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Support Groups, Marriage, and the Management of Ambiguity among HIV-Positive Women in Northern Nigeria

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Abstract

In the context of the African HIV epidemic, support groups are not simply spaces for discussions of social and health well-being; neither are they institutions functioning solely to cultivate self-responsible and economically empowered patients. HIV-positive women in northern Nigeria have appropriated a support group to facilitate their marriage arrangements. In this group, women negotiate the threats of stigma and the promises of respectable marriage through what I call the management of ambiguity surrounding their HIV status. I further argue that the practice of support group matchmaking reveals the local political economic dynamics that shape social and illness trajectories in resource-poor settings.

Keywords

HIV/AIDS; Stigma; Support Groups; Kinship; Gender Politics; Nigeria

Introduction

On a hot, rainy day in 2004, I met with a group of non-married¹ 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

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¹This 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."

²The 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 of their husbands.

³Kano 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.

⁴All 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.

⁵This 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 in a support group in the city of Kano carried out intermittently in 2004 and 2006 through 2007.

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 manifest 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 article: 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

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

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. Others 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 very scientific terms and practices of researchers (see 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 help promote 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

⁶Interestingly, 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*].

⁷This 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.

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.

⁸This 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.

Months later, one of her close friends was getting married in the church, and Patience was obligated to attend. Having me 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

⁹During 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.

¹⁰Colossians 3:18–19.

¹¹Holland 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.

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 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

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

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

¹⁴Following 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 [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.

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

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

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 with 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 of both Muslim and Christian communities. Fundamentalist Islamic and Christian movements aimed at transforming the whole of Nigeria through 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 child-birth... 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 in 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, lines were extremely popular (most Nigerians own a cell phone). Starcomms was different from services and required that one have a second handset. 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 the gift demonstrated the appropriate amount of respect for a woman of her status. A woman might refuse to speak to a man if he did not come with a small token for her. She may send out another family member to tell him she does not have the time to speak. A man, in turn, might seek other ways to pursue a woman, such as sending her cards or love letters, expressing his interest in marriage. He sends friends and other relatives to meet with a woman’s families and gain their approval. These meetings and negotiations are met with great formality as families intensely interview men and investigate family backgrounds.

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, or 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

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

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 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 with which I worked in Kano were projects that 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. Women in the group tell others that they meet in the ARV clinic about 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 seroconcordant 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 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. While women face intense scrutiny within the group over their lives, they often lack the ability to sanction the inappropriate behaviors of male support group members. I later learned that Jummai's baby girl died shortly after she gave birth to her.

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 northern Nigerian 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 alongside 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 their partners learn of their status, and because of the obvious possibility of transmitting the virus to their partners, 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. Just as church leaders arrange and facilitate marriages, so too do these group leaders. Support group matchmaking thus enables 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 rights 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.
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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 article 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.

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¹⁹In 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).

