

**AIDS the Islamic Way:
Treatment, Masculinity, and Ethics of Care in Northern Nigeria**

by

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DEDICATION

To Harold Gatewood,
who has seen me through from beginning to end.

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Abstract

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This dissertation is an ethnographic account of the AIDS epidemic among Muslims in Northern Nigeria. Based on research among HIV-positive people in clinical and support group settings and with different types of healing practitioners who treat them, I examine how the transmission, treatment, and care of HIV/AIDS are imagined and enacted in the region. My research demonstrates how Northern Nigerians draw upon the moral authority of Islam to make assertions about where HIV/AIDS comes from, what obligations arise from the disease, and how it should be prevented and treated. The research further reveals that despite recent efforts to assert a unified Islamic response to AIDS, substantive disagreements persist over how to intervene in the epidemic, which treatments are most efficacious, and how those living with disease should be morally evaluated.

This dissertation makes four main scholarly contributions. First, it advances the critical medical anthropology of infectious disease and global health programs by demonstrating the interaction of micro- and macro-level forces that affect the AIDS epidemic in a specific cultural context. I do this by analyzing local responses to the United States President's Emergency Plan for AIDS Relief, a program that has

significantly improved the life prospects of HIV-positive people. Second, I examine how patients negotiate different healing systems this era of expanding therapeutic options with an account of the expansion of Islamic prophetic medicine in the region. I show how this is linked to the broader Islamic reorientation of Northern Nigerian society since 2000.

Third, I contribute to studies of masculinity and health with in-depth accounts of the lives of HIV-positive Muslim men, demonstrating how HIV infection paradoxically brings about heightened obligations and opportunities to achieve ideal masculinity. I demonstrate, however, how these same masculine expectations have foreclosed upon addressing the epidemic among men who have sex with men, and argue that this has broad social and epidemiological implications in a society where heterosexual marriage is compulsory.

Fourth, I conclude the dissertation by proposing several culturally appropriate interventions that would lessen the burden of the epidemic in Northern Nigeria.

Chapter 1: Introduction

The title and subject of this dissertation, 'AIDS the Islamic way', arose from a conversation I had in 2007 during my first research trip to Kano, Northern Nigeria's largest and oldest city. Interested in meeting people living with the human immunodeficiency virus (HIV), I visited the office of an HIV support group about which I had learned from the local office of a national Nigerian AIDS organization. Arriving unannounced at the support group's office on a Wednesday afternoon, I happened to meet Fahad, the group's vice president, a man in his mid-thirties wearing the customary Hausa long men's kaftan [*dogon riga*] and matching cap [*hula*]. I explained that I had come to Nigeria to study the AIDS epidemic and he agreed to talk to me.¹

"I got HIV the Islamic way," Fahad told me, half-smiling, as we sat under the shade of a neem tree in the office's walled courtyard.² Noticing a look of curiosity on

¹ I use pseudonyms for people and places throughout the dissertation and alter certain identifying characteristics to preserve the anonymity of research participants. The exception to this is public officials who agreed to have their names used.

² *Na samu HIV ta hanyar Musulunci* in the original Hausa. English is Nigeria's national language, but Hausa is the *lingua franca* of Northern Nigeria and the country's most widely spoken indigenous language. I estimate that 85% of the interviews and speech recounted in fieldnotes in the dissertation were in Hausa. For the sake of readability I translate into English and only give the original Hausa phrases uttered parenthetically when I think they would be of particular socio-linguistic interest to Hausa speakers. I use standard quotation marks when speech was directly transcribed from a recorded interview, or by hand when I wrote speech down word-for-word in field notes. When I recall the gist of what someone said rather than a word-for-word account, I use single quotations.

my face, he continued by elaborating on what he meant: He had married a second wife who, unbeknownst to him at the time of their marriage, was HIV-positive. This new wife subsequently infected him with HIV. Before he became aware of her HIV status or his own HIV seroconversion, he also unknowingly infected his first wife, to whom he was also still married. His second wife subsequently died of AIDS, leaving behind several children from her first marriage and from her marriage to him. He later learned that his second wife's previous husband had died of AIDS.

When Fahad said that he'd gotten "HIV the Islamic way", it seemed a pithy, if darkly ironic, aphorism. He also affirmed his acceptance of God's irrefutable will in the matter. Many Muslims presume that following Islamic tenets will protect against HIV infection. But as Fahad implied, doing something considered properly Islamic and therefore morally praiseworthy in his community—in his case, marrying a widow as a second wife—constituted the grounds for HIV transmission to himself and other members of his family.

This dissertation is an ethnographic account of the many ways that Islam and HIV/AIDS are interrelated in Northern Nigeria. The main question I pose is: *how are HIV/AIDS transmission, treatment, and care imagined and enacted among Muslims in Northern Nigeria?* My principal argument throughout is that Muslims in Northern Nigeria understand and respond to the AIDS epidemic in ways that reflect their local social-moral order. They draw upon the authority of Islam to make assertions about where AIDS comes from, what moral obligations arise from the disease, and how it should be prevented and treated.

Yet despite recent efforts to assert a unified Islamic perspective on HIV/AIDS, substantive disagreements persist over how to intervene in the epidemic, which treatments are most efficacious, and how those living with the virus should be cared for and morally evaluated. I explain how the Islamic response to AIDS in Northern Nigeria is created and contested by Islamic scholars and organizations, government officials, biomedical practitioners and other healers, and HIV-positive people, all of whom have stakes in which practices and discourses about the epidemic prevail. The dramatic recent expansion of international AIDS programs in Nigeria further demonstrate how the Islamic response has been forged not only through religious doctrine and practice, but also through transnational flows of discourse, policy, and material resources.

This dissertation illuminates how religious ideologies, historical and political-economic processes, assumptions about illness and healing, and social practices together shape the AIDS epidemic in Northern Nigeria. I focus on three constitutive issues where the relationship between HIV/AIDS and Islam is most crucial.

First, *what treatments do HIV-positive Muslims pursue? What organizes the region's therapeutic economy of AIDS?* Northern Nigeria is a medically pluralistic society. People seek betterment for their afflictions from biomedicine and also from healers working in traditions of prophetic medicine and with natural products prescribed in Islamic texts. There has been a dramatic expansion of Islamic scholars working in the traditions of prophetic medicine since 2000, concomitant with the institutionalization of Shari'a law in the northern states. Over the past decade there

has also been a massive therapeutic migration to biomedical treatment of HIV/AIDS as foreign aid programs have made these treatments more widely available. In this context, how have Muslims conceptualized Islamically suitable therapy for HIV/AIDS, and how has this changed in response to expanded treatment options?

Second, *how do religious ideals and cultural practices of gender, sexuality, and family affect the epidemic?* In Nigeria, 90% of primary HIV infections occur sexually. (Nigerian Agency for the Control of AIDS 2012: 23) Northern Nigeria is a highly married society, where proper Islamic marriage sets the bounds of morally permissible sexuality. At the same time, divorce and remarriage rates are very high, and polygyny is socially idealized among men. Men's and women's roles, obligations, and prerogatives within marriage are distinct. In this context, how are locally enacted rules of Islamic sexuality and marriage protective of HIV transmission? Conversely, how do these rules set the conditions for transmission? And how has HIV transmission and treatment been addressed for those who transgress religiously sanctioned sexuality?

Third, *how have Northern Nigerian Muslims imagined and enacted care for people with HIV/AIDS?* Northern Nigeria is a deeply religious region where people strive to bring their society and their individual lives into accordance with the teachings of their faith. As the AIDS epidemic is recent and was thus not discussed directly in Islamic scripture, Northern Nigerian Muslims have endeavored to make sense of and respond to the epidemic in ways that they understand as consistent with Islam. In this context, how have Muslims understood and practiced medical and social care for HIV-positive people? What do HIV-positive people themselves

understand as their obligations to enact self-care the care of others who have HIV, and how do they meet these obligations?

Theoretical framework

Locating "tradition" in African AIDS care

Anthropologists have conducted research on ethnomedicine—"native" medical systems, including categories and etiological models of illnesses, symptoms, courses of sickness, and treatments (Kleinman 1978; 1980)—for nearly a century. While ethnomedicine was never the exclusive focus of early 20th century monographs, it was sometimes considered as a piece in the holistic study of a given culture. Early ethnographic studies of ethnomedicine focused on witchcraft, illnesses caused by supernatural forces, and the folk healers and shamans who mediated these forces on behalf of the afflicted.

E.E. Evans-Pritchard's 1937 *Witchcraft, Oracles, and Magic Among the Azande* remains respected by subsequent generations of anthropologists for its nuanced relativism about the "correctness" of Zande causality beliefs and for theorizing the cultural specificity of conceptions of misfortune and harm more broadly. In shifting the analytic focus away from the objective validity of Zande philosophy, Evans-Pritchard demonstrated how belief in the force of witchcraft was coherent and rational in the context of Azande society, supplying the Azande with an explanatory link between two events that would be causally independent from a Western scientific perspective.

Robin Horton's (1967a; 1967b) influential, if controversial, comparison of "African traditional thought" and Western scientific thought followed Evans-Pritchard's trajectory. Horton argued that modern Western scientific explanation is "open" insofar as alternatives to established theoretical tenets are recognized and incorporated; traditional African thought, by contrast, is "closed" such that appeals to personal and spiritual entities for explaining reality limit the ability to see beyond one's own social context. Other scholars have critiqued prevailing conceptions of 'tradition' in social science, arguing that such conceptions are problematic to the extent that they presume an unchanging core of ideas and customs handed down from the past (Handler and Linnekin 1984). In a similar vein, Eric Hobsbawm (1983) investigated the social construction of 'tradition', arguing that many seemingly longstanding traditions are in fact invented to justify the existence and importance of nation states and their dominant institutions.

