations to provide financial gifts to newlywed couples. Ladi describes how marriages are encouraged:

> At our meetings, if a guy sees a girl and likes her, then he will tell her about his interests. Quite a number of us have gotten married and are still together now! The guy might talk to her directly or he will tell a friend. And then, she would tell the guy if she finds him okay. But, if she already has somebody outside of the group, then you, as her friend, will inform him and offer to introduce him to another girl, if he so wishes. So, that is what happens. Sometimes the guy's friend approaches the girl, and she will tell him whether or not it is fine. There are some of them who are not after marriage, so you would see the signs of love and then no marriage! The leaders of the group know if there is a marriage in progress. Sometimes they just see the signs and they give gifts when the marriage takes place. Every member on the occasion of his or her marriage will get the same cash gift…the amount is 1,000 Naira [$8].

While this new ethical concern driving the formation of sero-concordant partnerships and marriages appears to be a thoroughly novel development in light of the changes in the therapeutic economy of HIV, numerous elements of this kinship process unfolding within support groups resemble those that characterize the institution of marriage throughout northern Nigeria. In the group I studied, as in the wider Nigerian society, not only are there matchmakers and exchanges of money, support group leaders act as representatives for the women members in negotiating the terms of the marriage between partners and their families. Witnesses that can testify to the social reputations of engaged couples are crucial to the “tying” of Nigerian marriages. This is particularly the case among families who have concerns about the ability of partners to take care of their daughters and their children.

In addition, just like family members, support group members also closely monitor women’s sexual behaviors and reinforce a set of expectations surrounding appropriate relationships; namely, those that do not jeopardize the health of their partners. While the moral concerns surrounding infecting partners with HIV are new dynamics in relationship formation, fears of and attempts to control women’s sexuality map onto larger social anxieties and gendered power differences in northern Nigeria.

The Making and Unmaking of Support Group Relationships

Stories that women would tell each other about the successful marriages of support group members cemented their beliefs that they could find husbands and marry or remarry. One example continually referred to by the women group members I met with was the marriage between Lantana and her husband, a former president of the support group. Soon after her first husband divorced her and she learned of her HIV status, a doctor from one of the NGOs who assists the support group introduced her to her next husband. As Lantana recalled:

> Time was not wasted. After two months of courting me, my husband’s family sent his family to visit my family, and my family accepted. The marriage was “tied” [finalized] a week later… My life with him was beautiful. We had food: meat, chicken, milk… Anything I wanted, he would provide. I was even the one who misbehaved to him, sometimes. You see he was old enough to be my father. My husband’s friends would joke with him about how much he loved me. It was all he could talk about. I would never complain about him… We were inseparable until he died two years ago.

As a married woman with a supportive HIV-positive husband, Lantana was able to disclose her status to both her family and even disclosed her HIV status to her community because of the protection her married status offered. The stigma of being HIV-positive, which came in the insults and avoidance behaviors of some of her family members and neighbors, came only after this second husband died. Her second husband not only met the expectations of providing economically for his wife, but, additionally, his position in the support group gave him access to resources from the governmental and non-governmental organizations devoted to assisting HIV-infected persons in their medical and social needs. Virtually all women in this group desired a relationship trajectory similar to this – where they no longer would be responsible for managing their day-to-day economic and health needs, and their fears of stigma would diminish under the protection of their husbands.

When I first met Lantana in 2004, this second husband had passed away and she was thin and constantly ill. Although her CD4 count was low enough to qualify her for government-subsidized antiretroviral therapies, irregularities in her liver function prevented her from immediately receiving these drugs. As she took medications for her liver, the little energy that she had was spent navigating the bureaucratic maze of NGOs and governmental agencies in order to get the sponsorship documents necessary to be treated. If her husband had still been alive, he would have managed this business for her. Without husbands or other supportive family members upon whom they could rely, I could understand why so many would give up, exhausted, sick, and unsuccessful. I did not expect to see Lantana the following year. And yet, when I returned in 2006, Lantana was healthy, receiving free ARVs, and serving as an adherence counselor at a local hospital. Preparations for her next marriage to another member of the support group were underway. Lantana married this man in 2007. Her ability to fight and defy abandonment through her relationships exemplified both the efforts and the ideals of all women within the support group.

Not all relationships formed within the group are successful, nor do they necessarily meet women's ideals of respectability. Hadiza describes her experience in a relationship with a man in this group:

> I enrolled [in this group] just to get a husband to marry. The men do not come to the meetings because usually fights and arguments and rubbish talk is what goes on there. Some of them think that it is women's group and men would never get to participate, so they do not return. Initially I did not understand the motive or objectives behind the organization. At my first meeting I simply observed that none of the men were okay by my standards. The chairman…found me a husband at [the hospital]…We met and although he was set to be introduced to some other girl, on seeing me he liked me. We started a good relationship even though he did not have any money…Then we had a problem. He assumed I was above his class and would not be satisfied with whatever he brought home if married to me.

This former boyfriend was previously engaged with another woman in the group before moving on to Hadiza. And, after this affair with Hadiza, he later married another woman, Jummai. Jummai described her marriage:

> We met at a meeting and he spoke to me saying he loved me and wanted to know my house…Although my father wanted me to wait a little longer, he later sent his parents and my dad agreed. At the time I was very happy thinking, so death did not come and now I have a husband and will soon marry… The only reason he gave for rushing to get married was to protect himself from committing sin. That was why we got married so fast. I became pregnant after two months. At this time I thought I have gotten this support group, I have a husband and now I am pregnant, wow… [But] three months later we had problems and by five months the marriage was over. His problem was if anything got between us, he would beat me. On this day he came back and I brought him porridge. No sooner had I turned to go get him a spoon, then he hit me with the lid of the plate on my head. He followed up with beating. I just kept begging him for God's sake and the Prophet's sake, but he continued. He insulted my parents to no end. Afterwards, he divorced me by handing me my divorce papers… I never thought of what

> might have caused it. I wondered what happened or if I had offended him but could not remember what I could have done…I heard that Hadiza [the former girlfriend of this partner, whom he rejected] cursed us but I do not know. In my understanding there is nothing I can do… Now I cannot say anything.

During the time of this research, Jummai was seven months pregnant. She had yet to go to antenatal clinic to monitor the health of her pregnancy or to receive advice on to how to prevent transmitting HIV to her child. Many of the women in the group were concerned about her. When she did not show up to the last meeting I attended, members of the group arranged to relay a message to her [former] husband, who remained in contact with her. This man has since moved on to a relationship with another woman in the support group, and expects to marry her. I later learned that Jummai's baby girl died shortly after she gave birth to her.

While women face intense scrutiny within the group over their sexual lives, they often lack the ability to sanction the inappropriate behaviors of male support group members. These women's cases reinforce the fact that HIV-positive marriages – during times of profound economic and social insecurity – are fragile and sometimes fraught with horrific abuses. Like all Nigeria women from these particular social strata, their relationships may be subject to unfulfilled reproductive plans, intense altercations, health and illness dilemmas, divorce, and widowhood. The promises of marriage exist along side the possibilities of exploitations and abandonment.

Dilemmas of Discordance

Given the problems women have had with their support group relationships, they face intensely difficult moral dilemmas and uncertainty as to whether or not they can pursue boyfriends whose HIV status is unknown to them. Men continually approach women seeking their attention, giving them gifts and desiring marriage. The longer women seclude themselves and delay their negotiations with potential marriage partners, the more pressure families who are not aware of their status will place on them. Among women's many concerns is the fact that the length of time in which their health will last is also unpredictable. Both the "deadly" representations of the virus in Nigeria and women's actual experiences in caring for family members who have died of AIDS, continue to be highly influential in shaping the urgency many women feel surrounding marriage. Hauwa, an HIV-positive widow, for example, has stated:

> Everyday I get someone interested in me. So long as I go out, then I will definitely get someone professing their interest in me… The way I am now, if wishes could be granted, I would like to be married. If I don't now, time will pass me by… I want to marry because I will have protection. People will respect me and I will have more children. I want to have children because I have only one now and he can die. So, if I have more, then Allah can leave some for me.

HIV-positive women fear marriage partnerships with HIV-negative men, both because of the likelihood of the relationship dissolving if her partner learns of her status, and because of the obvious possibility of transmitting the virus to her partner, thereby putting the couple's health at greater risk. Ladi said, "We positive women experience the problem of men wanting to marry us, wanting to have sex with us, but we do not tell them our status. I have many suitors and I tell them that my husband traveled to Saudi Arabia, so, Islamically, I have to wait for four years. If he does not return, then I can marry again." For many women, these encounters result in an elaborate string of excuses or lies such as that which Ladi has used. There is also the very real fear that boyfriends might reveal their HIV status to others.

Balaraba describes the challenges of being single and having boyfriends:

> I know that since I am single there have to be times when I will think of men. On those days, I get upset, but then I find even that is useless. I cannot do anything about it. So I have solved the problem for myself by having sex with one of my [HIV-positive] boyfriends that I trust. I do not want to have sex with my negative boyfriend...I cannot marry the positive boyfriend because he has certain attitudes that do not fit into marriage. That is, I can tolerate him from time to time just to satisfy my needs. I am only with him for that…His attitude that I talked about will not permit a stable marriage because he is a "womanizer"…Definitely, I can be in love without having sex and in fact I am in love with someone, but I wish to protect him.

This statement not only speaks to the discontent many women feel with the available men in their support group, but it also reveals the ways in which women's partnership choices reflect the fears of and stigma surrounding sero-discordant partnerships instilled within the support group– or at least it reveals their fears to share the details of these partnerships with me.

Behaving both respectably and responsibly in relationships is a complex and even contradictory endeavor, exemplified in Hadiza's experience:

> Now I have a boyfriend who is negative. I love him like I would die and he loves me like he should swallow me, so much that he fights on my account. I made him take an HIV test hoping he might turn out positive, but he was negative. I would tell him stories about marriages made by positive and negative individuals, just to test his frame of mind and he would say, even he can marry a positive person. I am afraid of telling him because I fear he will expose me to the community…I sometimes think that I will marry him and on our first night I will tell him my status. I will request that he take another wife until I become cured. And then, we would live happily ever after. But please understand I have 30 different thoughts every day [about what to do about him]. If he would persevere and remain married to me after I have told him my status, then what I would do for him, I would not even do for my parents! Someone who does this for you [remaining married after learning of one's wife HIV status] has done everything in the world for you! Even if he humiliates you, it is nothing…After marriage, my precaution would be to use two condoms for every act so I can fully protect him. Because two condoms would mean that I am protecting the protection, since the outer condom might burst.

Hadiza married this boyfriend, and she gave birth to their first child in 2007. I never learned how or if she ultimately disclosed her status. She no longer is active in the support group, and only stays in touch with other women when she collects her medications at the hospital. Most of her friends within the support group are not sure of his HIV status, or again, they were unwilling to share it with me. I, too, was complicit in this secrecy, not willing to let these women know that I learned of his negative HIV result and Hadiza's marriage dilemma a number of years ago. Hadiza likely remained silent or lied about her boyfriend's status during their courtship and then left the support group once married, avoiding their accusations or judgments.

The Management of Ambiguity

Jean Comaroff (2007) writes, "Maintaining the ambiguity of one's status, or the presence or absence of the disease, can be an act of self-preservation, defiance, or resignation in the face of an apparently implacable fate" (202-203). The HIV-positive women in my study have acknowledged their status and "gone public" by joining a support group, but they do so to find husbands, *not* necessarily to maximize their benefits from public health projects channeled through these groups. The connotations of the term, "going public," ubiquitous across support groups' prevention and education projects, is misleading. In recent literature on HIV, two nuanced ethnographic studies have demonstrated how going public has been made meaningful following cultural logics different from those from the West. Whyte and her colleagues' examination (2006) of HIV-positive persons in Uganda, for example, portrays the willingness of these individuals to speak out as a virtue that speaks to a deeper theme in how people deal with misfortune. Similarly, Lyttleton (2004), in his study of HIV support groups in Thailand, suggests that the Buddhist doctrine of achieving a "balanced life" is reflected in public disclosure, as a support group offers a socially condoned way for women to "live [their] life for the benefit of society" (21). "Going public," and its converse, "going private," take on distinctly different meanings among HIV-positive women in northern Nigeria.