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REFERENCES

- Agamben, G. *Homo Sacer: Sovereign Power and Bare Life*. Palo Alto, CA: Stanford University Press; 1998.
- Biehl, JG. *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton, NJ: Princeton University Press; 2007.
- Biehl JG. The Activist State: Global Pharmaceuticals, AIDS, and Citizenship in Brazil. *Social Text*. 2004; 22(3):105–132.
- Callaway, B. *Muslim Hausa Women in Nigeria: Tradition and Change*. Syracuse, NY: Syracuse University Press; 1987.
- Callaway, B.; Creevey, L. *The Heritage of Islam: Women, Religion, and Politics in West Africa*. Boulder, CO: Lynne Rienner; 1994.
- Carpenter LM, Kamali A, Ruberantwari A, Malamba SS, Whitworth JA. Rates of HIV-1 Transmission within Marriage in Rural Uganda in Relation to the HIV Sero-status of the Partners. *AIDS*. 1999; 13(9):1083–1089. [PubMed: 10397539]
- Clark S. Early Marriage and HIV Risks in Sub-Saharan Africa. *Studies in Family Planning*. 2004; 35(3):149–160. [PubMed: 15511059]
- Cohen, A. *Custom and Politics in Urban Africa*. Berkeley: University of California Press; 1969.
- Coles, CM.; Mack, BB., editors. *Hausa Women in the Twentieth Century*. Madison, WI: University of Wisconsin Press; 1991.
- Collier, SJ.; Ong, A., editors. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Malden, MA: Blackwell Publishing; 2005.
- Comaroff J. Beyond Bare Life: AIDS, (Bio)Politics, and the Neoliberal Order. *Public Culture*. 2007; 19(1):197–219.
- Comaroff J, Comaroff JL. Millennial Capitalism: First Thoughts on a Second Coming. *Public Culture*. 2000; 12(2):291–343.
- Das V, Addlakha R. Disability and Domestic Citizenship: Voice, Gender, and the Making of the Subject. *Public Culture*. 2001; 13(3):511–532.
- Epstein, S. *Impure Science: AIDS, Activism, and the Politics of Knowledge*. Berkeley: University of California Press; 1996.
- Ferguson J, Gupta A. Spatializing States: Toward an Ethnography of Neoliberal Governmentality. *American Ethnologist*. 2002; 29(4):981–1002.
- Foucault, M. *The History of Sexuality: An Introduction*. Vol. 1. New York: Vintage; 1978.
- Ginsburg, FD. *Contested Lives: The Abortion Debate in an American Community*. Berkeley: University of California Press; 1989.
- Hirsch JS, Meneses S, Thompson B, Negroni M, Pelcastre B, del Rio C. The Inevitability of Infidelity: Sexual Reputation, Social Geographies, and Marital HIV Risk in Rural Mexico. *American Journal of Public Health*. 2007; (97):986–996. [PubMed: 17463368]
- Kelly RJ, Gray RH, Sewankambo NK, Serwadda D, Wabwire-Mangen F, Lutalo T, Wawer MJ. Age Differences in Sexual Partners and Risk of HIV-1 Infection in Rural Uganda. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 2003; 32(4):446–451.
- Levy JM, Storeng KT. Living Positively: Narrative Strategies of Women Living with HIV in Cape Town, South Africa. *Anthropology & Medicine*. 2007; 14(1):55–68.
- Lyttleton C. Fleeing the Fire: Transformation and Gendered Belonging in Thai HIV/AIDS Support Groups. *Medical Anthropology*. 2004; 23(1):1–40. [PubMed: 14754666]
- Masquelier, A. How is a Girl to Marry Without a Bed? Weddings, Wealth, and Women's Value in an Islamic Town of Niger. In: van Binsbergen, W.; van Dijk, R., editors. *Situating Globality: African Agency in the Appropriation of Global Culture*. Leiden: Brill; 2004. p. 220-256.
- Martin, E. *Flexible Bodies: Tracking Immunity in American Culture from the Days of Polio to the Age of AIDS*. Boston: Beacon Press; 1994.