Ethnographic research on the etiological beliefs and healing practices of "native" populations was also put to the service of colonial officials, whose "civilizing" project included the prohibition of "irrational" native medicine and the control of colonized populations with biomedical technology (Vaughan 1991). Medical pluralism, the coexistence (and frequently the comingling) of two or more healing systems, occurs in virtually all societies where biomedicine is practiced. Only later—and still partially, given the dominance of biomedicine in many parts of the world—has cultural relativism yielded recognition that biomedicine is itself a form of ethnomedicine (Rhodes 1996). This insight built on the ethnographic research of Latour and Woolgar, which demonstrates how “the daily activities of

working scientists lead to the construction of scientific facts" in research laboratories (1979: 40).

Considering the previous anthropological engagement with ethnomedicine and disease epidemics, anthropologists were not surprisingly among the first researchers to write about African indigenous healers and AIDS. Whereas many African health officials in the 1980s and 1990s derided traditional healers, and some countries have attempted to prohibit them from practicing (Swarns 1999), anthropologists since the early days of the African pandemic have advocated for the utility of traditional healers' involvement in both HIV prevention and AIDS treatment.

Charles Good (1988) was the first of several anthropologists to advocate for traditional healers' participation in HIV/AIDS initiatives, on the grounds that traditional healers are "geographically and functionally well-situated" to address the disease (97). More importantly, Good argued, traditional healers were already involved in treating people with HIV/AIDS since for many Africans, "self-treatment, visits to [traditional healers], and resort to biomedical services may occur serially or concurrently during episodes of the same illness" (Good 1988: 100). Since traditional healing and Western-styled biomedical services are highly interconnected for many Africans seeking healthcare, Good viewed traditional healers as "both subjects and agents of change: they participate in an on-going, essentially unsystematic process in which they variously "borrow", reinterpret, and apply selected biomedical ideas and practices—including the use of mass-produced drugs—in everyday contacts with patients" (1988: 100).

Good's assessment of traditional healers as "both subjects and agents of change" was elaborated by medical anthropologist Brooke Schoepf, who has written prolifically on African traditional healers' engagement with AIDS. Preferring to keep 'traditional healers' in quotation marks due to the confusion the term evokes, Schoepf queried the very meaning of "traditional" in relation to healers—and the implicit dichotomy that such a designation sets up with "modern" biomedicine. Echoing Hobsbawn, Schoepf argued that "traditional" healers are constantly *reinventing* tradition, and doing so in ways "that demonstrates to biomedical practitioners that they are in possession of knowledge which is unassailable by "modern", i.e. biomedical, criteria" (1992: 232; see also West 2006). "African healing methods and theory", she argued, "have not remained frozen in a timeless ethnographic present, but have changed and adapted with the times." (1992: 232) In the findings of her research in Zaire (today the Democratic Republic of the Congo), Schoepf emphasized the role that healers might play in HIV prevention, particularly in counseling risk assessment and condom use.

Schoepf acknowledged that healers have not always been perfect partners in HIV prevention, and that healers unknowledgeable about the disease sometimes echo common cultural misconceptions, such as the belief that patients could rid themselves of AIDS by transmitting it to others. Nevertheless, she argued that given appropriate training, healers are valuable sexual behavior change agents for several reasons. Most importantly, they were an authoritative presence for many in people in Zaire and were regularly consulted for sexual and reproductive health disorders.

They also often played roles as advisors and decision-makers in relations between sexual partners (1992: 234).

Like Schoepf, Edward Green argued that healers are well positioned to play a role in HIV prevention by encouraging condom use, partner reduction, and other behavior change. But Green put greater emphasis on healer's roles in another factor affecting HIV transmission: other sexually transmitted diseases. Sub-Saharan Africans suffer inordinately from common STDs like gonorrhea, syphilis, chlamydia, and cancrroid, and having another STDs makes someone already infected with HIV many times more infectious to others due to viral shedding and genital sores. Moreover, for an HIV-negative person with another STD, the risk of becoming infected by an HIV-positive partner is several times greater both because STDs weaken the immune system and provide a physical passageway for infection.

Green argued that efforts to limit the heterosexual transmission of HIV in Africa should emphasize the treatment of other STDs (1994: 7). Rather than assuming that exotic sexual practices or promiscuity are the cause of Africa's high rates of AIDS and other STDs (e.g. Hrdy 1988), Green pointed to larger structural and biological determinants, including "a chronic shortage of funds and personnel for STD prevention and treatment that constrain virtually all health programs in Africa, reluctance on the part of STD sufferers to consult medically trained personnel, inappropriate self-medication, and growing antimicrobial resistance to standard antibiotics such as penicillin" (Green 1994: 11).

Since, as Green noted, most Africans do not access Western-styled biomedical treatment for symptomatic STDs, "indigenous practitioners"—Green's preferred

terminology for ‘traditional healers’—are the first points of contact for many STD sufferers. Moreover, such practitioners are often successful in treating STDs using a combination of herbal remedies and modern antibiotics. To contain the spread of STDs, and hence HIV, he argued for programs to teach indigenous practitioners to the rudiments of diagnosing major STDs (Green 1994:238). He further asserted that in HIV-endemic countries indigenous practitioners be authorized to proscribe antibiotics—a position that has been met with heavy resistance by many medical doctors and political officials in Africa. “The problem [of AIDS in Africa] is extreme,” argued, “therefore a radical solution is justified” (Green 1994: 245).

More recently, anthropologists have turned to considerations of how the knowledge and power of so-called traditional healers in Africa are “inextricably bound up with *their transgressions of* boundaries between categories such as “indigenous”, “scientific”, “traditional”, and “modern” (West 2006: 24). Collaborations between biomedical and traditional practitioners, while often fraught with mutual suspicion and a sense of competition, have also brought about “shifts in the meaning of traditional medicine, in the position of healers and medicine within the state”, and in the practices that national and international organizations sanction as healing (Langwick 2011: 71).

This dissertation contributes to scholarship on traditional healers and AIDS in Africa with a historically informed ethnographic account of Islamic prophetic medicine in Northern Nigeria. Throughout the region and for much of the epidemic, naturopaths and Islamic scholars (*malamai*) working in the traditions of prophetic medicine were the first resort to care for many people suffering from HIV/AIDS.

Many of these practitioners have maintained that they can cure HIV/AIDS, premising this assertion on the Qur'anic tenet that every disease has a cure. Biomedical practitioners and others have refuted this claim with alternative scriptural exegeses.

Some *malamai* have responded to the increasing therapeutic dominance of antiretroviral therapy (ART) by leveling criticisms against the drugs and those that have made them available. Many nevertheless draw upon biomedical idiom and quasi-clinical practice in an attempt to remain authoritative and profitable in the therapeutic economy of HIV/AIDS. Yet their attempts have yielded limited success as HIV-positive Muslims have overwhelmingly migrated to ART (where these drugs have become available). My research shows how historical and political processes, scriptural exegeses, and the arrival of new therapies converge to determine which therapeutic strategies are considered Islamically orthodox in Northern Nigeria.

AIDS, citizenship, and global health programs

Medical anthropology has generally oriented towards applied research to address health issues in specific cultural contexts. Particularly in the field's formative years in the mid-twentieth century, explanatory models of illness tended to be narrowly focused on the local level and emphasized how ecological conditions, cultural configurations, and psychological factors affected health-related beliefs and behaviors (Singer 2004: 24). These emphases on local ecology, culture, and psychology reflected the larger discipline's tendency, at the time, to represent

cultures in small-scale societies as self-contained systems little affected by outside forces.

Without dismissing the contributions of localized analyses of illness and healing, in the 1980s medical anthropologists began shifting attention to how health and illness in particular cultural settings are affected by the “vertical links” that connect the social group under study to larger regional, national, and global factors (Mullings 1987). This *critical* approach to medical anthropology emphasizes how health and illness are inexorably linked to larger, historically delineated political-economic contexts (Morsy 1996). The shift reflected greater analytic attention in anthropology at large to how local cultures are shaped by history, incorporation into regional and global economic systems, social ideologies, and the machinations of power (e.g. Wolf 1992).

From the vantage of critical medical anthropology, illness and suffering are not only embodied by the individual; they are also inexorably linked to the social body and to the body politic (Scheper-Hughes and Lock 1987). This approach has been particularly useful for understanding a pandemic as infectious and politically galvanizing on the global scale as AIDS. AIDS discourses, programs, and medications are crossing geo-political boundaries with increasing speed. That the experiences of people living with HIV/AIDS are shaped by not only by local cultures and belief systems, but also through the maneuverings of nation-states and the global political economy, is increasingly apparent (Farmer 1999; Barnett and Whiteside 2003; O’Manique 2004; Biehl 2007; Fassin 2007; Padilla 2007; Nguyen 2010; Peterson 2012).

Biopower, the "numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" by the modern nation-state (Foucault 1976: 140), is one lens through which HIV-positive people's experiences can be considered in the global system—particularly as the AIDS pandemic has become reframed as an issue of 'international security' (Elbe 2004). Michel Foucault's original coinage of the term referred to the increasing preoccupation of nineteenth century European states with controlling their populations, which he argued operated both on the population level and on the level of individual bodies.³ In the era of AIDS we can see the workings of biopower in education campaigns to prevent transmission, state regulation and criminalization of sexuality, and the management of HIV in individual bodies and at the population level through antiretroviral therapy, to name a few.