Among some HIV-positive evangelical Christians, the expectation that individuals must confess their HIV status to their family and religious community, in particular, is often expressed in the idiom of being *born again*. In doing so, individuals believe they may be redeemed from their perceived sin and presented a future of virtue and prosperity. These ideals, however, are weighed against the actual practices of churches that excommunicate HIV-positive individuals, humiliate and denounce their behavior, and forbid them from marriage. Premarital HIV screening is increasingly becoming the norm in many churches. Support groups consisting predominantly of Christians, in many respects, resemble Evangelical church services, and marriage arrangements are common. Just as church leaders arrange and facilitate marriages, so too do these group leaders. Support group arranged marriages thus enable individuals to avert the sexual and social scrutiny of their churches.

Among HIV-positive Muslims, one of the rationales informing their reluctance to speak openly about HIV derives from the belief that, if Allah does not reveal their HIV status, public disclosure is not appropriate. Rather, to repent, one must immediately halt his or her behavior, understand and feel deep regret for this possible transgression, pray, and reinvest in efforts to act virtuously. Improving one's marital comportment is a fundamental aspect of reinforcing one's relationship with Allah. Remarrying without disclosing one's status, however, poses the risk of spreading the virus, thereby repeating the wrongdoing of others. HIV-positive Muslim women are thus compelled to join support groups and inform others of their status in order to pursue the promises and virtues of marriage. Both Muslim and Christian women alike are agents in maintaining and managing ambiguity surrounding their status in the hope of establishing new families, and new, virtuous futures.

"Going public" through joining a support group is, consequently, not the end result of women's ambitions to achieve a religious or cultural expectation, just as it is not solely to fulfill their economic or psychological needs. Membership within these groups, instead, is a *mechanism* through which women can forge marriage partnerships – social relations that relieve them from relying upon their own individual efforts to navigate the social and economic challenges of therapeutic management, stigma, and gendered life trajectories in a society rife with poverty and inequality. Marriage is preferable to the direct assistance offered by health and development projects, in both reaffirming kinship ties and securing their respectability. As described above, marriage enables women to enlist the support of larger kinship networks to share the responsibility of meeting their social, economic, and health needs. Consequently, it allows them to move out of public attention, reinforcing this social protection and security.

Support groups, however, are often compromises, not panaceas. The risks of stigma, manipulation and coercion, abuse, and abandonment persist. In relationships formed outside of support groups, women's success in managing ambiguity and maintaining respectability in their relations is also often a fraught endeavor. These trajectories are not merely a result of the HIV epidemic and its constraining and marginalizing effects on women’s life ambitions and social positions, but in fact reflect larger goals and experiences of all women pursuing protection, support, and care in times of profound economic and social insecurity.

Conclusion

Support groups have been at the center of attention by scholars in relation to the effects of reconfigurations of global flows of health information, capital, technologies, and development programmatic aims and ideals, characterizing contemporary “cultures of neoliberalism” (e.g. Comaroff and Comaroff 2000, Collier and Ong 2005). Rabinow (1992, 1996) has argued that biotechnological developments and the dissemination of biological knowledge, in particular, have influenced (and have been influenced by) the formation of associational communities whose memberships are based upon biomedically- and genetically-defined conditions (cf. Ginsburg 1989, Rapp 2000, Rapp and Ginsburg 2001, Rose and Novas 2005). The significance of these biosocial groupings, scholars have suggested, lies particularly in their political projects involving claims of recognition and inclusion based upon a particular illness, or what has been called, their “politicized biology” (Petryna 2002, Biehl 2004).

Governments in developing countries, either characterized by the lack of disciplinary institutions or by institutions ill-equipped to enforce their disciplinary techniques, have been, in many cases, replaced by global assemblages of public-private collaborations between corporations and local governments, global health and development NGOs, and transnational religious and missionary projects (Collier and Ong 2005, Ferguson and Gupta 2002, cf. Foucault 1978). In the context of HIV/AIDS, many of these conglomerations investing in the activities of support groups do so to empower individuals to make claims for the right to universal access to treatment and other health and social needs. Medical anthropologists have described these enactments as *therapeutic* citizenship (Nguyen 2005, Robins 2006, Biehl 2007, see also Robins 2004, Levy and Storeng 2007). Claims to citizenship and belonging thus are expected to begin within the microcosm of the support group.

And yet, as described above, I have observed a very different set of activities unfolding within these groups. My findings reveal not emergent forms of therapeutic citizenship, but rather the claims of recognition and inclusion that underscore women's attempts to enact *domestic* citizenship. As described by Das and Addlakha (2001), domestic citizenship is defined by the ways in which claims of membership and belonging are negotiated in the routine domestic affairs of families. While the stigma surrounding AIDS has stripped many HIV-infected persons of the social roles of good wives and good husbands, the matchmaking efforts of support groups function to counter this stigma. And, through the group's collective recognition of women as social and sexual beings – as opposed to polluted, diseased and abandoned individuals – HIV-positive persons are motivated to pursue these larger life goals of reconstituting families. Marriage is perceived to be a way to reinforce women's larger kinship ties that can make these claims for protection and support, countering the seemingly "implacable fate" of abandonment that Comaroff (2007) critiques.[19]

Where perhaps these biomedical and public health techniques, theories and tools, *have* made the most inroads into transforming northern Nigerian forms of domesticity and sociality, is in the ways in which they have contributed to the reproduction of social stigma and abandonment within these associational communities. Far from being a source of political activism, many of these groups are known for coercing impoverished women into participating in activities that potentially threaten to expose their status. Support group leaders have used the leverage they possess in organizing these activities and the resources that accompany them to enter into relationships with women – particularly those in dire need of support. For many women, desperation often drives them into unsupportive and sometimes abusive relationships, as my cases have revealed. Women are often constrained from ending these relationships, both because of support group and family pressures. Support group members may sanction women who pursue sexual relationships with HIV-negative men outside of the group, and consequently drive these relationships underground – reinforcing the risks of stigma, abuse, abandonment, and threats to the couple's health. The management of ambiguity, while illustrating the powerful ways in which HIV-positive women assert their agency, can inadvertently reinforce the processes of structural violence that led to their HIV infection in the first place.

In my research, I have observed the ways women defy processes of social abandonment but lack the full recognition necessary for political and social embrace. They engage webs of signs, relations, and affect as the tools through which their intentions can be met. Individuals move into and out of their lives, leaving women perpetually in search of new supportive persons and networks. They tell some individuals their status in order to hide it from others. Women join support groups and reluctantly take part in their activities to access the economic resources occasionally channeled through these groups. And then they run away from other activities that might jeopardize their social status. They enter relationships with HIV-positive men in the group who use the economic benefits of these activities to care for their girlfriends and wives in ways that others are unwilling or unable to provide. And yet other men, who lack the power, influence, or dedication to care for their partners, divorce without political or social sanction. Women pursue relationships with HIV-negative men to avoid the pitfalls of unsupportive support group members, and yet still risk stigma and abandonment. This chapter has offered a vantage point onto the gendered dynamics of kinship processes and the tensions that emerge between local and global expectations of health citizenship shaping the course of HIV-positive women's social and illness trajectories.

ENDNOTES

[1] The term “non-married” refers to all women without husbands, regardless of whether they have never married or are currently not married as a result of divorce or the death or their husbands.

[2] Kano State, though dominated in population by Hausa-speaking Muslims, is also home to large populations of Hausa-speaking Christians both native to the state and those who have relocated to Kano from other northern and middle-belt states, as well as non-Hausa speaking Muslims and Christians from across both southeastern and southwestern Nigeria.

[3] All of the names of organizations, support groups, and clinics have been withheld. The names of the persons in this text are pseudonyms. In certain passages, details have been removed or altered to further protect the identities of my informants. Many of the passages have been translated from Hausa to English with the aid of a Hausa-speaking research assistant.

[4] This study is informed and motivated by a series of volunteer and ethnographic projects on HIV prevention, education, and treatment in healthcare and community settings both in the north and middle-belt regions of Nigeria spanning the years 2002 through 2008. The material for this paper, however, is necessarily narrower. Specifically, I draw on ethnographic research carried out in a support group in the city of Kano carried out in 2004 and 2006 through 2007.

[5] Polygamy is permitted and widely practiced among Muslims in northern Nigeria.

[6] Interestingly, there exist numerous earlier Hausa examples of "biosocial" groups such as the *k’ungiyar guragu*, that is, “associations for the lame,” (polio victims) and other groups centered around physical disability (blindness) or disease (leprosy). Renne (2006) explores the history of associations for the lame in Nigeria, and suggests an intriguing shift between the colonial and post-colonial era in the ways these organizations structure themselves in relationship to claim-making. Whereas in the 1950s during the late colonial period, these groups were led by titled chiefs under the patronage of local traditional rulers, during the 1980s (designated “the Decade of the Disabled” by the United Nations), these groups were oriented around taking advantage of state development initiatives that sponsored vocational education and other employment programs for the disabled. Cohen (1969) described the institutionalized ways in which begging was supported during the colonial era in Ibadan. In addition to an organization for the lame, there were also those for the blind and for lepers, each led by chiefs who would, for example, collect a certain portion of earnings and take responsibility for assigning the places in the city where members would beg. Among Muslim Hausas, Cohen states, begging is a highly organized institution and is based upon the Islamic pillar of alms-giving, which requires Muslims to regularly give to a part of their income to the needy. Far from being a stigmatized category of persons for their lack of economic productivity, these beggars are granted an important role in the moral economy of blessings [*baraka*].

[7] This woman's statement alludes to the complicated relationship between stigma, begging, and social activism, differentiating the case of contemporary HIV support groups from other groups with visible disabilities and long histories in northern Nigeria.

[8] This message was translated into pidgin English, as well as the other major languages in Nigeria, and broadcast on billboards, stickers, and pamphlets with the photos of celebrities and other individuals. In Kano, I was told that they had a very difficult time finding a young woman to be the "face" of the message. Many believed that she was indeed HIV-positive and thus subjected to the same suspicions and fears to which all HIV-infected Nigerians are potentially subjected. In other words, this message had the unintended consequence of instilling HIV as something to be *universally* feared, and represented another socially produced vector of stigma.

[9] During this conversation, I remained silent about my actual purpose for being in Nigeria, as I do with all of my HIV-positive friends who bring me to meet people who are unaware of their status. I allow whatever lies or assumptions people make to go unchallenged…even if it means inhabiting the uncomfortable position of being perceived perhaps as a missionary.

[10] Colossians 3:18-19

[11] Holland wax print cloth, the most expensive and coveted fabrics among northern Nigerian women, are fashioned into skirts that are wrapped and tied around women's waists.

[12] Shari'a is defined broadly as Islamic law based on the teaching of the Qur'an and the Sunnah.

[13] Barbara Callaway refers to this as *kullen zuciya*, or "seclusion of the heart" (1987:57).

[14] Following the surrender of power by the Nigerian military in 1999, 12 northern Nigerian states adopted shari'a criminal law, and have taken numerous steps to enforce the existing shari'a civic code. In Kano, this includes the efforts of *A Daidaita Sahu,* the Directorate of Social Reorientation under the administration of the state, which aims to reinstate Muslim traditional values and whose programs are seen as an important step toward realizing the goal of the implementation of shari'a in Kano [http://www.adaidaitasahu.org/mission.html]. One of its most visible projects is a public transportation system offering subsidized rickshaws exclusively for women, granting them an alternative to riding on the back of motorcycle taxis, driven by men.

[15] e.g. Serwadda et al. 1995, Carpenter et al. 1999, Kelly et al. 2003, Clark 2004

[16] e.g. Porter et al. 2004, Smith & Watkins 2005, Schatz 2005

[17] This is referred to as *mahr,* meaning marriage gift, and is more commonly referred to by the Hausa term, *sadaki* [gift] or more traditionally in Hausa Muslim society, *kayan daki,* which means literally, "items of the room."

[18] This point is particularly well illustrated by Masquelier (2004) in her examination of Nigerien Muslim brides and their response to changing religious norms suggesting these gifts should be more symbolic than material in value.

[19] In response to the ways scholars have employed Agamben's concept of "bare life" (1998) to understanding the biopolitics of HIV/AIDS, Comaroff cautions, "While the will to power or the effects of structural violence might significantly sever life from civic protection and social value, no act of sovereignty…can actually alienate humans from entailment in webs of signs, relations, and affect" (2007:209).