- Nguyen, VK. Antiretroviral Globalism, Biopolitics, and Therapeutic Citizenship. In: Ong, A.; Collier, S.J., editors. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. London: Blackwell; 2005. p. 124-144.
- Office of the United States Global AIDS Coordinator [OGAC]. [November 1, 2008] Care for People Living with HIV/AIDS. 2008. Accessed from www.pepfar.gov/documents/organization/84863.pdf on
- Office of the United States Global AIDS Coordinator [OGAC]. [November 1, 2008] The President's Emergency Plan for AIDS Relief: US Five-Year Global HIV/AIDS Strategy. 2004. Accessed from www.state.gov/documents/organization/29831.pdf on
- Parikh SA. The Political Economy of Marriage and HIV: The ABC Approach, Safe Infidelity, and Managing Moral Risk in Uganda. *American Journal of Public Health*. 2007; 97(7):1198-1208. [PubMed: 17538057]
- Petryna, A. *Life Exposed: Biological Citizenship after Chernobyl*. Princeton, NJ: Princeton University Press; 2002.
- Pittin, RI. *Women and Work in Northern Nigeria: Transcending Boundaries*. Basingstoke: Palgrave Macmillan; 2002.
- Pittin, RI. Houses of Women: A Focus on Alternative Life-Styles in Katsina City. In: Opong, C., editor. *Female and Male in West Africa*. London: George Allen and Unwin; 1983. p. 291-302.
- Porter L, Hao L, Bishai D, Serwadda D, Wawer M, Lutalo T, Gray R. HIV Status and Union Dissolution in Sub-Saharan Africa: The Case of Rakai, Uganda. *Demography*. 2004; 41(3):465-482. [PubMed: 15461010]
- Rabinow, P. *Essays on the Anthropology of Reason*. Princeton, NJ: Princeton University Press; 1996.
- Rabinow, P. Artificiality and Enlightenment: from Sociobiology to Biosociality. In: Cray, J.; Kwinter, S., editors. *Zone 6: Incorporations*. New York: Bradbury Tamblin and Boorne Ltd; 1992. p. 234-252.
- Rapp, R. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. New York: Routledge; 2000.
- Rapp R, Ginsburg F. Enabling Disability: Rewriting Kinship, Reimagining Citizenship. *Public Culture*. 2001; 13(3):533-556.
- Renne EP. Polio and Associations for the Disabled in Nigeria. *Journal of the International Institute*. 2006; 13(2):8-9.
- Renne, EP. Gender Roles and Women's Status: What They Mean to Hausa Muslim Women in Northern Nigeria. In: Szreter, S.; Sholkamy, H.; Dharmalingam, A., editors. *Categories and Contexts: Anthropological and Historical Studies in Critical Demography*. Oxford: Oxford University Press; 2004. p. 276-294.
- Robins S. From 'Rights' to 'Ritual': AIDS Activism in South Africa. *American Anthropologist*. 2006; 108(2):312-323.
- Robins S. Long Live Zackie, Long Live': AIDS Activism, Science and Citizenship after Apartheid. *Journal of Southern African Studies*. 2004; 30(3):651-672.
- Rose, N.; Novas, C. Biological Citizenship. In: Ong, A.; Collier, S.J., editors. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. London: Blackwell; 2005. p. 439-463.
- Schatz E. 'Take Your Mat and Go!': Rural Malawian Women's Strategies in the HIV/AIDS Era. *Culture, Health & Sexuality*. 2005; 7(5):479-492.
- Schildkrout, E. Widows in Hausa Society: Ritual Phase or Social Status?. In: Potash, B., editor. *Widows in African Societies: Choices and Constraints*. Palo Alto, CA: Stanford University Press; 1986. p. 131-152.
- Schildkrout, E. Dependence and Autonomy: The Economic Activities of Secluded Hausa Women in Kano. In: Opong, C., editor. *Female and Male in West Africa*. London: George Allen and Unwin; 1983. p. 107-126.
- Serwadda D, Gray RH, Wawer MJ, Stallings RY, Sewankambo NK, Konde-Lule JK, Lainjo B, Kelly R. The Social Dynamics of HIV Transmission as Reflected through Discordant Couples in Rural Uganda. *AIDS*. 1995; 9(7):745-750. [PubMed: 7546420]

- Smith DJ. Modern Marriage, Men's Extramarital Sex, and HIV Risk in Southeastern Nigeria. *American Journal of Public Health*. 2007; 97(6):997–1005. [PubMed: 17463366]
- Smith KP, Watkins SC. Perceptions of Risk and Strategies for Prevention: Responses to HIV/AIDS in Rural Malawi. *Social Science and Medicine*. 2005; 60(3):649–660. [PubMed: 15550312]
- Smith MG. The Hausa System of Social Status. *Africa*. 1959; 29:239–252.
- Solivetti LM. Family, Marriage, and Divorce in a Hausa Community: A Sociological Model. *Africa*. 1994; 64(2):252–271. [PubMed: 12320089]
- UNAIDS. [June 1, 2008] Report on the Global AIDS Epidemic. 2006. Accessed from data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN2_en.pdf on
- Wardlow H. Men's Extramarital Sexuality in Rural Papua New Guinea. *American Journal of Public Health*. 2007; 97(6):1006–1014. [PubMed: 17463367]
- Whyte, SR.; Whyte, MA.; Meinert, L.; Kyaddondo, B. Treating AIDS: Dilemmas of Unequal Access in Uganda. In: Petryna, A.; Lakoff, A.; Kleinman, A., editors. *Global Pharmaceuticals: Ethics, Markets, Practices*. Durham, NC: Duke University Press; 2006. p. 240-262.