However, as Vinh-Kim Nguyen points out, the biopolitical technologies deployed to control HIV in contemporary African contexts are "a curious, "nongovernmental" biopower that disseminates through a patchwork of international organizations and community groups" (2010: 113). In many contemporary African nations, the deployment of AIDS technologies occurs largely

³ Megan Vaughn has "argued that the history of 'bio-power' in colonial Africa was rather different from that described by Foucault for Europe. The fundamental difference was that Africans were always conceived of as members of a collectivity as colonial people, and beyond that as members of collectivities in the forms of 'tribes' or cultural groups." (1991: 202). Ann Stoler counters that, "Vaughan misses just this point that nineteenth-century biopower represented a shift toward the regulation of the social body, toward the normalization of collective identities, and away, from individualizing disciplinary regimes. Vaughn dismisses Foucault's account precisely because she understands biopower to be a form of individualization rather than collective regulation." (1995: 33 n.39)

outside the parameters of 'the state', narrowly defined. Instead, foreign governments, international organizations, NGOs, and private actors seek to achieve specific health goals independently of a systematic government-monitored approach to public health (Lock and Nguyen 2010: 18-9). In contemporary African contexts, this has resulted in what Duana Fullwiley (2004) calls "discriminate biopower", whereby the funding prerogatives of international organizations, NGOs, and foreign governments prioritize certain diseases, while leaving others that local people see as more critical unaddressed.⁴

Nguyen instead advances the notion of 'therapeutic citizenship', a "thin citizenship, solely focused on a particular disease [...] that arises where large, stable institutions that can grant access to life-saving therapy are absent" (2010: 109). Based on his ethnographic research in Burkina Faso and Cote-d'Ivoire in the late 1990s, Nguyen argues that therapeutic citizenship was "fashioned from the ground up, in everyday life" (134) as patient-activists in Africa living with HIV "developed a powerful sense of rights and responsibilities inherent to their medical predicament" (9). Therapeutic citizenship furthermore constitutes "the linkage of practices, commodities, and bodies" that "confers on individuals specific rights (to health, in this case) as well as responsibilities (such as not infecting others)" (186).

Nguyen joins other anthropologists in analyzing how HIV can constitute the grounds for claims to political belonging and material security (e.g., Comaroff 2007; Robins 2006; Ticktin 2006). However, his account shifts the emphasis away from

⁴ Elisha Renne's (2010) ethnography of resistance on the part of some Northern Nigeria Muslims to the Global Polio Eradication Initiative is a prime illustration of discriminate biopower and its effects.

the state, "in places where the state does not reliably carry out biopolitical functions associated with ensuring population health" (Nguyen 2010:186). This analysis resonates with the situation in Nigeria; where government measures to address population health, including sanitation programs, maternal and child health initiatives, the control of endemic diseases, and road safety, remain grossly inadequate. With among the world's very worst government health systems, the state's effects on its population in Nigeria are felt more through *absence* than through intervention.

In this context, tens of billions of dollars for HIV/AIDS treatment and prevention have flowed into the country over the past decade, primarily from the United States President's Emergency Plan for AIDS Relief—the largest bilateral program to address a single disease in history. This dissertation advances the critical medical anthropology of infectious disease and global health programs by demonstrating how responses to the AIDS epidemic in Northern Nigeria are connected to larger national and global flows of capital, knowledge, and resources. Crude oil accounts for more than 98% of export earnings and about 83% of federal government revenue in Nigeria. By far the biggest importer of Nigerian oil, the United States has key interests in maintaining enough political stability in Nigeria to assure uninterrupted access to this natural resource. I maintain that the dynamics of Nigerian client-U.S. patronage that organize the control of Nigeria's vast oil resource are a necessary starting point for understanding the pivotal role the United States government plays in AIDS intervention in Nigeria.

Moreover, in Northern Nigeria *religious* power and membership are also

critical in shaping understandings and experiences of HIV treatment. The therapeutic migration to biomedical therapy has involved a process I call *the Islamification of ART*: Islamic organizations, biomedical practitioners, and Muslims living with HIV/AIDS have striven to reconcile therapeutic adherence with religious adherence. In so doing they come to frame ART as the Islamically requisite treatment for HIV. However, dissenting perspectives on the efficacy and acceptability of ART on the part of *malamai* working in the tradition of Islamic prophetic medicine persist.

Masculinity, sexuality, and AIDS in Africa

HIV is primarily sexually transmitted; Islam, like most religions, regulates sexuality. Many Muslims see the disallowance of sexuality outside of proper Islamic marriage as protective against the transmission of HIV and other sexually transmitted infections (STIs). Insofar as Islamic tenets concerning sexuality—normalized in social practice—deter sexual behaviors, contexts, and couplings that may be conducive of the spread of HIV, adherence to Islam has the potential to curtail the AIDS epidemic.

Of course, there is a distinction between what sacred texts and religious scholars indicate that Muslims should and should not do sexually, and what people *actually* do. Islam provides a template for sexual behavior, but adherents often diverge from these dictates. These divergences are consequential for all sorts of reasons: some that have to do with the risk of viral transmission from specific sexual behaviors; and some that have to do with the social taboo of *addressing*

transmission through sexual behaviors that are outside the bounds of permissible sexuality.

In this dissertation I consider how breaking the rules of sexuality set the condition for HIV transmission. I am equally concerned, however, with how *the rules themselves*, as interpreted and practiced in Northern Nigeria, also sometimes constitute the conditions for HIV transmission. As Fahad's story and his assertion that he "got HIV the Islamic way" indicate, one can live according to the rules of Islam as they are normalized in one's society and still become infected with HIV.

Gender, related to but not reducible to sexuality, is another domain where the relationship between AIDS and Islam is most evident. Islamic scripture makes demands of Muslims irrespective of gender, but it also establishes rights and obligations that are specific to men and women. In the context of family life, a man's responsibility is to financially support his wife and children; a woman's primary responsibility is to fulfill the roles of wife and mother (Ahmed 1992).

The AIDS epidemic is virtually incomprehensible without an analysis of gender. Cultural factors including imbalances of power in sexual relationships, sexual violence against women, and norms about numbers of sexual partners powerfully shaped epidemics, particularly across Africa where heterosexual sex is the main route of transmission. Relatedly, women's economic dependence and lack of control over assets relative to men contributes to the gendered context of sexual transmission. Differences in occupational roles of men and women and the risks of infection posed by certain occupations further shape the epidemic. Physiologically,

women are many times more vulnerable to HIV infection through vaginal-penile intercourse than men are.

In this dissertation, I focus on Muslim men and how ideal masculinity in Northern Nigeria is implicated in the AIDS epidemic. Despite the voluminous social science literature on AIDS in Africa and growing attention to African masculinity (Lindsay and Miescher 2003; Ouzgane and Morrell 2005), there have been relatively few accounts that focus explicitly on HIV-positive African men's experiences living with the disease. There are at several reasons for this.

First, although studies of masculinity and health have become increasingly common in recent years, masculine gender remains largely unmarked and underexplored in gender studies as a whole. While there has been increasing recognition of the fact that that men are just as "gendered" as women, the often implicit employment of 'gender' to mean 'women' continues in AIDS research and programming. The gender-specific causes of HIV vulnerability among men have considered been much less often (Green and Ruark 2011: 187). Signifiers of masculinity such as independence, self-reliance, physical strength, toughness, risk taking, emotional detachment, and sexual prowess are crucial to understanding the gendered dynamics of health-related beliefs and behaviors generally (Courtenay 2000). The exclusion of masculine gender from analyses of HIV vulnerability is all the more striking because most transmission occurs in the highly gendered context of sexual behavior.

A second explanation for why there have been fewer accounts of African men with HIV/AIDS is that African epidemics have disproportionately affected women.

Around three quarters of all women in the world living with HIV are in sub-Saharan Africa. In 2009, there were around 12 million women living with HIV and AIDS in sub-Saharan Africa, compared to 8.2 million men (Joint United Nations Programme on HIV/AIDS 2010). The African situation is thus the inverse of epidemics in much of the rest of the world, where the disease has disproportionately affected men, particularly men who have sex with other men. African women's higher HIV prevalence compared to African men in the context of a largely heterosexual African pandemic is related to the fact that females are more biologically susceptible to infection than men from vaginal-penile intercourse. African women's generally lower social and economic standing relative to African men also contributes to their higher risk of contracting HIV.

A third explanation for why the experiences of African men living with HIV/AIDS have been less well examined than those of African women pertains to assumptions about the gendered differences of moral culpability in the epidemic and resulting gendered differentials in sympathy that HIV-positive men and women evoke. In popular accounts of AIDS in Africa women have generally been cast as innocent victims of the epidemic.⁵ Conversely, African men have frequently been framed, implicitly or explicitly, as culpable in spreading the virus to wives and girlfriends as a result of their philandering.

⁵ Not all African women living with HIV/AIDS evoke the same sympathy, however. Female prostitutes and other women who "cheat" the patriarchal control of women's sexuality by having concurrent sexual relationships with different partners have been subject to censure not faced by "virtuous" women.

Lastly, putting a woman's face or a child's face on HIV/AIDS makes it more fundable (Hirsch 2010). The AIDS pandemic in Africa has received tens of billions of dollars in funding from international, bilateral, and non-governmental organizations. Constructing representations of the crisis that garner sympathetic response is particularly important in the contexts of AIDS "donor fatigue", and as global health funding priorities shift away from the protracted and expensive AIDS challenge to other health problems seen as more cost-effective to address. Because men are often perceived as "tough", and because they are often cast as perpetrators rather than victims of AIDS, men with HIV/AIDS are unlikely to garner the same sympathy (and hence charitable response) as women and children.