CHAPTER FOUR

VITAL CONTINUITIES: SEQUENTIAL MARRIAGES AND HIV

Introduction

The marriage aspirations of HIV-positive women reflect both the everyday encounters where these social expectations are manifest, and the particular dynamics of their previous relationships and their dissolutions. Anthropologists have posited that marriage is a process, not an event, constituted by an array of rituals, exchanges, and the passage of time. I argue these social bonds, resources, and negotiations carry over and affect the formation of new relationships. A marriage, in other words, does not end at the moment of divorce or the death of one's husband. The dissolution of marriage, just like marriage formation, must be understood as a process that invokes symbolic and material continuities over time. HIV is not the only thing that is transmitted from union to union, nor is marriage an independent variable in determining HIV risk. However, this chapter does not address whether or not HIV drives marriage transitions. As I have learned, HIV is just one of many conditions produced by a union, all of which have a significant impact upon the future relationships of positive women.

I begin this chapter with a review of the anthropological literature on marriage. While it has been argued that structural functionalist anthropology has exhausted the theoretical purchase of marriage (e.g. Fortes 1962), it has since been revisited and examined through new analytical lenses (e.g. Comaroff 1980, Gough 1971, Parkin 1980).

Focusing on the constructivist and processual conceptualization of marriage, anthropologists have called attention the heterogeneity of this institution across space and time, and the innovative perspectives it offers on a diverse array of issues including gender, agency, and political economy (e.g. Parkin and Nyamwaya 1987, Bledsoe and Pison 1994). Studies of marriage have enabled scholars to explore the relationship between processes of globalization and interpersonal intimacy (e.g. Collier 1997, Rebhun 1999, Giddens 1992). Feminist anthropologists, however, have raised an important caution to this literature. They have argued that an exclusive focus on marital status obscures other dimensions of women's social roles, such as their contributions to household work and parenting, and their status vis-à-vis wealth and age (e.g. Moore 1994, Cornwall 2005). These different literatures offer important contributions toward theories of relationship formation and dissolution, but few explicitly address sequential marriages.

Through my own work with HIV-positive women who have married multiple times, I trace the significance of reproduction, the persistence of economic insecurity, and the affective and material exchanges between husbands and wives within broader kinship networks. I focus in particular on the exchanges that take place over concerns related to women's health. These issues are not only are present within women's marriages, but they also affect the formation of subsequent relationships. HIV infection, as will be demonstrated, is a concern that accompanies these larger social issues and magnifies their consequences for subsequent marriages.

Anthropological Perspectives on Marriage, Divorce, and the Life Course

In 1965, Evans-Pritchard posited that in simple societies, there is no such thing as an unmarried woman; companionship is weak and women have little choice in whether they will or will not marry. In this view, marriage is a universal or nearly universal social institution across African societies. It plays a fundamental part of what has been termed the "development cycle in domestic groups." This concept defines the family as a process unfolding over time (Fortes 1949). Given the breadth of kinship studies across sub-Saharan Africa, Fortes proclaimed that the topic of marriage has been exhausted in anthropological thought (1962:1). "So much is now known about the customs and institutions of marriage in all human societies that it might seem doubtful if anything new can be added. Nor are there conspicuous lacunae in the theoretical study of the subject," quotes Borneman (1996:215). The prevalence of marriage across the continent, however masks its heterogeneity, the historical changes that the institution has undergone in local contexts, and the shifts and variations in social roles and statuses of people both within and outside of marriages.

Since its early structural functionalist renderings, African marriage has been subject to reexamination by a number of scholars (see, for example Comaroff 1980, Gough 1971, Krige and Comaroff 1981, Parkin 1980, Sansom 1976, Singer 1973). The edited volume The Transformation of African Marriage by Parkin and Nyamwaya (1987) has reviewed several important contemporary themes including efforts to: place marriage practices within their political, economic, and ideological contexts; explore the significance of plural marriages in present-day rural and urban contexts; pursue the social implications of changing divorce rates; and evaluate the scope given by new economic orders to the exercise of female autonomy.

The life histories collected in my study intersect with these themes in intriguing ways. One could easily read women's chronic sickness, and the deaths of children and husbands as consequences of HIV-relate illnesses, even when the precise causes are unknown. In the context of a country with one of the highest rates of maternal and child mortality in the world and life expectancies of just 47 years at birth, however, it is often impossible to distinguish the immediate cause of death. It is further impossible to know at what point women contract the virus. In northern Nigeria marriages are often polygamous – and it is evident that co-wives played fundamental social roles, as will be demonstrated. Divorce rates in northern Nigeria not only reflect the micro-power relations between husband and wives and among networks of kin, they also are associated with larger forces driving the economic instability of households. For many women, to exercise autonomy is to seek and to stay in a marriage, being supported by one's husband and one's kin, in addition to oneself.

Bledsoe and Pison (1994) argue that a processual and constructivist approach should be taken in investigations of marriage. That is, rather than a discrete event established by clear legal, ritual, and economic transactions, marriage is often much more ambiguous (4). Marriage is a process constituted by transfers of wealth, the initiation of sexual relations, the birth of children, etc. Social identities such as that of "wife" or "mother" are fluid, or continually recreated (Comaroff and Roberts 1981). Comaroff (1980:172), for example, describes Tshidi marriage in Botswana as a "process of becoming, not a state of being." He reveals how Tshidi try to perpetuate ambiguities in the status of particular relations as long as possible to leverage upward mobility through marriage. Individuals continually strategize to gain access to resources, to improve their status and secure other aspects of wellbeing through social and reproductive relationships. Family structures themselves are thus are subject to these efforts. For example, while formal, arranged marriages in the strict sense are less common in urban Kano than they have been in the past, it is not uncommon for parents and others to make introductions that result in marriage. Marriage is widely acknowledged to be a mechanism for upward mobility, and introductions and arrangements reflect families' efforts to extend support to women when they have difficulty providing for them.

For Muslims, the Qur'an dictates that husbands must be able to economically support their wives. In northern Nigeria, however, this ideal is rarely met and women continue to seek help from their families even while married. As will be shown in the cases that follow, women's wealth is invested in their wedding gifts, clothes, jewelry, as well as inheritance items such as farm animals or houses. They can carry these items from marriage to marriage, providing women a "savings account" for future needs and emergencies. In one of the large markets in Kano, there exists what is referred to as a "divorcees market," where women make an informal business out of selling their furniture and other wedding gifts. Women's autonomy is intertwined with their marriage status, rather than independent of it.

A Process of Unbecoming

Marriage in northern Nigeria, consequently, is not only a process of becoming, but also a process of "unbecoming." In classic anthropological theory, studies of marriage dissolutions were fueled in particular by Max Gluckman (1950) who, in his study of kinship and marriage among the Lozi and Zulu, hypothesized that the frequency of divorce is correlated with social structures of a particular type. Specifically, marriages within patrilineal societies should be more stable than those in matrilineal societies, as bridewealth is lower in matrilineal societies and conjugal ties have little effect on the interest of the lineage, making divorce easy and therefore frequent (see also Gluckman 1972). This position drove extensive research efforts toward the development of analytical tools (cf. Epstein 1967, Barnes 1949) and the accumulation of quantifiable data on marriage, divorce, and fertility rates by Manchester School anthropologists. Gluckman's theory about marriage were also investigated by a number of scholars, including: Schneider (1953), Fallers (1957), Leach (1957), Mitchell (1961), R. Cohen (1961), and Lewis (1962), many of whom argued that this correlation did not work (see R. Cohen 1971 who summarizes some of these critiques).

Other studies from this period relevant to examinations of marital instability are Levi-Strauss (1969) and Leach (1957) who stress the role of women and marriage in creating links between groups. They assert that the stability of legal marriage varies with the groups' desire to maintain political alliances. Additionally, Cohen (1971) has developed a psycho-cultural explanation for marital instability among the Kanuri (Bledsoe 1980:174*n*1). E.N. Goody (1962) contributed to this set of studies by distinguishing between divorce and terminal separations, which is where post-menopausal women return to their kin (and thus re-establish the complete sibling group that was divided at marriage) rather than stay with their husbands (J. Goody 1995:95-96, see also Fortes 1949). Contemporary anthropological studies of marriage dissolutions have shifted away from the legal frameworks for divorce legislation and the correlations between societies' divorce rates and their political structures. Divorces are not "clean breaks" that reveal broader social processes of disruption, fragmentation, and endings; rather, they reflect a "complex tangle of ongoing and disputed ties, obligations and dependencies…[generative of] *vital continuities* in the way that one generation passes on its status, property, identity and accumulated wisdom and folly to the next" (Simpson 1998:2, emphasis mine). These continuities, as I argue in this chapter, take place not only between generations, but also as women proceed from one marriage to the next.

Complicating Marital Status

To understand women's marital transitions in northern Nigeria, it is necessary to identify the particular affective and material resources that women seek. Interpersonal emotional intimacy has become central in larger questions about the globalization of capital, information and lifestyles, as well as particular economic and social transformations (Collier 1997, Rebhun 1999, Ahearn 2001, Yan 2003, Hirsch and Wardlow 2006). Placing the struggles for intimacy in the context of these global forces, Giddens (1994) describes the "post-traditional society" (the condition of late-modernity) as one in which, "social bonds have effectively to be made, rather than inherited from the past – on the personal and more collective level this is a fraught and difficult enterprise, but one which also holds out the promise of great rewards." (196). It has been argued that 'home' might be more appropriately located in movement rather than in stasis (Rapport 1997). Similarly, it may well be that what passes for family is increasingly located in a kaleidoscopic flux of relationships over time rather than in stable structures predicated upon long-term relationships of consanguinity and affinity (Scanzioni et al 1989; in Simpson 1998:4). However, I am less concerned about grand narratives of modern family life and intimacy in non-Western contexts. Instead, I view this scholarship as posing important questions about the resources that motivate marriage formation and are negotiated in women's marriage transitions.

In focusing upon the movements of women between marriages, I seek to complicate what a married identity means in northern Nigeria and raise questions for cross-cultural analyses. One of the central critiques of studies of African social organization is that a focus on marriage – heterosexual normative relationships between men and women – obscures the significance of other kinds of relationships and other dimensions of 'gender' difference, such as seniority and wealth (Moore 1994, Peters 1995, in Cornwall 2005:4-5, see also Sudarkas 2005). These arguments, it has been pointed out, have the effect of reproducing an intellectual trajectory in which African women are understood only in their coital and conjugal sites (Ogundipe-Leslie 1994). Motherhood, for example, and the significance of 'maternal politics' has been undervalued (see Amadiume 1987, 1997; Acholonu 1995, Nnaemeka 2005). It has suggested that reproduction is, in fact, often *overemphasized* by anthropologists when considered in reference to the everyday concerns and activities of African women. Similarly, the privileging of nuclear families and households often comes at the expense of broader networks of patronage. Patronage indexes unequal relations of power between persons and the processes with which individuals gain status through the control and manipulation of others. Such a social system is maintained by both coercion and something like consent, albeit not an unproblematic consent (Johnson-Hanks 2006:30, see also Comaroff and Comaroff 1991). For example, while senior males acquire wealth and maintain their dominance through the control of women and young men, women and young men also receive symbolic and material benefits through strategic relationships with well-positioned patrons. Unlike these studies, I do not view married identities, reproductive identities, and the uneven positioning of women within patronage networks as mutually exclusive.

Even the home itself can be the space of not one, but multiple domesticities that differentially structure the experiences of women, particularly their experience of violence (Das 2007). In northern Nigeria, both state and religious normative discourses reinforce the dichotomies of responsible husbands and obedient wives. In fact, women's contributions to household economies are often hidden from view despite the fact that men are unable to maintain large families alone (Cornwall 2005). While women may strategically deploy and enact these discourses and images of virtue and helplessness to make claims for resources, they also have potentially violent consequences, silencing and stigmatizing those who are unable to conform. Nevertheless, even among those who do deviate from collective scripts of honor and shame, the ways in which family members attempt to provide support and care to their marginalized kin are often concealed from view (Das 2007). Perhaps more than any other topic, women's experiences in living with HIV illuminate and complicate critical dimensions of gender politics.