Several notable contributions in recent years have begun to reverse the underrepresentation of African men's experiences of HIV/AIDS. Anthony Simpson's (2009) life history-centered ethnography of Zambian men, masculinity and HIV risk is the most fully realized of these new accounts. Recognizing the value of women-centered analysis in the epidemic (e.g., Reid 1997), Simpson builds the case that constructions of masculinity that demand the performance of sexual prowess render both men and women vulnerable to HIV infection. Central to his investigation is the exploration of "the power men exercise over women, but also the power of ideologies of masculinity that imprison men" in gendered sexual behaviors that may ultimately prove consequential for HIV transmission (Simpson 2009: 10).

Beginning from the fact that husbands and long-term partners pose the greatest risks of contracting HIV for many women around the world, contributors to

the critical comparative ethnography, *The Secret: Love, Marriage, and HIV*, focus on men's extramarital sex as "a fundamental aspect of social organization" across their field sites (Hirsch et al. 2009: 13). In his chapter examining male infidelity and modern marriage in southeastern Nigeria, for instance, Daniel Jordan argues "that particular aspects of the performance of infidelity have become important markers of class position and masculinity", and that these contribute to the spread of HIV (2009: 85).⁶

Robert Wyrod's ethnographic research with HIV-positive men in Kampala, Uganda demonstrates that normative gender relations and "hegemonic notions of masculinity that frame men as self-reliant family providers subordinate HIV-positive men as unmanly and inadequate", leading to experiences of interpersonal and internalized stigma for such men (2011: 453). Mark Hunter (2010) stresses how socio-economic inequalities in South Africa, brought about by apartheid and chronic unemployment, produce ideas about masculinity, femininity, love and sex that create an economy of sexual exchange which perpetuates HIV transmission. With their emphases on how African masculinities arise from and change according to historical events and socio-economic conditions, these ethnographically situated analyses move beyond more facile accounts that depict African men as sexually rapacious and culpable in spreading HIV/AIDS.

⁶ One weakness of Smith's argument is the tendency to employ his ethnographic insights from southeastern Nigeria to make claims about "modern marriage in Nigeria" writ large. As I elucidate in Chapter 4, the polygynous context of "modern" marriage among Northern Nigerian Muslims is distinct—and in ways that are highly significant to marital HIV transmission.

This dissertation expands on analyses of masculinity and AIDS in Africa by focusing on the experiences of HIV-positive Muslim men, a group heretofore under-examined in social science research AIDS. I examine how hegemonic notions of masculinity shape cultural responses to HIV/AIDS in Northern Nigeria, rendering men and women differentially vulnerable to infection and its consequences. The dissertation contributes to understandings of kinship and care during the AIDS pandemic with emphasis on the moral obligations and family aspirations of HIV-positive Muslim men.

As HIV treatment modalities change and quality of life for many people living with the virus improves, the effects of HIV infection on the lives of Muslim men have become increasingly ambiguous. Muslim men face a range of physical and social harms from HIV infection, some of which are intensified by ideals of hegemonic masculinity. However, a surprising finding of my research is that HIV infection also has the potential to improve a man's social standing. I demonstrate this with reference to gendered differentials in HIV prevalence, religious assumptions about men and women's mutually constitutive obligations, and the masculine ideal of polygynous marriage.

Deviation from religiously sanctioned sexual behavior poses heightened epidemiological and social vulnerability to particular groups of men. Men who have sex with men [*masu harka*, in the in-group vernacular] have been among the most affected by the epidemic because of their increased bio-behavioral vulnerabilities, and moreover because religious propriety has restricted publicly addressing homosexuality except in the context of condemnation. My research reveals how

hegemonic masculinity and norms about religiously permissible sexuality fuel the epidemic for men who deviate from these standards.⁷ In a society where marriage is expected of virtually all adults, I further contend that the unaddressed high HIV prevalence among *masu harka* has broader epidemiological and social implications.

Islam in Northern Nigeria

Islam, like all global religions, is practiced differently across time and place. It has entailed different meanings and different practices for Arabs, Persians, Southeast Asians, and Africans; within these regions people in different countries have practiced it differently; within different countries it has been practiced differently by various segments of society. Moreover, Islam has meant different things to particular Muslim communities at different points in their histories (Fallers 1974: xv).

In *Islam Observed*, Clifford Geertz developed this idea through a historical and ethnographic comparison of how Islam, as practiced in Morocco and Indonesia, emphasizes different cultural values and distinct ways of being religious. Geertz drew a distinction between the "force" of a cultural pattern like Islam, the thoroughness with which such a pattern is internalized by individuals in a society; and its "scope", the range of social contexts with which religion is considered as having direct relevance. Comparing the two societies central to his analysis, Geertz argued that Islam in Morocco had greater force but less scope than it did in

⁷ Condemnation from both Muslim and Christian religious leaders have contributed to this sort of discrimination in Nigeria.

Indonesia. Religious considerations in Morocco were more intense, but they covered fewer aspects of everyday life than they did in Indonesia, where almost everything was understood as having elements of religious significance (1971: 111).⁸

Applying Geertz' framework, Islam has both high force *and* scope in contemporary Northern Nigeria. The force of Islam is strong to the extent that Northern Nigerian Muslims deeply internalize and apply religious considerations in their daily lives. Islam's scope is broad to the extent that virtually all spheres of life are considered as having religious import; Islam is considered inseparable from political, civil, and domestic spheres. The force and scope of Islam in Northern Nigeria, as I maintain throughout this dissertation, is crucial for understanding how Muslims there have imagined and enacted responses to the AIDS epidemic.

Islam is practiced throughout Nigeria, and just over half of the country's 162.5 million people are Muslim; slightly under half are Christian. The twelve states that comprise the Northern region of the country have by far the greatest Muslim majorities.⁹ Essentially all of rural Northern Nigeria is Muslim. The larger cities in the southern band of Northern Nigeria have sizable Christian minorities, particularly the region's former colonial capital, Kaduna. Metropolitan Kano also has

⁸ See also Varisco's sharp critique of Geertz's work as "neither scientific nor ethnographic", and in which "the only natives in sight are those viewed generically through the lens of the absent ethnographer's own highly crafted rhetoric. Flesh-and-blood Muslims are obscured, visible only through cleverly contrived representation and essentialized types" (2005: 29).

⁹ As a general rule, the farther north one is in Nigeria the more Muslim the population and the farther south the more Christian the population. In major cities throughout the country, however, there are sizable numbers of religious minorities. While the social dynamics I describe in the dissertation may find some applicability to Muslim communities in southern Nigeria, the scope of my arguments is limited to Muslims in Northern Nigeria.

a sizable Christian community. Most live in and around Sabon Gari ('New Town'), a densely populated neighborhood established outside the medieval walled city of Kano during the formal British colonial era, 1900-1960.



Figure 1: Map of Nigeria with the 12 Northern states that have adopted Shari'a. (NB: The southernmost regions of Niger, Kaduna, and Gombe states have not fully adopted Shari'a) (Source: <http://www.informafrika.com/wp-content/uploads/2012/04/Nigeria-map.png>)

This dissertation is about Islam as practiced in Northern Nigeria, and most specifically in metropolitan Kano. The research is most concerned with the period between the late 1990s and the present day. There are two reasons for this contemporary focus. First, Northern Nigeria has experienced a period of fundamentalist Islamic revival in the years leading up to the new millennium; this

revival has brought rapid social change that continues to the present day. Second, while the AIDS epidemic began in Nigeria in 1986, the epidemic appears to have peaked in 2001. The rise of AIDS and the revival of Wahhabi-inspired Islam and Shari'a in Northern Nigeria have thus been historically coeval.

Islam expanded to what is today Northern Nigeria around 1,000 years ago. It came to dominate as a religious and cultural system following the 1804–1810 *jihād* (religious struggle) led by Usman dan Fodio, which consolidated the seven Hausa city-states and surrounding areas as an Islamic state. At the beginning of the 20th century, this region was divided by the colonial regimes of Great Britain, who created Northern Nigeria, and France, who created Niger to the north. Northern Nigeria and the south-central region of Niger still share much linguistic, religious, and economic continuity, although their colonial partition and subsequent postcolonial histories have resulted in cultural differences specific to the nations in which the two polities are embedded (Miles 1994).

The vast majority of northern Nigerian Muslims are Sunni, with the Sufi *Qadiriyya* and *Tijaniyya* brotherhoods comprising the greatest proportion of Sunnis for the last 200 years (Paden 2005). Over the last several decades, and particularly in urban centers, several newer anti-Sufi reformist and Islamist groups have grown in size and influence. The growing anti-Sufism that began to emerge in the 1960s reflected the sweeping economic, political and social transformations that characterized Nigeria in the postcolonial era:

It was amidst the affluence of the oil boom, the rat-race of rugged individualism, the trauma of rapid urbanization, perceived moral and religious lapses, the shift in the locus of political power from the emirates to

the nation state, the concentration of political power in the hands of a tiny minority and the political marginalization of the multitude of Nigerians, all taking place between the 1960s and the 1980s, that anti-Sufism took definite shape and became popularized. (Umar 1993: 177)

Anti-Sufi and Islamist groups have attracted primarily younger adherents who rail against Western influences and aim to bring Northern Nigeria into conformity with stricter interpretations of Islamic doctrine—in particular, those found in Saudi Arabia and Iran. The most influential among these newer reformist movements has been the Wahhabi-inspired ‘Society for the Removal of Innovation and Reinstatement of Tradition’ (*Jama’atul Izalatul Bid’ah Wa’ikhamatul Sunnah*), popularly known as *Izala* for short, or *’yan sunna* (Kane 2003). The *Izala* movement, along with other anti-Sufi Islamist groups such as Malam Ibrahim al-Zakzaky’s primarily Shiite ‘Islamic Movement in Nigeria’, have advocated for literalist interpretations of the scripture and the rejection of what they perceive to be un-Islamic—especially American—influences in Nigeria (Paden 2008).