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To explore the symbolic, social, and material continuities across women's marriage transitions, I draw upon three case studies of HIV-positive, Hausa-speaking Muslim women. Although serial partnerships are common among Christians and

Muslims alike in northern Nigeria, the women I discuss are not meant to be representative the norm of all marital relations. Rather, I draw upon these particular complex marriage histories to draw out questions that could be asked in the context of any woman's relationship trajectory, regardless of religion or HIV status. In these examples, I emphasize three interrelated issues that are both shaped by and affect women's health: reproduction, economic instability, and the affective and economic exchanges both between husbands and wives and within broader kinship networks.

Jummai

Jummai grew up both in Cameroon and in northern Nigeria. She was one of the youngest of her eleven siblings. When she was in school, her sister divorced her husband and her son was taken to live at his father's house, so Jummai was sent by her parents to live with her. They wanted to keep her sister from feeling lonely. When her sister remarried, Jummai went to live with another brother, who was in the Nigerian army. It is not uncommon for children to be shuttled back and forth between family members as they grow. Divorce is one event that might separate children from their mothers, but children of married couples are just as likely to live with grandparents, grown siblings, and both their father's and mother's extended family. Hausa-speaking Nigerian traders work throughout West and Central Africa, so these extended families can stretch across multiple countries, as in the case of Jummai's relatives.

When Jummai was around 15 years old, she met a man who used to come to her town on business. He traveled frequently throughout Central Africa for his work. He told his friend that he was interested in marrying a girl from their town. His friend met with Jummai and asked for her photograph. He then gave Jummai his picture. "Really," she explained, "at the time, I just wanted to see him first to know if he had any disabilities, and then I would say yes, since I always wanted to marry someone from far away." They continued to write to one another until he came to visit her. She liked him immediately. After they met, he went to her house to meet her parents and then brought his parents to ask for her family's permission to marry. They asked Jummai three times if she wanted to marry him, to which she answered yes. His family brought kola nuts as gratitude and after about two months, they carried gifts to her village, including a suitcase filled with wrappers [cloth], which were distributed to her relatives to announce the engagement. Next, the date for the wedding was set and they brought the wedding trousseau for Jummai.

During the wedding, her husband stayed with friends in Jummai's town. She explained that, in their tradition, the bride hid on the night of the "bride catching," which was also referred to as henna night. The groom's parents would come in search of her and would "bargain" with the bride's friends for her release. The bride would then be brought out crying. Next, the ceremonies started and for three days henna was applied to decorate Jummai's skin. The groom's parents came and bathed her in perfume before she was taken to a room and dressed in new clothes, pampered with cosmetics, and money was "sprayed" upon her. Later in the day, she was taken to her mother's room for "advice, scolding and preaching" in preparation for married life. Jummai's mother advised her to do everything her husband said she should do. Following *Magrib* prayers, elderly women took her to her husband's house. She performed her ablution and prayers were offered. Then, she entered the house.

While all this was happening, her husband's friends came with cars and picked up a "fake bride" after paying her sums of money. They went around town singing and celebrating. Then they went and visited Jummai in her new house, and gave her money. Jummai said, "You see marriage in Cameroun is expensive. There, brides are given a box of clothes from each parent, while in Kano you just get just one." Among the most common popular critiques of Kano society was how "cheap" weddings were. The driving force behind Kano's high divorce rates, it was widely argued, was how inexpensive it was for young men to remarry. In my observations, however, I found the opposite to be true. Weddings involved the circulation of enormous sums of money, relative to the average expenses of northern Nigerian households. This was especially true among women marrying for the first time. More importantly, the gifts a woman receives for her marriage are assets that she can sell when she needs money or desires new items for herself or her children. There is an enormous demand for jewelry, used wrappers, and furniture, and women have little problem selling these items. While in practice this is not always the case, Islamic law protects a woman's rights to her possessions, which she carries with her even if the marriage dissolves.

Jummai's husband did not show up until the next morning after the ceremony she described, when food was being cooked. This time, Jummai's friends were present and playfully paid money for the coming of the groom. "Were you afraid?" I asked:

> After everyone had gone, all I felt was fear because I had never been separated from my home and now I was alone with a man. The next day, the feeling of fear was still there although gradually it became bearable. It was a new life and I did not know how it would unfold. My husband did not have any fears or inadequacies, though. We discussed the issue of children, birth, fertility almost every day. After four years, we sought medical advice, went for tests, took drugs and got lots of guidance, including prayers. But, I never conceived. So, he married another wife from my town who was also fifteen years old. When he told

> me his intention [to marry another wife], I did not feel bad because I felt maybe the problem was from me. All the tests showed he was at fault, however. He was told that, but I never knew. He wouldn't say, because I was quite young. I only discovered myself later.

Jummai and her husband were together for five years before he took his second wife. But when the wife was unable to bear children, it occurred to Jummai that he might have been at fault after all. Before she married him, he had been married to another woman who left him because she could not cope with the marriage. She had remarried, and got pregnant soon after. Later Jummai's husband took a third wife, one who had been married before. She had children from a previous marriage, but in this marriage, she too could not get pregnant. This wife left the marriage quickly, remarried and had children again. Jummai remained married to him with the second wife for close to 15 years before he passed away.

Reproduction is central to women's social identities and the fulfillment of their marriage expectations. Infertility, consequently, is a highly distressing condition, and women are commonly faulted for these reproductive failures, regardless of the biomedical cause. It is both grounds for husbands to marry additional wives and grounds for the dissolution of marriages, as Jummai's case revealed. Within a woman's kinship networks and the broader community, she faces both economic abandonment and ostracism. Jummai went to great lengths to explain to me that though she had no children, she was not infertile. Given the social and economic stakes in women's ability to have children, Jummai's preoccupation with who is at fault makes sense. She stressed her commitment to her marriage as a sign of her virtuous character.

Following the death of her husband, Jummai returned to Kano from Cameroon. She courted another man for two years before marrying again. Jummai's new boyfriend had three wives and had already paid a bride price for a fourth, when he saw Jummai. He had intended to cancel the fourth marriage, but his father refused. So he married this woman and then divorced her after her first child was born. Islam prohibits men from marrying more than four wives, but as women continually point out, men circumvent this prohibition by divorcing a wife in order to remarry. Jummai was aware of what was going on in this relationship when she was courting her boyfriend, but she did not expect him to divorce his wife on her behalf. Moreover, she had returned to Cameroon during this time. When she came back to Kano, he told her that he ended the marriage and proposed to her. Her brother was living in Niger state at the time, and they had the wedding ceremony at his house. In addition to his three current wives and the wife he had recently divorced, her husband had been married two other times. Jummai was his seventh bride.

The symbolic importance of marriage among Muslims misleadingly suggests that these partnerships are static, stable entities over time, when in fact they are highly fluid for both men and women. Women are often ambivalent about courting men who have multiple wives. Men claim they are sincere in their desire to marry their girlfriends, but women are often hesitant to take these claims seriously or to emotionally commit to partnerships until a formal offer of marriage is extended. They juggle multiple relationships waiting to see which might result in an actual proposal. As a woman in Jummai's support group reminded me, "Every Muslim knows that there is divorce. As soon as you are married you know, because marriage has life span. When its life is spent, no matter how good the life is, you separate. Divorce does not have a time for coming. Nobody fixes a date for it. Whenever Allah decrees it, it happens, even though it is what Allah hates most." Jummai did not expect that her husband's marriage would end; rather, the possibility for its dissolution was part of a tacit knowledge and set of assumptions she has surrounding relationships.

Although northern Nigerian women are increasingly aware that they should screen for HIV before they remarry, few feel they could ask a potential husband to take a test. Such a request could jeopardize the relationship:

> At around the time we were about to marry, I went to Sokoto Hospital because I had heard about HIV and wanted to know my status. They told me I was negative…I went for another test and was negative still. I was thrilled, but I could not approach [my husband] on the issue of taking a test. [Even before our marriage], he had been constantly ill. Sometimes, he would turn so dark and when I asked him about it, he would say he had pile [hemorrhoids]. So I was afraid he would say I did not trust him, if I requested he go for a test. I was afraid he might decide not to get married. I was under pressure from my family to get married because I lived at home and had not found any other suitable boyfriend. I also wanted to have my own home.

Jummai's husband was sick, even at the time of their wedding in Niger. His friends had later told her he had no appetite and was not well. When she moved into his house, she learned that two of his wives were also constantly ill. Her husband had rashes on his leg, which he said "must have been something from the bush." His second wife always had a cold and constant diarrhea. The third wife had problems with body aches and fever (malaria). The first wife, however, was completely healthy and was the only one among them who had children. Jummai did not want to think about HIV, however. She said she didn't know all of the symptoms and was not aware of being susceptible.

More importantly, she did not want to raise any problems or confusion in the house that might result in divorce.

After about seven months of marriage, her husband fell seriously ill and was not able to work. Jummai and the other wives wondered what type of illness it could be that would not respond to medication. He would say he was charmed or cursed because people did not want to pay debt they owed him. He did not know he had HIV until his brothers took him for testing. When his brothers learned of his status, they told Jummai and the other wives that he was anemic and that their blood needed to be checked to see who could donate to him. When their blood was screened, they all tested positive, although none of them were told their results. The third wife, soon after, died. Jummai continued:

> Before then, I had tried to get the truth from him but he would never give in and tell me. I would talk about different STDs and diseases that were around these days and even showed him my [negative] test results. He would say that I was too inquisitive. What would I have done if I discovered I was positive at the time? And I said I would not have married. I was the only one who talked about it the others never did. After some time, his brothers then gathered us in the first wife's room and said he had TB. So I asked if it was detectible in one's blood? And they said yes, so I asked if we had caught it and they said it was very possible, but that we would not start treatment until our husband had finished his.

While Jummai had said that the wives all wondered what their husband's sickness could be, it was clear, in retrospect, that Jummai knew much more than she would say. She knew that it was a disease shared between a man and his partners. She knew the accompanying symptoms of rashes, fevers, and diarrhea, and TB – and she knew to ask her husband's brother if the disease could be detected in their blood. Even so, the social negotiations between husbands, their families, and their wives over issues surrounding diagnoses and treatment do not follow a simple binary of ignorance and awareness. An amalgam of concerns including the cost of treatment, the social threats posed by a positive diagnosis, and the gendered norms about sharing health information, all enter into the decision not to disclose.

Jummai's husband divorced her. After their divorce, she insisted he tell her what his ailment was. He said to her, "That is why I have divorced you -- in order to cleanse myself of any responsibility or blame for the infection. Because you are my fourth and most recent wife." He then admitted to being HIV-positive. She reminded him of her proof that she was HIV-negative at the time of marriage and finally he accepted that she was telling the truth. Nonetheless, they did not reconcile. He promised to provide her medication and money for transportation to the hospital, which he did until his death four months later.

Mairo

It was Mairo's stepfather who introduced her to her first husband. This man had complained to her stepfather that his current wife was not caring for him properly. Taking pity on him, her father told him he had a daughter. He encouraged this man to meet with Mairo first to see if she would be a suitable bride. They arranged the visit and sent her to his house. Even though she knew from the beginning that she did not like this man, she lied and told him she did. Her father repeatedly asked her whether this was true and she insisted. Mairo explained, "But this was only because I was afraid that if I said no, I would run into problems with both my parents and even my grandmother. I also agreed to marry him because my mother had advised me that you shouldn't always say everything you think. Some things, you must simply swallow." Further, Mairo did not want her mother to think that she disrespected her husband, or for her stepfather to think she was being disagreeable because he was not her biological father. That, she felt, would have disgraced her mother. So she agreed.

> The date for the wedding was fixed and then we were married. My friends were so happy. After I was taken [to my husband's house], I spent a week not paying him any attention. Even when he spoke to me, I would never answer him. I was always in a bad mood. He would corner me and force me to have sex. I kept running home only to be sent back to him. So, even though we continued to have sex, I was very unapproachable. He would have to leave my money for food on the table [because I refused to speak to him]. After four months of this attitude, he started to beat me. Sometimes he would beat me severely and then proceed to have sex with me. But sometimes, he would not succeed, as I would even bite him.