Following Nigeria’s return to civilian rule in 1999, and largely in reaction to widespread corruption and government mismanagement, the twelve states that comprise Northern Nigeria began formally adopting *sharia*, the Qur’anic codes that stipulate that there be no separation of religious and civil life. In Kano State, implementation of Shari`a courts and criminal codes began in 1999. In 2003, Governor Ibrahim Shekarau greatly expanded *sharia* institutions, establishing a new Sharia Commission, a *hisbah* (vigilante) board, and in 2005 he introduced a wide-ranging program of ‘social reorientation’ known as *A Daidaita Sahu* (‘Straightening The Rows’) which aimed at bringing Kano into better alignment with Qur’anic laws

and principles (Ostien 2007).

The push for Shari`a in the twelve northern states was indeed a major goal of newer conservative reformist movements (such as the *Izala*), and to an extent it indexed the increasing importance of these groups vis-à-vis the older and more politically entrenched Sufi brotherhoods (O'Brien 2007). However, the institutionalization of Shari`a was not the result of any one sect's efforts; rather, these social realignments found support among a broad cross-section of Northern Nigerian Muslims concerned about corruption, the Nigerian government's unaccountability, and the perceived pernicious slide towards un-Islamic influences (Last 2008).

In the late 1990s and early 2000s, hope was high among Northern Nigerian Muslims that the institutionalization of Shari`a would redress the perceived evils and injustices of the secular Nigerian state. The Nigerian state was, and continues to be, seen as immoral, disordered, unjust, and corrupt; the formalization of sharia would, it was hoped, bring about morality, order, justice, and the banishment of corruption. In the intervening years, however, growing insecurity and violence, heightened Muslim-Christian tensions, and the further devolution of already inadequate public services have been undeniable in Northern Nigeria, especially in the cities.

While far from representing mainstream attitudes, increasingly violent and frequent attacks since 2009 by the Islamist group People Committed to the Propagation of the Prophet's Teachings and Jihad (*Jamā'a Ahl al-sunnah li-da'wa wa*

al-jihād in Arabic; better known by their Hausa moniker *Boko Haram*¹⁰) can be seen as expressions of disenfranchisement and the radical rejection of institutions perceived as un-Islamic. Since 2011, the group has claimed responsibility for attacks on the Nigerian Police headquarters and the United Nations headquarters in Abuja, on immigration offices and the State Security Service office in Kano, and on Christian churches and businesses in several northern states. I discuss the implications of these and other recent violent attacks more extensively in the conclusion.¹¹

This research may find certain resonances with how the AIDS epidemic has progressed and been responded to in other Muslim-majority societies—about which there has been very limited ethnographic research. But the cultural and historical specificities of Islam as comprehended and practiced in Northern Nigeria, and the specificities of the AIDS epidemic in the region, delimit the scope of my analysis and findings.

The social epidemiology of HIV/AIDS in Northern Nigeria

Nigeria

Nigeria's estimated adult HIV prevalence of 4.1% is considerably lower than that of southern and eastern African countries, where the pandemic has been the most virulent. Yet given the sheer size of the country's population, Nigeria has over

¹⁰ Generally translated as 'Western education is forbidden'.

¹¹ It is unclear at this time whether all the ongoing violent attacks in Northern Nigeria since 2009 have been carried out by Boko Haram, if some have been carried out by unaffiliated groups *claiming* to be Boko Haram, or if some have been *attributed* to Boko Haram by the Nigerian and foreign governments and the domestic and international media (Herskovits 2012).

3.4 million people living with HIV—the second highest HIV/AIDS burden in the world following South Africa. HIV prevalence appears to have peaked at 5.8% in 2001, but the epidemic remains severe. In 2011 an estimated 388,864 Nigerians were newly infected with HIV and an estimated 217,148 died of AIDS (Federal Republic of Nigeria 2012: 17).

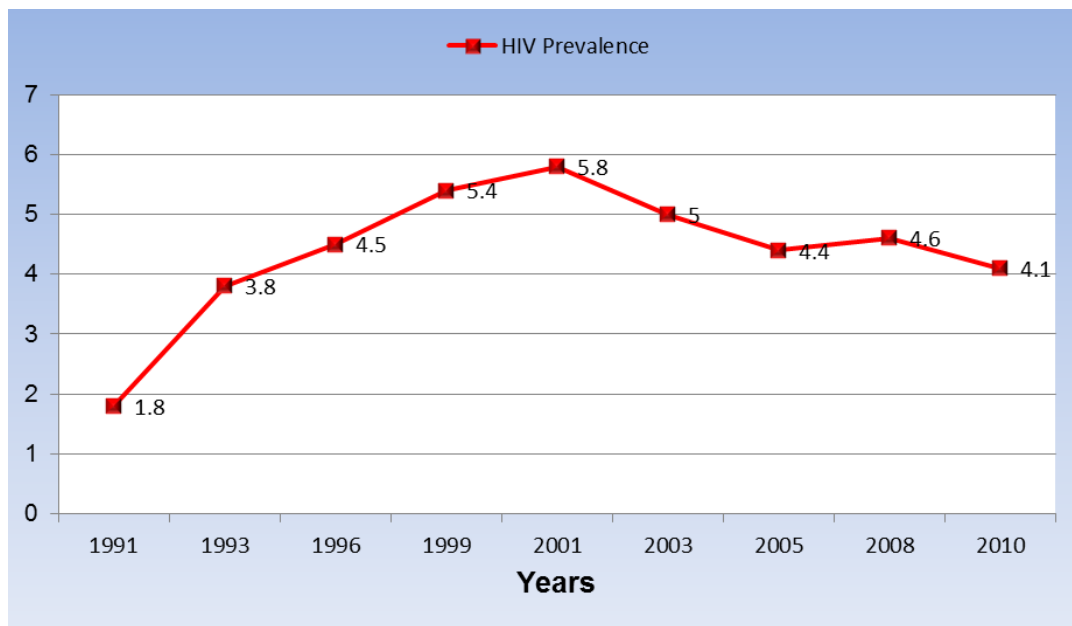


Figure 2: Trend in HIV prevalence over time in Nigeria, 1991-2010 (Federal Republic of Nigeria 2012)

Heterosexual sex has been the main route of HIV transmission across Nigeria, contributing an estimated 80% of infections (NACA 2011: 3). As such, Nigeria's epidemic reflects the pandemic across sub-Saharan Africa, while differing from epidemics in much of the rest of the world where homosexual transmission has predominated. With more HIV-positive women than men, Nigeria's epidemic also follows the trend of a feminized pandemic across sub-Saharan Africa. Of the

estimated 2.1 million Nigerians who have died of AIDS, an estimated 1.61 million (76.6%) have been female (NACA 2011: 3).

HIV prevalence is considerably higher in Nigeria among certain stigmatized populations, particularly among female sex workers (estimated at 24%) and men who have sex with men (MSM; estimated at 17%) (Federal Ministry of Health 2010).¹² Despite the estimation that female sex workers, MSM, injection drug users and their partners contribute as much as 36% of new HIV infections in Nigeria, these groups have received less than 1% of the country's HIV funding (NACA 2011: 3). Incommensurate responses to addressing the epidemic among marginalized groups reflect widespread cultural attitudes about the moral culpability of these groups, and the difficulties that foreign donors and international NGOs have faced in launching and sustaining interventions for them.

Northern Nigeria

HIV prevalence in predominantly Muslim societies is generally low, a fact which has been attributed to a range of possible factors including the universal circumcision of Muslim men, prohibitions against alcohol consumption, and restricted opportunities for socialization with the opposite sex (Gray 2004; Hasnain 2005; LaGarde et al. 2000). Moreover, predominantly Muslim regions of Africa tend to have lower HIV prevalence rates than predominantly Christian regions (Velayati et al. 2007). But given their location in what is what is by far the world's most HIV

¹² Tocco et al (2012) studied the extensiveness and experiences of Nigerian men who engage in transactional sex with other men; however, no studies have yet estimated HIV prevalence among *male* sex workers.

endemic region, the Muslim communities of sub-Saharan Africa constitute the most HIV-affected majority Muslim societies worldwide.

Northern Nigeria has among the highest HIV prevalence among predominantly Muslim societies. HIV prevalence in several Northern Nigerian states is below the national prevalence of 4.1%, however the northern region as a whole has an estimated adult HIV prevalence that is only slightly lower than the national average. As in other African countries, such as Chad and Tanzania, where populations of Muslims and Christians are roughly equivalent in number, there does not appear to be a substantial difference in HIV prevalence among the populations of Muslims and Christians in Nigeria.¹³

As in the rest of the Nigeria, heterosexual sex is the main route of transmission of HIV in the northern region. Recent epidemiological research demonstrates however that as in the rest of the country, female sex workers and MSM bear a disproportionate burden of HIV (IBBSS 2010). Considerably higher HIV prevalence in urban areas of the region compared to rural areas also follows national and international trends of disproportionately urban epidemics.

¹³ It is not clear why this is the case, despite lower HIV prevalence among Muslims globally. Further research into why Muslims and Christians in countries like Nigeria face roughly equivalent levels of HIV prevalence might consider factors such as equivalent rates of male circumcision among Christians, intra-national mobility and inter-religious 'culture contact,' and the effects of national HIV/AIDS campaigns.