In some respects, Mairo's narrative about the beginning of her marriage maps onto one of the dominant discourses among northern Nigerian women, which emphasizes the fear, pain, shame, and powerlessness they feel in their sexual relationships with their new husbands. In most of my interviews and conversations with women, their accounts of their first marriage often begin with descriptions of large, jovial celebrations, followed by terrifying sexual experiences. They would describe the schemes that families devised to entice women into the bedroom to "meet" their husbands, and elaborate on how excruciatingly painful this occasion was for them. Rarely would women describe their initial sexual encounters as consensual, and many would stress the violence that accompanied sex with their husbands. Mairo's case was exceptionally violent, however. While running away from one's husband is also characteristic of many young brides' experiences, Mairo faced much humiliation as she had to explain to her family why she ran away. Resisting the sexual advances of one's husband is widely understood to be unacceptable behavior for young brides.

Mairo continues:

> Finally, after some time, my stepfather intervened and told my husband that he did not give me to him to be beaten. My husband promised not to beat me again. My stepfather told him to document it -- that the next I was beaten, the marriage would be over. But then, not long after, his wife came to my house and asked we were around. They had fought, and she had, in turn, come looking to fight with me, but I wasn't home. When I came back, my husband was home and he was furious. I asked him for money for food, and said there wasn't any. There was rice cooking on the fire and it had started to boil, so I took it off the stove. He asked me why I did this. He then began insulting my parents, so I prepared myself and tied my scarf around my waist. I returned every insult he threw at me, telling him "not my parents." He then beat me thoroughly. I was crying out to God to save me. I said, "Oh my God, divorce me," until I could no longer talk. He punched me in the jaw and nose that night, and then he left me in the house and went to his other house. I could not get up till the next morning. While all this was going on, our neighbors, both men and women, came out and begged him to unlock the door, but he would not listen to them.
>
> The next morning, I came out and headed for the toilet. My neighbor advised me not to leave, but I told her no. She said to go on and have my bath, massage my body and take some Panadol [acetaminophen]. After she left, I went to my parents' home. I told my stepfather what happened and he said, "I hope he does not come here and tell us you have been lying." I said, just ask him and our neighbors. At the time I was pregnant, but I wasn't worried. When my husband came to find me, and my stepfather asked what happened, he confirmed beating me. My parents asked him to divorce me, but he refused.

Women depend upon their families to intervene in their marriage when they are being mistreated. They must possess both the power and the desire to do so, however. The fact that Mairo's stepfather required her husband to sign a contract to ensure that he would no longer beat her is a measure not often taken by other families and reveals the sincerity of her family's investment in the course of her marriage. While beatings are common in northern Nigerian marriages, I rarely have heard of conflicts as violent as Mairo's. Other elements of her narrative were more common, such as fights over a husband's relationships with other wives and disputes over various forms of economic neglect. While neighbors and families do attempt to intervene in these issues, they tend to stress reconciliation, as in Mairo's case. The fact that her husband had signed a contract meant that Mairo felt reasonably secure that she would not have to return to his house. Her family could not, however, persuade him to divorce her. She remained in her parents' house.

At the time of this encounter, Mairo was nearly full term in her first pregnancy and, soon after, went to the hospital to have the baby. Her husband was on the staff of the hospital, so when they got to the maternity section, her father went to inform him that his wife was about to give birth. Her husband came out, and said to their shock, that she should not deliver in the hospital. He would not assist her and she should be taken back home. He said simply that he would pray for her. As this conflict between her husband and stepfather was going on, she was in labor. She was stubborn during this birth, Mairo explained, and removed the IV from her arm because the pain was too much. She had not gone for antenatal checks, and the birth became difficult. She had to have a Caesarian section. She delivered a healthy, large baby boy.

Forty days after she gave birth, Mairo took her husband to court:

> In court, he was asked if he used to feed me and he said no. We were asked to return after one week. My husband then denied to the court the he had said anything to them. They sent him to jail for a week, and on return, I reported that he had never given his son a naming ceremony. The judge ordered him to buy a ram. He showed up with a skinny one and was told to get another one. He then sent a message to me to send him the head and legs. Of course I would do no such thing. Back in court I told the judge what he had said and the judge admonished him. Next, the judge asked me three times if I wanted to return to his house and I said no. He then said to my husband, "I have tried to get Mairo to return to your house with no success, so I order you to divorce her." My husband then pronounced one divorce.

Though *shari'a* courts are present throughout Kano and they are able to mediate divorce cases, few women who divorce require them. So again, Mairo's case is exceptional. While her husband's violent temperament was the central reason Mairo desired to end her marriage, issues of neglect – particularly over children and subsistence needs – were far more likely to be socially and legally sanctioned. It is this latter issue that is relevant to the marriage dissolutions of northern Nigerian women, more broadly.

About two years after this divorce, Mairo married her next husband. He was a shop owner and one of her boyfriends prior to her first marriage. "In fact," Mairo said, "we had been in love." After he heard news of the divorce, he sent one of his friends to ask whether she still had feelings for him. "Was there still something there?" And she let him know that there was. Before they could wed, she had to wean her son and complete her *iddah*, a three-month waiting period after a woman's divorce. They married five months later. "This time it was a love marriage." Even while women are married, their admirers and boyfriends do not dissipate entirely. As discussed in Jummai's case, northern Nigerians all know that marriages may not last. They do not, consequently, entirely sever their ties to these other relationships. When married, women take extra care to hide from the attention of men, but marital status does not necessarily deter men from pursuing them.

Mairo got pregnant four months after the wedding. When her son was around three months old, her husband started falling sick. He hid this from her for months and took his medications only at work. One day, however, his friends brought him home from work and that was when she learned he had of his repeated illnesses. He was relying on a boy to help display his food items at the shop. She continued,

> My husband's attitude then began to change and he started to admonish and insult me. I felt bad because he had never done this before. For example, our neighbors were having a ceremony, and my husband came home the night before. He complained that all the clothes were dirty and he had none to wear the next day.

> So I washed the clothes that night. In the morning he said the sleeves were not clean, so I washed them again and put them on the fan to dry. He continued to complain about the time it would take for them to dry. Afterwards, he ironed them while I drew his bath water. When he was dressed, he started insulting me, stating that my parents who lived near his shop would not even come to buy from him. He called them paupers. I cried and said, "Well marriage is not by force -- I will go home." After he left, my neighbor asked me where I was going. So I told her that there was a wedding in our neighborhood and I was going there. When I got home, I told my uncle what happened. He said to wait until his brother comes. Later, we were called for reconciliation. My husband said that my story was not true, but since that's what I said, so be it. I was told to go back inside while he handed them a divorce letter for me.

Mairo speculated that it was HIV that led her husband to divorce her. The next day she returned with her family to get her things from his house, but her husband stopped them from entering and said he would bring the things back to her house himself. Not wanting trouble from him, they accepted and a week later he brought the things. Two months later his brother came to beg her parents for her to return. Mairo told him no. As she explained, "His attitude and behavior had shocked me and I no longer wanted to think about him. I told him to tell my husband that I would go find a pauper like me to marry, and he should seek an heiress for himself."

Insults over the class backgrounds of partners are central components of marital strife. Routine household duties – such as cooking, cleaning, and clothes washing – are often the spark that ignites these fights. Women threaten to run away to their parents' house and commonly do. Again, neighbors and friends intervene to attempt to reconcile couples, and maintaining a good reputation among one's neighbors is essential. Stubborn brides are not respected. Many negotiations involve family members who act as representatives for the man and woman, who rarely confront one another directly. According to Islam, a husband must divorce his wife three times for the marriage to be completely dissolved. If the man only divorces a wife only once, he leaves open the possibility for reconciliation. Far from a discrete event, a divorce is in fact an elongated process of ending and reforming a marriage.

Her husband persisted and finally Mairo's mother convinced her to return to him, "if only for the sake of her child." So she went back to him:

> After some time, he asked me if I knew about AIDS. He then told me his status. I was stunned and exclaimed: "from God we come and to him we shall return" – *inna lillahi wa inna ilaihi raji'un*. I then asked him where he got it from. I told him that, "you know my first husband does not have it," and he said yes. And then I said, "you know I am not promiscuous either," and again he said that he would vouch for me. He told me that the kids and I would be taken to hospital for tests. The children were negative, but I was positive. From then on, I was so unhappy. I stopped looking after myself, stopped eating, and was turning down invitations to ceremonies. I would tell them that my husband forbade me from attending. They would let me off and blame him. I also stopped going to school [*Islamiyya*] so my teachers and classmates kept coming to see me. I stayed home from graduation and told them I was okay, but I was having fevers and was never well. That was when my husband brought me to the doctor. I did not think much about how I got infected. I simply understood that God brought it on us, so I accepted it. He put the burden on me and that's the fate that was written for me.

A woman's first concern when a partner discloses his HIV-status is ensuring her reputation. The act of disclosure might, in fact, be an accusation, so women demand that their partners acknowledge that they are not promiscuous or unfaithful. Rarely do partners actually know from whom they have contracted HIV, so these exchanges have more to do with social status then they are about the virus. Traditionally, married Muslim women are expected to be secluded in their houses, but in my observations in urban Kano, this is not often the case. Hausa women – both married and non-married lead intensely social lives, visiting family and friends, attending weddings and other social events, and going to school. To withdraw from these activities is, consequently, a much more profound act than it seems. Women say constantly that they are not aware of the source of their infection and repeatedly state that HIV was their fate. This does not necessarily mean that they are not concerned with their husband's character or the management of their own reputation.

At this point, the relationship between Mairo and her husband improved considerably. Her husband was both affectionate and would buy all of the drugs they needed: "For example, in the mornings we would put olive oil [*zaitun*] and garlic powder in our food, and then we would pray [*qul huwal llahu* and *kursiyyu*] onto the water we drink. We also ate *habbatu sauda* seeds. He ate so much garlic that, before cooking he would send me about a hundred bulbs to put into the food. It was so much I used to tease him to find a separate place to keep his clothes because they all smelled of garlic!" He replied jokingly, "You mean I should stop coming into the bedroom?" This went on for almost two more years.

One of the most visible signs of a good marriage is the effort a husband and wife exert to take care of one another when they are sick. It is both an economic and a social exchange. It also involves participation in a series of Islamic rituals that demonstrates a man and woman's commitment to their faith. While symbols of disruption, fragmentation, and abandonment dominate popular and public health representations of the social consequences of the illness, HIV can also reveal the enduring virtues of marriage. HIV, as I have argued, also magnifies the importance of reproduction both within and beyond one's marriage. Finding their health much improved, Mairo's husband began to persuade her to have another baby:

> He said to me, "Mairo, I am tired of this investment without any returns." And when I became pregnant, he was so happy…This time the pregnancy was as difficult as the first. When I went to the hospital, I was sent for a scan. I was advised by the doctor to either go for a C-section or take medication to protect the

> child. Also, I was not supposed to breastfeed when the baby was born. But I simply left everything to God. Another doctor told me I could breastfeed for 3 months. I knew that, at home, my parents would ask why I could not breastfeed. They would assume it was a way of family planning and my secret might become known. But now I have weaned him. He is about 18 months old though he does not look as strong as the older one. I have been advised to wait until he is 2 years old before conducting a test.

Mairo's successful birth reinforced the symbolic, social, and economic virtues of her marriage. Moreover, it mitigated the suspicions both her family and the community had surrounding the tensions in her marriage. However, the steps Mairo would have needed to take to ensure the virus was not transmitted to her child could have potentially jeopardized the respect and social assurance that motherhood produces within these social networks. Recalling Mairo's previous marriage, one of the fundamental ways a woman may protest her own maltreatment within her marriage is to demonstrate her husband's failures to meet responsibilities to his children.

Mairo's marriage again soured and they divorced a second time. Mairo explained that he began to insult and curse her. All of the members of their support group were aware of this change in behavior and the doctor who volunteered with the group chastised him for it, but it only got worse. He would not provide anything for her son's naming ceremony and again insulted her parents. He took his son's bed, clothes, and other items and sold them in his shop. He used to look after the child when Mairo was bathing. And soon after, he stopped paying attention to the child altogether when Mairo was present.

Furious at Mairo, one day he dismantled her bed, mattress and knitting machine, and threw them out in the rain. She collected her items and put her bed back in the room. He returned home that evening and asked, who brought these things back in the house? Mairo protested, "You did not even tell me why you took it apart." To that he said he was tired of the marriage. She answered back, "Then divorce me because I am no longer the type to run home after quarrels." I asked Mairo whether she had a new boyfriend after leaving her husband's house. She said:

> In fact, I have already been asked by men for both sex and marriage about four times since then. I tell those who want marriage that I have not finished my *iddah* because at the time I had not. But also I say it because then my secret [her HIV status] will be known by everyone. I hate my husband for putting me in this position, because our secret would never have to be exposed if we could have remained married and accepted fate…especially with children involved. But he could not. Now, I do not even get to see the older son.