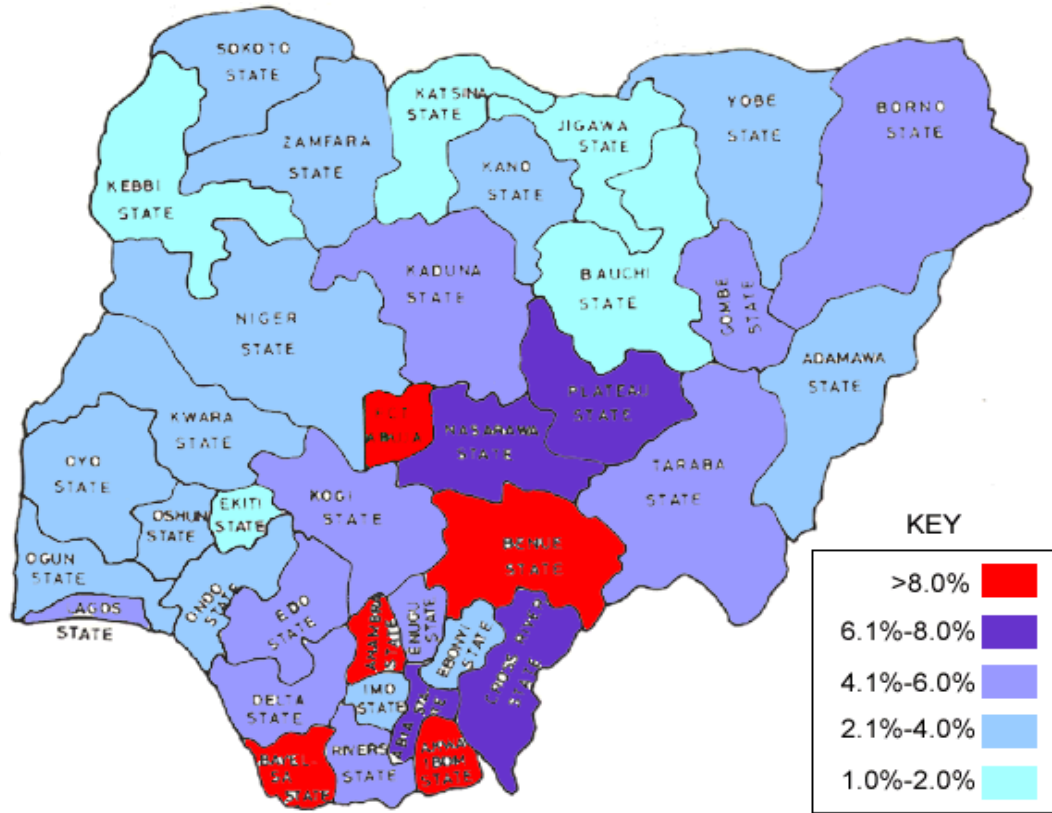


Figure 3: HIV prevalence in Nigeria by state, 2012 (source: Federal Republic of Nigeria 2012: 21)

Kano

Most of the research for this dissertation was done in metropolitan Kano, Nigeria's second most populous city after Lagos, the *de facto* capital of Northern Nigeria and Hausa society, a major commercial hub and West Africa's most populous Muslim majority city. The HIV clinic where I conducted my participant observation and surveys, the HIV support group I attended and from which I recruited interview participants, many of the government officials I interviewed and from whom I collected primary data, and many of the practitioners of Islamic

prophetic medicine I interviewed and observed were in Kano.

Kano is the most populous of Nigeria's 36 states with over 9.4 million people, and has an estimated adult HIV prevalence of 3.4%. Within the state, prevalence is lower in rural areas than in metropolitan Kano (Federal Republic of Nigeria 2012). Overcrowding, high levels of poverty and unemployment, grossly insufficient infrastructure, and wide economic disparities between different social strata burden metropolitan Kano. Kano is an important place to conduct research on the social and religious dimensions of AIDS because it is the center of Northern Nigeria's recent Islamic revival and has experienced a flourishing of Islamic healing practices in recent years. Moreover, several hospitals in Kano are recipients of international donor funding which has brought a massive influx of biomedical treatment for HIV/AIDS over the last decade.

Throughout the dissertation when I write about 'Northern Nigeria', I do so with the recognition that my research most accurately addresses Muslims in urban Kano. I try to be clear about when I am referring to the situation in Nigeria as a whole, Northern Nigeria as a region, Kano State, metropolitan Kano, and specific groups and institutions therein. I nevertheless posit that much of my analysis applies to trends seen throughout Muslim communities in Northern Nigeria.

Research Methods

This dissertation is based on 17 months of fieldwork in Northern Nigeria between 2007 and 2010, with eleven months of this fieldwork conducted during 2010. Most of the fieldwork took place in metropolitan Kano, the largest city in the

region; other participant-observation and interviews were conducted episodically in other cities and peri-urban areas.

The methodological basis of the research was participant-observation and in-depth interviews with HIV-positive Muslim men and the different health and religious professionals with whom they engage. My main research sites were the HIV clinic of a large hospital, private Islamic health centers and home parlors where healers work in the traditions of Islamic prophetic medicine, and the office and meeting space of a support group for HIV-positive people. I also attended events including a national AIDS conference, live broadcasts of a local radio program about HIV/AIDS, and marriage ceremonies.

I conducted semi-structured interviews with 30 HIV-positive Muslim men recruited from a HIV support group. Interviews covered various domains of inquiry to understand the effects of HIV on the men's lives. The interviews were structured to focus on personal disease histories, experiences with and aspirations for marriage and family, treatment decisions and beliefs, and the men's ideas about being Muslim men. The majority of the interviews were conducted in one meeting of between one and two hours; others were conducted over two meetings.

I also conducted interviews with 30 other individuals involved in AIDS, including biomedical practitioners, drug adherence officers and home-based care volunteers, Islamic prophetic healers, leaders of Muslim organizations, government health officials, and NGO staff. Most individuals were interviewed once for between one and two hours; some key respondents were interviewed up to four times. These respondents provided context on various social, religious, political-economic, and

epidemiological aspects of the epidemic and the Muslim response. Most interviews were conducted in Hausa and some in English (based on the preference of the respondent) and were later transcribed and qualitatively coded for analysis.

With the help of a research assistant I also undertook a 25-question survey with 174 HIV-positive men recruited from the HIV clinic where I did much of my participant-observation. The survey collected demographic data, information about health behaviors and beliefs, and treatment histories.¹⁴ HIV-positive interview respondents and survey respondents were given a small cash remuneration for their participation.

I also collected a range of primary materials related to my topic, including: reports and other publications from international organizations, federal and state governments, NGOs, and religious organizations; newspaper articles; health pamphlets and posters; clinical forms; healers' promotional materials; feature films; radio broadcasts; photographs of public signs and billboards. These materials provided context on the epidemiology of HIV/AIDS, discourses about the epidemic, and policy responses to it.

“Positionality”: social identities in ethnographic research

There has been a trend in sociocultural anthropology towards greater emphasis on the ethnographer's social position in relation to his research at least

¹⁴ The hospital's research review board reviewed my study materials and approved the research. They required only one change: that a question about which sect Muslim respondents affiliated with be removed from the survey. I speculate that this question was stricken because it was seen as drawing attention to differences among Muslims.

since the discipline's so-called reflexive turn in the early 1980s. By the 1990s, it had become common for ethnographers to lay out their personal history as it related to their interest in the research topic. Concurring that the social background of the ethnographer can be relevant to the ethnographic research and that the interweaving of personal details about the ethnographer and her experiences can add certain analytic value, Jennifer Robertson (2002: 790-1) nevertheless cautions against assuming that these can stand in for rigorous scholarship:

Family history, ethnicity, sexuality, disability, and religion, among other distinctions, can be usefully woven into an ethnographic narrative, but only if they are not left self-evident as essentialized qualities that are magically synonymous with self-consciousness, or, for that matter, with intellectual engagement and theoretical rigor. Their usefulness must be articulated and demonstrated because such distinctions are not fixed points but emerge and shift in the contiguous processes of doing and writing about fieldwork.

I concur with Robertson that an ethnographer's social identities can be usefully woven into an ethnographic narrative, and I do this in several places in this dissertation. I also share her concern about how these social distinctions can be *assumed* important in ethnography without being explained. In this section, I explain how several of my social identities were important in determining the analytic scope of, access to, and findings of my research.

Ethnicity and nationality: on being an American bature

The Hausa Muslim concept and practice of *ba'kunci*, defined as both the state of being a guest, and the hospitality that one affords a guest, was central to my fieldwork experience. As a foreigner, my default status in Northern Nigeria was that of *ba'ko* ['guest', 'visitor']. The idealized treatment of a guest in Hausa society is

encapsulated by the Hausa proverb, *ba'konka Allah ne* ('Your guest is your God'). Northern Nigerian Muslims consider showing hospitality to visitors as one way of enacting Islamic piety. Because of my *ba'kunci*, and particularly the fact that in Hausa racial-ethnic categorization I am a *bature* [a European or person of European descent; pl. *Turawa*], I was almost certainly granted easier access to participant-observation, interviews, and documents than I would have been otherwise.¹⁵

Conversely, despite being visibly different from most people in terms of skin color and facial features, I was not usually paid *too* much extra attention. This was particularly the case in metropolitan Kano, where residents encounter people of many different backgrounds when they travel to Saudi Arabia for *hajj* [Islamic pilgrimage] and to other countries. My ability to carry out participant-observation as a foreigner without attracting scrutiny was beneficial to my research to the extent that my presence did not *appear* to disrupt peoples' normal behaviors much.

My nationality was another salient social identity during my research, particularly in the HIV clinic where I conducted my most extended fieldwork. The clinic was built by and operated on funding from the United States PEPFAR program; hospital administrators and clinic staff were used to holding meetings and receptions when U.S. government officials came to Kano on official business. I endeavored to be clear that my research was not formally endorsed or supported by the PEPFAR program, but the mere fact of my American-ness may have led staff to

¹⁵ Due to my facial features, my fluency in Hausa, and the fact that I generally wore locally styled clothes, I was also assumed by many people to be *balarabe*, an Arab—and particularly Lebanese, since Kano has a sizable and long-standing Lebanese community. Like *Turawa* [Europeans], *Larabawa* [Arabs] generally have respected social status and relative economic clout in Hausa Muslim society.

be particularly open in allowing me access to the clinic. (Conversely, while I have no evidence of it, it is also possible that I was subtly steered away from information that would have cast the clinic or its staff in a negative light, out of apprehension that I would expose untoward occurrences to PEPFAR administration.)