In this final statement, Mairo raises a number of points relevant to the ways in which one marriage affects subsequent relationships. First, she refers again the issue of her husband's lack of consideration for his child and his economic neglect. These claims morally validate the marriage's dissolution and are central to how Mairo maintains her reputation within her kinship network. However, while she continues to care for their baby, her oldest child no longer lives with her, which was a source of great distress. The social organization of childcare following marriage dissolutions has lasting significance. Second, she has little tolerance for her husband's abuse and no longer runs away in protest. While it is her husband who ultimately divorces her, she has learned how and when to ask for a divorce. Last, Mairo expressed anger toward of husband "because our secret would never have to be exposed if we could have remained married…" This marriage hid a secret [HIV] that she felt she could no longer adequately protect in her subsequent relationships.

Zainab

Zainab was 17 years old when she first got married and was 21 at the time she was first divorced. Her husband was a businessman and sold clothes. She had a co-wife in this household with three children. Initially, she was reluctant to share the details of her divorce – likely because this was early in the interview and I was hesitant to push her to describe it. She warmed to me as we proceeded, as is evident through the increasingly detailed descriptions she offered about each subsequent marriage. Zainab's only two children came from this husband, one she left behind after her marriage ended and one she took with her to her next marriage. Children are expected to be cared for by their fathers when marriages end, but they – like their mothers – more often move into and out of both their fathers' and mothers' households. Zainab's first husband died just a couple years after this marriage, as did her first child.

Her father arranged her second marriage and she had visited with this man only three times before getting married. She was twenty-two years old then and moved from Kano to his village in a nearby state. Her husband both farmed and taught in an Islamic school. Again, she had a co-wife. Zainab complained, "I had no money, nor did my husband give me money. I had to sell some of my furniture whenever I was in need of necessities like toiletries and bathing soaps, and when I needed to buy food…because, sometimes there was no food in the house." With few family members to consistently rely upon, she sold her bride gifts to generate income – a strategy used by many women lacking employment or other informal work opportunities.

She continued, then, to tell me how this marriage ended:

> Three months after this marriage, I was sick: everyday a fever. Because I was not menstruating – I had yet to wean the baby – I could not know if I was pregnant.

> My husband and I thought I was pregnant. I went to the hospital and I explained to the doctor all that happened and they tested my urine, but the result showed I was not pregnant. About two weeks after that, I weaned my baby. I told my husband that I wanted to go and see my family if he agreed. Two weeks after I returned to my husband's house, I saw my menses. So I told my husband, but he said it was possible to see blood a few months after conceiving, that this was not surprising. I told him that I was not pregnant, but he did not believe the result. But then two weeks after that, he said I should pack my things. He was taking me to my home. I asked him, "Did someone die? Or was someone sick?" He said there was nothing wrong. After I had finished packing my things, he wrote on a paper that he had divorced me, and he gave me the paper. I did not ask him the reason for the divorce. But he told my father that I was pregnant and had an abortion the time I last saw my family. I told my father that we never quarreled, that that was just the reason. We spent seven months together in total. So, I returned to my father's house, and my daughter died three months after I left this husband.

A number of themes emerge from Zainab's narrations of her first and second marriage. First, as suggested also by Jummai, marriages not only involve a relationship between a husband and wife, but also between co-wives. For example, both Zainab and her co-wife in her first marriage gave birth at the same time. Remarking upon this, in particular, Zainab was assessing both the woman's competence as a mother and assessing the environment within which her child would be raised following the dissolution of her marriage. The relationship a woman has with co-wives matter even after a divorce, given that co-wives often take over the responsibility of caring for her child. Both of these marriages were arranged by Zainab's family and it was her father's house that she returned to when the marriages ended. Families are not only called upon to assist their daughters in the periods between marriages, but also during the marriages themselves, when husbands, for example, are unable or unwilling to provide their wives with food or medicine. In her second marriage, it was evident that her husband's accusations were motivated, in part, by more basic concerns of household economic instability. More importantly, what this conflict reveals is the centrality of issues of reproductive and maternal health in the dissolution of marriages. Women are expected to have children immediately upon marriage and they are scrutinized for signs of pregnancy. Given the centrality of children to one's marriage, infertility as I have argued, is a stigmatized condition. An abortion, consequently, is perceived as an abomination.

Shortly after her divorce, Zainab married her third husband, and it was during this period that she began to fall sick:

> It was my grandmother who introduced me to my third husband. He lived in Kano, and I was in his house for four months when I fell sick with stomach pain. They brought me both medicine from a chemist and traditional medicine in a bottle, which I soaked in water. I got better, but after about five months, my vagina started itching. I did not tell anyone, since it was a secret. I thought it was cancer or…My husband bought medicines from the pharmacy – at 150 naira. I told him that they said he should also use the cream. He used it once, but he said he was not going to use it again. Three weeks later, the situation was unbearable, and I returned to the hospital, where they prescribed a capsule, and then a cream. The capsules cost 950 Naira. I went back home and asked for the money, but he did not have it, so I should find my way out. I didn't know what to do. I didn't have things to sell that could cover this cost. I went to my uncle and he gave me the money. I began the treatment and the itching stopped, but after two weeks, a very big boil appeared inside my vagina. I could not walk properly and I could not leave the home, even to go to the hospital because I had no money… My husband avoided me. He could not have sex with me because of the boil. He was fed up with the disease. He told me that he was going to bring back his first wife because I was sick. He rented a room for her in a different house, and when she came, he stopped providing me food. He gave me a note that he had divorced me the first time. I should leave the house.
>
> I told a member of his family about it. He met my husband and insulted him. He said that he was crazy to divorce me just a few months after marriage. He told me to go back to my husband's house. So I did. My husband, however, did not provide anything for me. Not food, soap, etc. He wanted to frustrate me so that I would leave the house. I told my mother about everything, but she said that since this family member has made an effort to save my marriage, there was nothing she could do. Sometimes she gave me some money. He checked every three of four days to see if I had left. One day he asked me what I was still waiting for. He gave me a note that he had divorced me the second time. Again, I told his relative who abused him and told me to return to his house. My husband still did not change. Finally, he divorced me the third time, and after the third time I could

> not go back to the house. All that time, my father did not know about all the trouble I went through. He knew the day I was finally divorced. I stayed at my father's house, though neither he nor I had any money, and I continued to have health problems. I had asked my uncle for money several times, so I could not ask him again. I sold my remaining furniture and ornaments so that I could go to the hospital.

It became clear that Zainab had acquired some form of a sexually transmitted infection: an illness that is both intensely private and – by definition – shared. While she initially was able to secure support from her third husband, his ambivalence toward his own treatment and his ultimate denial of further assistance illuminate the ways in which material and affective exchanges can deteriorate in the face of chronic illness. The course of her sickness progressed concurrently with – and as a result of – the demise of these social resources. Zainab was shamed through her husband's neglect, abuse, and ultimate divorce. As I have argued, a northern Nigerian woman's recourse to such treatment lies in the extent to which she could convince other kin to challenge her husband's behavior. Zainab's resilience was expressed most vividly in her efforts to both mobilize his kin and her adamant refusal to leave her husband. Returning to her father's house, she had exhausted the resources her family could extend to her. Wedding gifts were once again her sole means of survival in the absence of these supportive persons.

She quickly moved on to her fourth marriage:

> Three months after the divorce, I met a new boyfriend. We courted for only three months, and then we married. We lived together for about two months when the boils appeared again, and the itching was terrible – like needles were pricking me on my vagina. I did not want my husband to know. I had to tell him. I told him I wanted to go to the hospital and he agreed. I went and they prescribed another cream, but the boils only increased. My husband was worried, but he said he did not have money. I had a necklace and took it to the market where I sold it for 1,000 naira [$8]. I saw an advertisement for a traditional medicine in *Sabon Gari* [a market]. When I used them, the boils and itching reduced, but I started purging non-stop. Even when I took drugs, it did not stop. I felt as if something was kept

> in my neck and food could not pass through. I lost weight and became thinner every day. My husband did not bother taking me to the hospital. He didn't care about me any more. He stopped entering my room. On one particular day, he went into my room. He said, "Zainab, you can see that I don't have any money. Sometimes I cannot even provide food for the family, and you are always sick. There is no point in me keeping you here without any medicine and good food. I think it's better for us to part." He gave me a divorce letter and I again returned to my father's house.

Relieved temporarily of her sickness, she remarried quickly. When she finally told her husband, he too initially assisted her. Ultimately, however, the relationship dissolved when her health did not improve. In his opinion, it was irresponsible to keep a wife who he could not care for.

Zainab initially hid her health concerns from her husband, because both the costs of treatment and the possibility of transmitting the infection to him would have prohibited the marriage. The marriage began amicably, but it became clear that her husband lacked the resources to assist her. Zainab was in a particularly difficult position as she had no source of income or support independent of her husband. Given the powerful religious and gendered norms that motivate men to take responsibility for their wives, undoubtedly Zainab's suffering, to some degree, emasculated her husband. While this man was more sympathetic than the prior two, he resolved this concern by abandoning the marriage altogether.

Zainab told her father what happened in this marriage and he prayed for her, but he had no money. She could not afford to treat her sickness. After about two months, her uncle heard about the divorce. He asked her what had happened between them and she told him about her series of illnesses. He said, "I think this disease is in your womb. You should back to the hospital, but make sure you see an experienced doctor, not a nurse. Even if you are going to undergo a surgery, it is better you are relieved of all this disease." Zainab told him that she had sold all of her furniture and did not even have a kobo [penny] to pay for the hospital. He gave her 5,000 Naira [$40] and he said they should do all tests necessary to diagnose her illness.

Having located a relative to support her, Zainab felt a great deal of relief. Patrons serve fundamental roles in women's lives and are often essential for their very subsistence. Beyond his economic assistance, her uncle's authoritative guidance was highly valued. By insisting upon a diagnosis – not simply the relief of symptoms, speculating on the cause of her symptoms, and demanding the attention of an experienced doctor, his support went above and beyond the care of any of the other men from whom Zainab sought assistance. Moreover, he promised his support until her illness was cured. His investment would potentially ensure not only the return of Zainab's health, but also, more importantly, her ability to remarry.

Zainab then went to meet her brother's friend who was an optician at the hospital. She told him what was wrong and he said that he would introduce her to a qualified doctor. She explained that she had gone to the hospital several times, but did not get better. So, he told her to meet him at the hospital the following Monday. He gave her a note to take to a dermatologist. The doctor asked her a number of questions, and gave her a consent form for a test. Zainab then went to a laboratory and gave them a blood sample. She returned to the doctor with the results and was prescribed a cream for the itching and swelling. The doctor asked her to come back to see her in two weeks, but not to show the results to anyone.

> I returned and met her at the hospital. She finished with her patients and called me into a room. She told me that the results showed that I had HIV. I repeated,

> "Me? Me? Me?" But, she said, you should not worry. I asked, "Why shouldn't I worry? I did not know I had a killer disease and now I have to worry about it." She said she was going to help me and gave me a note to take to her friend, a woman who was working at the faculty at the hospital, where they treat HIV.

The shock of a positive diagnosis was lessened by the multiple extensions of support she was offered. Zainab continued her story of the series of medical problems and ordeals she went through to acquire treatment. With the support of her uncle, she sought HIV medications, and regained her health. As she got stronger, he encouraged her to start a business, cooking out of her kitchen. She was successful, making enough money for her food, the maintenance of her treatment, and even buying clothes.

Zainab and I continued our conversation. After learning she was now living with her grandmother, I probed, "But why did you leave your father's house?"

> I left my father's house because I felt better and I was doing my business. He said I must get married; that maybe, if I even lived, I don't even have the virus. I gained weight and I did not have other health problems. I must get married. As a result of going out to sell food, people were coming to see me because they did not know what was going on – that they like me. So, my father thought, what if I wanted to marry one of them? If my admirers were not positive, though, and I married one of them, then that is deceit. So I convinced him that I will meet someone at the hospital. If someone meets me and says he loves me at the hospital, so we will marry and keep our secrets. But these other admirers that I had – I can't tell them to go away, this is the disease I am suffering from, and then reveal my secret! So, they will get tired of coming, since I was not the one that invited them. Anyone that sees I am not going to marry him will stop coming.

Zainab was not willing to give up her business, nor would she tell her boyfriends the actual reason she was not interested in marriage. Her father mistook her interest in business for her reluctance to marry, which was far from her intention. Rather, Zainab preferred to find an HIV-positive husband so that she would not have to deceive him about her status. She was set to marry her fifth husband at the time we did this interview.

Given the long and difficult marriage history she had described, I pressed her on what it was she wanted out of this marriage.

"I wish to be happily married, Zainab explained to me. "But a person does not have control over his or her life: your husband might mistreat you, you might have misunderstandings, and you may be divorced." So then what can you do, I asked:

> Honestly, I wish to have my own house, so that if I am divorced I can go straight to my own house and do my business the way I want…If God gives me the business to do, I will do it from my husband's house even though Islam does not encourage a married woman to go out and look for money, you have to do business in the house. If God give me this type of work, I will continue with it. If God gives me the ability to own my house – to "avoid a rainy day"…I am not praying for that to happen, I pray that does not happen…If God blesses you with children, you might not even live with them, but people will at least say you left behind something. If I get two or three children that can help me, may God bring them to us. Even if I don't get another one, I'll be all right…

A house, work, and children all establish a means of continuity, even as marital partnerships fluctuate. But, it is *through* marriage and larger kinship networks that women are able to access these resources. Zainab has effectively attained an ideal sought by women regardless of their marital or HIV-status. Women seek to establish "independent" sources of income, which will assist them both within a marriage and the time in between marriages. Opportunities for income, however, are a result of social networks, and these resources, in turn, are used to forge new social relationships. Income, consequently, is never independent, nor does it necessarily result in greater autonomy. In fact, it often has the opposite – and much more desirable – effect: securing and strengthening the relationships a woman has with her kin and community.

Conclusion

In northern Nigeria, young women currently constitute one of the most populations visibly affected by HIV. Waiting rooms in HIV treatment centers, for example, are filled with women and their children. Divorcees and widows, as I have described, predominate in support groups, and women are increasingly likely to learn of their status in antenatal clinics. Not only are more married women receiving tests, epidemiological evidence has also revealed that, increasingly, young, married women are at greater risk of contracting HIV than their sexually active unmarried counterparts. Across public health and popular representations, monogamous, faithful women are almost assumed to be “victims” of men’s immoral relationships. While these sexual incongruities certainly exist, it is also common for women to have multiple sexual partners, as I have shown. The symbolic significance of marriage misleadingly suggests that these partnerships are stable entities over time, when in fact they are highly fluid and variable. Even the point at which a marriage ends is ambiguous. Women move out of and back into a single marriage, and will likely transition into and out of a series of marriages over their life course. A processual understanding of marriage helps to elucidate the complicated association between marital status and HIV. This chapter has argued that a woman’s marriage does not end at the moment of her divorce or the death of her husband. Household economic instability, the significance of reproduction and its disruptions, and the affective and material exchanges between husbands and wives and their broader kinship networks – all reveal vital social, and economic continuities that persist through and beyond women’s marriages. HIV infection, I have shown, is a concern that accompanies these larger social issues and magnifies their consequences for subsequent marriages.

CONCLUSION

VITALITIES

Once largely an invisible epidemic, the presence of HIV/AIDS across sub-Saharan Africa is now ubiquitous. Despite early signs in the 1980s and 1990s that the prevalence of infected persons was increasing at a dramatic rate, Nigerian political leaders paid little attention to the advances in health infrastructure needed to support prevention, treatment, and care programs. Surveillance reports confirmed these signs, but few individuals – even among those who participated in these studies – knew of their HIV status and even fewer sought treatment. As public health campaigns sought to convince the public that HIV was a "real" disease by calling attention to the course of suffering and highlighting the fatal consequences of promiscuity, Nigerians avoided at all costs an association with the virus. An HIV-positive diagnosis was perceived to be a death sentence, presumed to place in jeopardy not only a person's health and family relations, but also her social reputation. As the Nigerian epidemic finally garnered global attention and the resources needed to develop the capacity to attend to the needs of its infected population, the number of diagnosed patients slowly increased. Once an undetectable disease whose sufferers lived and died of a sickness with an unspeakable cause, HIV-positive persons collecting life-extending antiretroviral therapies in Nigeria now number in the hundreds of thousands, with as many as a million more awaiting treatment.

This dissertation has explored the aspirations, dilemmas, and everyday lives of women participating in the world that these technologies, antiretroviral therapies, and global health campaigns have opened up. I have suggested that diagnoses, healthcare, treatment, and participation in biosocial organizations, can, paradoxically, allow HIV-positive women to maintain privacy surrounding their HIV status. They enable women to avert the threats that a positive diagnosis poses to the social identities, and forge new social relations that both reinforce their respectability and the protection they require to manage their health and subsistence. By cultivating particular interior states, bodily appearances, and other symbolic, social, and economic resources, I have attempted to show how women engage with *both* the ubiquity and the anonymity of the epidemic's political face. Further, I have argued that women's ability to make claims for and benefit from treatment are contingent upon the ways in which institutions, social relations, and their very physiologies intersect, creating new social trajectories for some and excluding others. In each of the chapters of this dissertation, I have juxtaposed the forms of knowledge, technologies, and interventions employed to understand and curtail the epidemic with the social aspirations and kinship trajectories of HIV-positive women.

Dilemmas of Diagnoses

One of the central "techniques of visibility" I have explored is diagnostic screening for HIV. Without a test to confirm the presence of the virus, the prevalence and presence of HIV in Nigeria can only be known through aggregate estimations and projections. Without a test, an individual is merely sick, or – more likely – is not sick, but either is currently, or was in the past, married to a sick partner. The symptoms of

HIV infection resemble those of any of a number of infectious or chronic illnesses also present in abundance throughout the country. Given the panoply of causes of these symptoms, an HIV screening was often an after-thought – one considered only after a range of biomedical and traditional treatments for typhoid, malaria, or other parasitic infections failed. Even more pronounced disorders associated with advanced stages of HIV are so prevalent that patients do not necessarily suspect that the virus is at fault. These include the painful effects that these infections have upon a couple's sexual life; infertility and infant mortality; dramatic fluctuations in metabolic processes, respiratory difficulties and fatigue, and even cognitive deficits. While HIV-positive persons are often a decade or two younger than those affected by these latter disorders, they are not necessarily – in and of themselves – remarkable in a country with an average life expectancy of under 50 years. Coupled with the fact that testing technologies, treatments, and awareness campaigns were largely unavailable until the late 1990s, it makes sense that AIDS was largely an invisible disease. And yet, there is more to be understood about the invisibility of HIV in Nigeria than that which can be concluded by these epidemiological facts.

An HIV test is not simply a tool employed to measure immunological malfunction. A diagnosis also confers a social fact. In this dissertation, I have asked why ordinary Nigerians would want to know their status and why they might not want to know. What specifically is at stake when one receives a positive result? I have focused upon how Nigerians contemplate diagnoses in reference to their sense of social identity as well as notions of family aspirations and obligations. And I have argued that the virtues and fears embedded in the act of taking a test are related to larger questions of how families and relationships might be reconfigured in light of a positive test result.

As HIV is most commonly transmitted through heterosexual sex between husbands and wives, a diagnosis is intertwined with the sexual and social lives of Nigerian couples and their families. Community and family reputations, financial stability, and health histories are all part of the calculus employed by families in marriage negotiations. Families – particularly those with limited resources – maneuver in strategic ways to ensure that partnerships are forged or dissolved. Despite the fact that most Nigerian women are aware of the ways in which HIV is transmitted and many of its symptoms, few are able to demand an HIV test of their partners. Following marriage, they are unable to abstain from sex, even if they suspect that their partner is infected. And finally, most do not possess the power to prevent their relationship from dissolving, if their husbands seek to divorce or abandon them. There are limitations to women's autonomy both in their relationships and their decisions over their health. Ultimately, the social risk of losing a partner outweighs the risk of HIV.

Fears of positive test results by both Muslims and Christians are brought about by perceptions of HIV's association with promiscuity. Northern Nigerian women widely agreed that men's promiscuous behavior was not only immoral, but also drove the spread of the virus to women, making women its victims. Most Nigerians I knew naturalized sexual drive, attraction, performance, and satisfaction into defined gender roles. Men innately need more sex than women. At fault, women suggested, was "Hausa culture," which propagates women's ignorance and feelings of shame about sex. Further, Hausa Muslim women, who are not able to appear beautiful, neat, and "cultured," risked losing their husbands to “outside women” (non-Hausa) who possessed these attributes. In order to meet these virtuous ideals, however, women must possess material resources, which – not coincidentally – men were responsible for providing. Men neglect their wives and thus have the justification for pursuing new girlfriends. At the same time, women blame themselves for their lack of culture, when it is larger social inequalities driving patterns of sexual behavior.

While misdirected accusations of promiscuity drive women’s fears of learning their status, most Nigerian women have had multiple sexual partners over their life course. Premarital and extramarital sex is common among women, as well as men. Adolescent women, particularly those in the north, are pursued by older men and often marry at a young age. Educational pursuits can delay marriages, but they do not necessarily delay the initiation of these relationships. Their boyfriends have often completed their education and devote large proportions of their income to providing young women gifts, money, and even their school fees. For women, premarital sex is intertwined with their marriage aspirations, and the material exchanges are symbolic of their boyfriends’ commitment. Most have sex with their partners *because* they want to marry, not out of a disregard for the importance of marriage. These relationships do not always result in marriage, however, and women are cognizant of this. Women frequently have numerous suitors concurrently and men vie for their consideration. One of the fundamental components of HIV counseling protocols is that clients evaluate their past partnerships to identify the behaviors that placed them at risk of contracting HIV. While women were aware that having multiple sexual partners and unprotected sex are associated with HIV transmission, less clear were the ways that they might have changed these relationship dynamics to lessen their risk. Women's partnerships and sexual behaviors are thoroughly enmeshed in their marriage aspirations as well as their material livelihood. Again, the risks of remaining unmarried and economically unstable (the latter of which reinforces the possibility of not marrying a respectable husband) outweigh the risks of HIV.

The protection of clients' privacy is another fundamental element of HIV counseling protocols. Without a patient's permission, counselors and medical staff cannot share test results with others. By its very definition, HIV is a shared disease. At stake when one receives an HIV test is not only the presence of an infection, but also, which individuals caught the virus first? Who is to blame? Even when a woman's virtuous reputation is well established among her in-laws, the suspicion of being responsible for infecting one's partner with HIV is grounds for her abandonment. While many women know when their partners have extramarital affairs, not all seek to dissolve their relationships. In fact, suspicions of affairs often motivate women to intensify their efforts to make claims for their husbands' economic support and affective commitment. Their ability to make claims upon their in-laws, however, is less secure. A woman has a greater chance of maintaining her reputation if she learns of her husband's status before he informs his family or he passes away. Herein lies the problem with hospital confidentiality policies. Although a positive diagnosis suggests that a man's partners were exposed to the virus, husbands frequently refuse to disclose their status to their wives. And without a husband's confirmation that she has been a respectable, faithful wife, a positive result in the hands of his kin and community jeopardizes more than her health. His family may take her children, or they may leave them without any support.

They may also take away her possessions and deny her the inheritance she is due. Her relatives may broadcast her status to the larger community, potentially spoiling her chances of remarrying. Women's concerns surrounding HIV screening are driven by how families and relationships might be reconfigured in light of a positive test result. From *whom* and *when* one receives this result are as consequential as what a test actually reveals.