Religion: on not being a Muslim

A common assumption about *Turawa* is that we are not Muslims. I am not a Muslim. Nigeria has been marred by worsening Muslim-Christian tension over the past couple decades. The worst of the interreligious violence has occurred in the Middle Belt region of the country, and particularly the city of Jos, where numbers of Christians and Muslims find greater parity and struggles for control of land and resources have been most intense. Muslim-Christian antipathy is often foregrounded in analyses of intergroup conflict in Nigeria. However, differences in religious identity frequently overlap with ethnic, regional, and linguistic, and class differences in ways that are crucial to understanding the complexities of the country's intergroup conflicts.

There *has* been markedly increased violence against non-Muslims in Northern Nigeria since the time that I finished my fieldwork in late December 2010. International news media have understandably focused their reporting on Northern Nigeria for the last few years on the increasingly violent attacks carried out by militant Islamist group Boko Haram, discussed more fully in the conclusion. However, as Northern Nigeria becomes increasingly represented as a place of Islamic extremism, it bears stating that the Muslims among whom I conducted

research frequently went out of their way to welcome me, explain their faith, and encourage my participation in religious festivals and social life. Not only did I never feel threatened as a non-Muslim, I experienced much encouragement by my hosts in pursuing research on Islamic society.

Both because I am not a Muslim and because my research is anthropological rather than theological, I have tried to avoid taking sides on theological debates over how to interpret Islamic scriptures and live according to tenets of the faith. I am keenly aware, however, that in writing about Islam and the lives of Muslims I am necessarily implicated in these debates by the nature of my research focus. Therefore in the conclusion, where I suggest interventions to diminish the AIDS epidemic in Northern Nigeria, I do so from a culturally informed epidemiological perspective rather than a theologically prescriptive one.

Gender: on being a man

A critique subsequently leveled by feminist anthropologists against much early ethnography is that while they purported to be holistic studies of a given culture, in actuality male anthropologists conducted research among men and generalized from this to explain the culture at large. As such, the concerns and perspectives of women were elided, and those of men were represented as those of the culture.

Being a man significantly determined my research focus on masculinity and my access to male informants. Having lived in a rural village in predominantly Muslim Hausa Niger as a Peace Corps volunteer in the early 2000s, among my

biggest surprises upon arriving to Kano for the first time in 2007 was the relative scarcity of women out in public. Social life is largely segregated by gender across Northern Nigeria, particularly in urban areas. The public sphere is considered the proper place for men, and the domestic sphere the proper place for women. This gender segregation has deepened following the institutionalization of Shari'a and is predicated on religious avoidance of social mixing among unrelated men and women.

My position as a male ethnographer working among men in a largely gender segregated society was simultaneously a limitation and an advantage of the research. By focusing on men's experiences of the AIDS epidemic, the realities of women are underexplored. This limitation arose in part because my male research assistant and I could not discuss certain topics with women without upsetting socio-religious norms of inter-gender comportment. Given time and funds, hiring a female research assistant could have ameliorated this limitation. But even having a female research assistant would have proven difficult: the owner of my rented apartment, who lived downstairs, strictly prohibited me from having any female guests.

Insofar as my research was *explicitly* focused on men and masculinity, being a male researcher had undeniable advantages. I was able to conduct participant-observation, interviews and surveys among HIV-positive men about personal topics, including sexuality, that would have been effectively off-limits had I not been a man. My gender also likely eased access to research among *malamai* (Islamic scholars), biomedical practitioners, government officials, representatives of NGOs and Islamic organizations, nearly all of whom were men.

In sum, the gender of an anthropologist working in Muslim communities in Northern Nigeria determines whom he or she can work with to a considerable extent. While somewhat different in scope and focus, this dissertation provides a counterpart to the work of anthropologist Kathryn Rhine (2009, 2010) whose research focuses on the experiences of HIV-positive women in Kano. I draw on her work most extensively in Chapter 4, when I consider the gendered dynamics of HIV transmission and care.

Ethnographers' sexual subjectivities were long elided from published accounts. There has, however, been increasing recognition that ethnographers negotiate their sexual positions within the communities they study—particularly when sexuality and gender are explicit research themes (Kulick and Wilson 1995; Lewin and Leap 1996; Markowitz and Ashkenazi 1999). My status as *mai harka*—a 'man who has sex with men' in the in-group Hausa term—was central to the ethnographic analysis of the male-male sexual transmission of HIV that I develop in Chapter 5. Given the secrecy with which *masu harka* guard their homosexual behaviors from outside purview, this ethnographic research would not have been possible without my *masu harka* acquaintances' acceptance of me as an insider in this community.

Health status: on being HIV-positive

Being HIV-positive influenced my choice of research topic. It altered my social position vis-à-vis the people among whom I conducted fieldwork, affected the nature of my participant observation, and influenced my analysis. My dual position

as researcher and patient in the HIV clinic that was my main field site (elaborated in Chapter 3) and as a member of an HIV support group (elaborated in Chapter 4) made me—at least in these contexts—more of an observing participant than a participant-observer (Kaminski 2004). Abu-Lughod's (1988) self-conception as a "halfie anthropologist", based on her Egyptian cultural heritage as an ethnographer working in Egypt, has certain resonances with my ambiguous role as an HIV-positive patient-researcher.

Perhaps naively, I had not put much thought into whether or how I might disclose being HIV-positive in Nigeria before I began my fieldwork. My unplanned admission occurred at the first Taimaka HIV Support Group meeting I attended in 2007. In addition to changing my others' perceptions of me and my self-perception within the group, it remains one of my most personally cathartic moments as a person living with HIV.

The meeting was held in the third-floor walk-up office of the support group on a hot and humid Saturday afternoon in June. Far too many people for the space, at least 80, were crammed into the office; there was almost no floor space left uncovered by people. Typical for Nigeria, the power was out. A generator on the balcony sputtered exhaust fumes and managed to power the ceiling fans enough to at least stir the hot air.

Having explained to the group's leaders before the meeting that I was conducting preliminary research for my PhD and hoping to observe the group's meetings and take notes, I was put on the agenda for the end of the meeting to introduce myself. For the next two hours I took in the meeting, wiped sweat from

my face, and nervously practiced my speech in my head in Hausa. When my turn came, I explained at some rambling length about who I was, the purpose of my research, and my hope to observe the group to better understand issues facing HIV-positive people. I concluded by asking if anyone had questions for me.

Immediately a woman's hand shot up. 'Yes, I have a question', she said, addressing the group's leaders. 'He says he wants to come to our meetings to do his research. But what about him—does he have it [HIV]?' All eyes in the room turned to me. I swallowed. 'Yes, I do have it.' It struck me then that for the first time in my life I was in a room full of only other HIV-positive people—other people who (despite my different cultural and racial background) had experienced many of the fears and anxieties and health issues I had. A huge and unexpected sense of relief overcame me. I felt what Victor Turner termed "existential communitas": an acute experience of group togetherness brought about through a rite of passage (1995: 129).

As my research continued and I developed relationships with other HIV positive people in Nigeria, my sense of incorporation into the community deepened. My identity as a group member seemed to overshadow my identity as an outside researcher, in my perception of the perspectives of other group members. Going to support group meetings on Saturday afternoons was exciting not only because I would be conducting research, but because of the contentedness I felt shaking hands with the other men, sharing jollof rice and bottled sodas, and simply being unconcerned for a while about guarding a stigmatized identity that many of us otherwise kept from public knowledge. As I explain in Chapter 4, being an HIV-

positive bachelor in the support group I was expected to be on the market for a spouse.

Another particularity of being an HIV-positive researcher conducting ethnography on HIV treatment was that my main field site, a hospital HIV clinic, is also where I was enrolled as a patient and collected my medications.¹⁶ The clinic staff seemed to have little problem with patient-ethnographer position. However, my institutional role as a patient may in some senses have restricted my scope as an ethnographer. Little of this was due to any restrictions placed upon my research by others; rather, these limits arose out of my own internalization of the subjective experiences of patient-hood.

My enculturation into the role of a (admittedly privileged) patient produced within me certain avoidances that I was virtually unaware of at the time I was in Kano. For instance, despite my interest in medicines as material objects, I never spent time in the pharmacy room where drugs were physically distributed to patients in the clinic. To me—and I dare say to many other patients—this was the most unpleasant space within the clinic because the rooms were narrow and small, left little space for any typical segregation of men and women, and staff were under pressure to quickly and accurately distribute medicine while making sure that patients understood when and how to take their pills. , I did not collect extended observational data from the pharmacy because as a patient I felt anxious to leave.

¹⁶ The irony never escaped me that as an American in America, my insurance company and I pay for my expensive ART and medical care, whereas in Nigeria my government, via PEPFAR, provided me with ART free of charge.

In little ways that I was aware, and possibly more of which I was unaware, I benefited as a patient from better treatment because of my complex and privileged role as simultaneously a researcher, colleague, foreign guest, friend, and patient. This may have skewed my perception of the typical patient experience in the clinic. I do not presume that my partial-insider status as a HIV-positive person produced better or more objective research. It did certainly alter others' perceptions about who I was and I what I was doing in several of my key field sites. I conclude this introduction chapter with an overview of the rest of the dissertation.