Support Groups and the Management of Ambiguity

Support groups and other organizations for persons living with HIV have played a central role in illuminating the presence of the epidemic and in advocating for the rights and needs of HIV-positive persons in Nigeria. Despite signs that the rates of HIV infection were growing swiftly over the 1990s, Nigerian political leaders did little to address the increasing need for prevention and treatment programs. Slowly this began to change with the initiation of the National ART Program in 2001, which purchased treatment for ten thousand adults and five thousand children. Overwhelmed by the demand for these therapies, political leaders sought assistance from global health institutions. Nigeria was identified by the National Intelligence Council as one of five countries comprising the "next wave" of HIV/AIDS with the epidemic predicted to surge from two to ten or fifteen million infected persons by 2015. Consequently, Nigeria became one of the focal countries of the American PEPFAR program, which has invested close to a billion dollars in treatment, care, and prevention activities in the country, and has increased the number of persons being treated for HIV to approximately two hundred thousand. Among the priorities of these initiatives was the involvement of HIV-positive persons in health programs and promoting venues, such as support groups, for addressing patients' "social care" needs. The health and development agencies funding these groups promote an array of activities including vocational training, education campaigns, and more generally, believe that support groups both facilitate disclosure and treatment adherence by alleviating patients' social fears and other barriers to health. While this economic and social assistance, coupled with new therapeutic options, should enable HIV-positive persons to become better "health citizens," the women with whom I worked in northern Nigeria pursued a different set of social aspirations. Seeking to constitute or reconstitute marriages and kinship networks, HIV-positive women have appropriated support groups in order to facilitate these aims.

In this dissertation, I have made three central points relevant to this development. First, I have argued that HIV-positive women's marriage aspirations are best understood through the virtues and resources they seek and negotiate in their broader kinship and social networks. Second, I have suggested that the practices of support group matchmaking and the material, social, and symbolic exchanges that concretize these relationships reveal many of the same dynamics that accompany relationship formations among all Nigerians. And third, I have elucidated the ways in which women manage their discreditable condition by strategically revealing their status to some individuals in order to hide it from others. That is, women "go public" by joining a support group in search of husbands and other supportive persons, but they do so with an ultimate aim of reestablishing privacy within their domestic and health affairs.

The manifestations and reproduction of stigma are tied to a number of key concerns among Nigerians. First, HIV is widely perceived to be an immediate "death sentence." Epidemiologists have estimated that close to a quarter of a million persons died from illnesses associated with HIV in the year 2005 alone. Early public health campaigns in Nigeria attempted to counter suspicions that HIV was a fictitious disease by employing pictures of skeletons, coffins, and blood to warn the public of its deadly consequences. However, these stigmatizing responses were not merely because HIV can be classified as a fatal disease. HIV is deemed a "bad death" because of the ways in which it troubles the moral ideals embedded in marriage and the family. To understand why fears of stigma persist among HIV-positive women, it is essential to recognize how a woman's moral and social authority is intertwined with her marital status. Further, these values explain why it is that (re)marriage is of such vital importance to HIV-positive women.

Among northern Nigerians, religious doctrines stress the importance of marriage, which pragmatically, offers women structures of social and economic support, the latter of which is of particular significance for poor women. Beyond the expectation that their husbands assist them in meeting their subsistence needs, married women are also better situated to request help from their larger kin networks. In turn, they are better able to reciprocate that support to their kin, cementing these exchange relationships. Further, this assistance extends beyond women's material needs. Married women, for example rely upon their kin to sanction their husbands when they are not meeting their obligations to them or when they threaten divorce. Marriage is perceived by both Muslims and Christians to function symbolically in protecting men and women from the dangers of immoral sexual temptation. Non-married women of reproductive age who do not seek to remarry are widely stereotyped as promiscuous, and even have been labeled prostitutes.

In need of these material, social, and symbolic resources and fearing these immoral, promiscuous stereotypes, it is unsurprising that HIV-positive women desire to marry or remarry quickly.

Non-married women often have multiple suitors who compete for their attention and affection. Determined men follow women to their homes and discuss their interest with women's relatives and friends. Couples are discreet in their relationships, communicating in private through phone conversations and love notes. Their relationships almost always include the exchange of small gifts – and sometimes, elaborative, expensive gifts or money. Marriage arrangements include long processes of negotiations between families, where the details of the bride's gifts are discussed. There exist enormous variability in the extent to which these items represent more of a symbolic offer or the transfer of actual wealth, just as there are vast differences between the religious ideals kin are expected to meet and the actual constraints with which families are faced in the marriage obligations of their kin. These transactions offer a woman and her family proof that a potential husband is capable of protecting her, providing for her, and treating her with respect. While HIV threatens women's material livelihoods in numerous direct and indirect ways, marriage does more than function to remedy these concerns. More importantly, marriage ensures women's social respectability and protects her from threats of stigma and neglect.

As I have described, in northern Nigeria, large numbers of relatively poor, non-married HIV-positive women are joining support groups to find potential husbands. Support group members facilitate these relationships both informally and formally. Just as in the wider Nigerian society, not only are there matchmakers and exchanges of money, members of the support group also serve as women's "representatives" in the marriage negotiations. Furthermore, these individuals also closely monitor the sexual behaviors of women within the groups and attempt to reinforce a set of expectations surrounding appropriate relationships; namely, those that do not jeopardize the health of women's partners. Some married women feel more comfortable disclosing their status to their families than non-married women, and others feel more secure in their ability to hide their HIV status. Ideally, husbands are able to assist in meeting women's subsistence and health-related needs. And when they fall short, women are more confident in their ability to ask for help from their kin networks, knowing that they will be able to reciprocate in the future.

Not all support group-arranged marriages, however, meet women's ideals of respectability, nor do they necessarily last. While women may face intense scrutiny by group members over their sexual relationships, men's inappropriate behavior often escapes any sanction. HIV-positive marriages – just like all northern Nigerian marriages during times of profound economic and social insecurity – are fragile and can be fraught with horrific abuses. While women are fearful of entering partnerships with HIV-negative men, for some women, these relationships are preferable to those within the group, and sometimes they are unavoidable. HIV-positive women are continually pursued by men not aware of their status. Their family members, also unaware of their status, will question why they are avoiding these relationships and why they do not remarry. Their kin will attempt to arrange a new marriage, and women are limited in their ability to negotiate. Some will disclose their status, but others cannot.

Vital Continuities: Sequential Marriages and HIV

Like much of sub-Saharan Africa, Nigeria faces a generalized, heterosexual epidemic, and young, married women currently constitute one of the most visibly affected populations. Waiting rooms in HIV treatment centers, for example, are filled with women and their children. Divorcees and widows, as I have described, predominate in support groups. And, global health projects to promote HIV screening have been most successful in antenatal clinics. Not only are more married women receiving tests, epidemiological evidence has also revealed that, increasingly, young, married women are at greater risk of contracting HIV than their sexually active unmarried counterparts. How is it, scholars have asked, that married women have escaped the attention of public health practitioners for so long? In Nigeria, for example, the sexual affairs of married men attract much public attention and scorn, and it is widely assumed that their equally culpable partners are promiscuous adolescent women. Monogamous, faithful women are almost assumed to be "victims" of these immoral relationships. While these sexual dynamics certainly exist in Nigeria, it is also common for women to have multiple sexual partners. To begin to untangle the association between marital status and HIV, marriage must first be understood as a social process, not an event. The symbolic importance of marriage misleadingly suggests that these partnerships are static, stable entities over time, when in fact they are highly fluid for both men and women. Even the point at which a marriage ends is ambiguous. Northern Nigerian women will move out of and back into a single marriage, as well as will likely transition into and out of a series of marriages over their life course.

In this dissertation, I have argued that a woman's marriage does not end at the moment of her divorce or the death of her husband. Through my work with HIV-positive women who have been married multiple times, I have traced the lasting effects of household economic instability, the significance of reproduction and its disruptions, and the affective and material exchanges between husbands and wives and their broader kinship networks. I have focused in particular on the exchanges that take place over issues related to women's health. HIV infection, I have shown, is a concern that accompanies these larger social issues and magnifies their consequences for subsequent marriages.

Northern Nigerian families are deeply invested – materially, socially, and symbolically – in the marriage arrangements of their kin. Family members often introduce women to their husbands, and while women are free to reject their suitors, they often have a difficult time declining their parents' choice. These introductions are particularly important for poor families. Marriages are widely acknowledged to be a mechanism for upward social and economic mobility. Among the most popular critiques of Hausa Muslim society was how "cheap" weddings were. The driving force behind the city's high divorce rates, it was widely argued, was how inexpensive it was for young men to remarry. Most women, however, stressed the exorbitant sums of money spent on their marriages. Marriage dissolutions were driven not by the expense of weddings, but by the economic instability within households. If husbands were to fail to meet the subsistence and health needs of their wives, women without other sources of income require families who could either assist them or intervene in the marriage and demand their husbands fulfill their responsibilities to their wives. Given the fluctuations in both the husband’s income and that of her kin, threats of dissolutions intensify and abate over time. The “event” of divorce is often an elongated process of ending and re-forming a marriage. It is impossible to understand the trajectories of marriage and the transitions between marriages without recognizing the role a woman’s larger kin network plays in shaping these relationships. Women exercise their agency in both running away from their marriages in some cases and refusing to leave their marriages in others; but they do so under the constraints, resources, and relations of power that exist within these larger social networks.

A second central issue influencing the transition of a woman from one marriage to the next is her reproductive experience. A woman’s children are central to her social identity and the fulfillment of her marriage expectations. Women are expected to have children immediately upon marriage and they are scrutinized for signs of pregnancy. A healthy birth reinforces the virtues of marriage, and is the dominant form of both affective and economic exchange between a husband and wife. They are also central to the relationships women have with their co-wives. One of the fundamental ways in which women can protest their maltreatment within marriage is by calling attention to a husband’s neglect of his children. Women without children are blamed for their reproductive failure, regardless of whether it is they or their husbands who suffer infertility’s biomedical cause. It is both grounds for husbands to marry additional wives and a dominant rationale for divorce. While men can abandon wives on account of infertility without sanction, women are often constrained from vacating their marriage, despite their lack of children. Women may stress their commitment to their husband despite it being a childless marriage as a sign of their virtuous character, but they suffer its consequences both while married and after the marriage dissolves. The social organization of childcare is an important window onto the cultural and economic dynamics of women's marriage transitions. A divorce may sever the ties a woman has to her children if her husband's family takes custody of them. If she keeps their children, a husband may refuse to provide for their support. Despite these constraints, children are the center of non-married women's social lives. They may also be their sole source of economic support, as even young children can assist in generating income. Children are thus vital dimensions of the symbolic, social, and economic continuities that persist through and beyond women's marriages.

Illnesses experiences by men and women within their marriage reveal both the social dynamics that drive their dissolutions and those that fortify relationships and kin networks. As cited by almost all northern Nigerian women, one of the most important and visible signs of a good marriage is the effort couples exert to care for one another when they fall ill. At its most basic level, marriage dissolutions are averted because the quality of this care lengthens a patient's life. Like childcare, healthcare is comprised of critical symbolic, social, and economic exchanges that are expected to take place in the context of caring for partners. Islamic law requires husbands to pay for their wives' medical expenses. There are more subtle signs of the ways these obligations matter. For example, the care partners extend to one another might include participating in a series of Islamic rituals that demonstrates a man and woman's commitment to their faith as well as their health. A man takes great pride in demonstrating his authority in matters of his family's health. Whether it involves speculating on the cause of symptoms, the credentials of the doctor, or elaborate displays of wealth spent on an array of treatments, healthcare reveals fundamental dimensions of masculinity in northern Nigeria. The same is true for women: those with whom I worked emphasized the prayers they offered, the food they cooked, the indigenous healers they consulted, and much of their everyday conversations focused on matters of their family's health.

The converse, however, is also true: poor health often leads to the dissolutions of marriages. Besides the obvious possibility of a partner's death, more importantly, a woman's illness experience exposes the limitations and fractures in her marriage and within her larger kinship network. The experiences of women living with HIV, I have shown, serves as an important window onto these dynamics. For example, what happens when women know they have an illness that affects not only themselves and their husbands, but also their co-wives? The social negotiations between husbands, their families, and their wives over issues surrounding diagnoses and treatment are ones that follow a different logic than simply ignorance and awareness. An amalgam of concerns including the cost of treatment, the social threats a positive diagnosis poses, and the gendered norms about the sharing of health information, all enter into these dilemmas. Ultimately, the ways in which these concerns are resolved reveal and reinforce the different positions of power within which women are situated. With supportive and invested kin and children, women are less likely to be neglected by their husbands and their marriages are less likely to dissolve. Housing, opportunities for work, education, children, and most importantly – health – all establish a means of continuity, even as marital partnerships fluctuate. But, it is *through* marriage and larger kinship networks that women are able to access these resources and consequently assure their re-marriageability.

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