Dissertation outline

Chapter 2: The Curative Word: Prophetic Therapies for a Modern-Day Pandemic

Among deeply religious people, religious discourses on illness and healing significantly shape practitioners' therapeutic approaches and patients' wellness-seeking behaviors. This chapter is about the treatment of HIV by *malamai* (Muslim scholars) and other practitioners working outside of the biomedical system. I consider the historical development and contemporary expansion of Islamic prophetic medicine and analyze how the recent revival of Islamic conservatism has reconfigured the therapeutic economy in Northern Nigeria. And I analyze how the etiological assumptions, therapeutic practices, and economic motives of *malamai* and Islamic herbalists structure their treatment to HIV.

I show how the authority of *malamai* to treat people living with HIV and AIDS has been put under considerable pressure by the massive influx of biomedical HIV therapies since 2004—a theme that continues into the next chapter about the U.S.

PEPFAR program. In response, *malamai* and other so-called 'traditional' healers assert the efficacy and safety of their treatments, premising these claims on the authority of widely agreed upon principles of Islamic faith. The chapter pivots on a popular expression of faith by Muslims in northern Nigeria: 'With every disease, Allah has also sent its cure'. Whereas, from the biomedical perspective, HIV is a disease from which one cannot be completely cured, some *malamai* and herbalists working in the traditions of Islamic prophetic medicine interpret this verse in ways that shore up their own religiously ordained authority and render competing biomedical strategies less authoritative. That is, they proclaim that their treatments cure because the omnipotent word of Allah makes it so.

Many *malamai* and herbalists nevertheless draw upon biomedical idiom and quasi-clinical practice in an attempt to remain relevant in the profitable therapeutic economy of HIV/AIDS. Yet these attempts at therapeutic syncretism have yielded limited success in keeping HIV positive patrons, as positive Muslims have overwhelmingly migrated to antiretroviral therapy (at least, where these drugs have become available). While some *malamai* and Islamic herbalists advocate that prophetic medicine and biomedicine be used complementarily, others advocate for the rejection of biomedicine altogether--a position that biomedical practitioners and an increasing number of HIV positive people consider dangerous and thus immoral. Mainstream Nigerian Islamic organizations and government have also increasingly disfavored prophetic and other herbal treatments for HIV/AIDS, evincing a paradigmatic shift towards biomedical care. This chapter and the next on biomedical responses demonstrate that despite recent efforts in Nigeria to assert a

unified Islamic perspective on HIV/AIDS, substantive disagreements persist over the causes, treatments, and curability of the disease.

Chapter 3: The New Orthodoxy: Faith, Pragmatism, and the Political Economy of AIDS

Biomedicine's arrival in Northern Nigeria was recent relative to other healing traditions; prior to the British colonial era, biomedicine was virtually unknown. While biomedical interventions of Western origin have found partial acceptance among Northern Nigerian Muslims, in recent years they have at times been met with suspicion and rejection. This chapter concerns the recent expansion of antiretroviral therapy in Nigeria and how it has altered and expanded the therapeutic economy of HIV. I ask how Muslims living with HIV/AIDS and the practitioners who treat them grapple with ART from the standpoint of efficacy and as objects requiring moral evaluation.

Despite its relative wealth, Nigeria has one of the very worst health systems in the world. Access to biomedical care today is highly stratified by wealth and relatedly by rural/urban location. The expansion in ART in Nigeria since 2004 is the result of a massive influx of international donor funding, the vast majority coming from the U.S. PEPFAR program—the largest bilateral health program focused on a single disease in history. Nigeria's heavy dependency on the United States for implementing HIV/AIDS services thus mirrors Nigeria's overwhelming dependency on American petroleum purchasing to support its economy, reinforcing the patron-client dynamic that structures the countries' relationship in the global economy.

There has been no large-scale public opposition to the provision of ART in

Northern Nigeria; most have warmly welcomed the arrival of the drugs. Yet some HIV-positive people, as well as practitioners working in Islamic traditions, express misgivings about ART. Some question the interests and profit motives of Western drug companies and governments in distributing ART for free, echoing recent mistrust of Western medical interventions in the region. Others express misgiving about the toxicity and side effects of ART as a chemically manufactured therapy. Still others question the efficacy of ART as a therapy that treats but fails to cure.

I argue that efficacy is the most important factor explaining the uptake of ART, but that efficacy alone does not explain this rapid and overwhelming therapeutic migration. Also crucial has been the Islamification of ART: international organizations, national Islamic groups, biomedical practitioners, and patients' groups have framed ART as the Islamically acceptable treatment for HIV/AIDS. This ongoing process of Islamification is occurring on several levels simultaneously: on the level of health policy, of scriptural exegesis, of doctor-patient communication, and among support groups of HIV-positive Muslims. Recent moves to emphasise ART as the singular appropriate treatment for HIV reflect how religious organisations often align themselves with broader secular, national and international AIDS policies about HIV.

Chapter 4: HIV, Polygyny and Ethics of Care Among Muslim Men

AIDS a force of both kin cutting and kin binding: the disease results in divorce, orphaning, widowing, and rejection, but is also instigates new marriages, fostering, and so-called imagined kinship among those who share HIV-positive

status. This chapter concerns AIDS in the context of Muslim family life with a focus on HIV-positive Muslim men and masculinity. Ethnographically the chapter centers on a local grassroots support group for people living with HIV in Kano, and demonstrates how support groups serve as key sites for the reconfiguration of kin relations for those affected by the disease.

Polygyny is the cultural and religious ideal for men in Northern Nigeria and indexes both socio-economic success and religious piety. One implication of this is that HIV prevention strategies urging faithfulness to one partner defy the Muslim Hausa cultural logic that defines the economic and sexual provision for multiple wives as a major component of ideal masculinity. I find that HIV-positive Muslim men's duty to marry—and often to marry multiple wives—is heightened by the socially engendered expectation that they provide for HIV-positive women and their children. Paradoxically, being HIV positive increases men's social standing, to the extent that they have increased access to the "surplus" of HIV-positive women in a society where HIV disproportionately affects women and constrains their marital choices.

Doctors, nurses, and other clinical staff care enact expected medical forms of care, but they are also sometimes involved in surreptitiously mediating marriages among their patients. Doctors also sometimes take money from their own wallets and give them to destitute patients in the exam room. The clinic, then, is not only a site of 'rational' scientific practice. It is also a place where Islamic ethics of care and family, both in the sense of individual families and in the sense of the Muslim community, are enacted.

Chapter 5: The Mode of Transmission That Dare Not Speak its Name: Islam and the Public Secret of Homosexuality

Extending arguments from the previous chapter about of how gendered expectations of morally righteous compartment and Islamic norms of sexual behavior structure the epidemic, this chapter is about *masu harka* [men who have sex with other men, or MSM] and their position in Northern Nigeria's HIV epidemic. I consider male-male sexuality and HIV transmission from the perspectives of *masu harka* themselves, from the perspectives of the broader Muslim community, and from the perspectives of public health organizations external to Northern Nigeria hoping to address the epidemic among MSM there.

Whereas early epidemiological models presumed Africa's AIDS epidemics to be overwhelmingly driven by heterosexual sex, mounting evidence indicates high HIV prevalence among MSM across the continent, and in Nigeria. As in other Muslim-majority societies, marriage is imperative for attaining the status of respectable adulthood. Sexual relationships outside of marriage are proscribed, but tacitly overlooked on the condition that they remain strictly inconspicuous. *Masu harka* enjoy considerable latitude to pursue same-sex relationships, given male privilege and Islamic norms of gender segregation. However they nearly always marry women and are at pains to keep knowledge of their homosexuality from everyone except other similarly inclined men.

Public acknowledgement of the male-to-male sexual transmission of HIV is rare in Northern Nigeria, and health initiatives addressing this mode of transmission

have been virtually non-existent. This silence and inaction is a consequence of cultural, religious, and legal injunctions against homosexuality. In this context, and despite massive international funding, dominant Western rights-based approaches to AIDS (which are predicated on admission of risk-specific identity) have failed to yield initiatives addressing the sexual health of *masu harka*. Along with the heightened bio-behavioral risks associated with anal intercourse, these silences and inactions have resulted in HIV burden among *masu harka* that is many times greater than the general population. Moreover, *masu harka* significantly underestimate their likelihood of contracting HIV from sex with other men.

Living in a society where marriage is a crucial predicate of respectable adulthood, *masu harka* nearly always marry women and have children, while keeping their same-sex sexual relationships hidden. I argue that this *de facto* bisexuality, in conjunction with low condom use and high HIV prevalence among *masu harka*, has underappreciated consequences. Integrated into larger sexual networks, such men contribute disproportionately if unwittingly to northern Nigeria's AIDS epidemic. These findings highlight the need for HIV interventions that specifically address male-to-male sexual transmission, while recognizing the volatility of such efforts.

Chapter 6: Conclusion: Ethics of Intervention

I analyze the recent violent turmoil in Northern Nigeria and consider what its effects might be on the region's AIDS epidemic. Next, I argue for a morally engaged anthropology, one that balances cultural relativism with social activism. This is an

effort to synchronize interventionist public health research and socio-cultural anthropology—a still-murky interdisciplinary terrain in which an increasing number of medical anthropologists find themselves. Drawing on exemplary cases of this type of social research, I argue that ethnography is keenly positioned to address problems of human suffering and advocate for social change.

I conclude with several recommendations for how HIV/AIDS prevention and treatment can be improved to lessen the human toll of the epidemic in Northern Nigeria within a culturally and morally acceptable framework.

Chapter 2:

The Curative Word: Prophetic Therapies for a Modern-Day Pandemic

The power of medicine stems not merely from the wonders of science. It stems, too, from the power of moral suasion.

--Paul Farmer, *Infections & Inequalities*

Introduction

Books and papers overtake Dr. Inusa's desk and stack behind him from floor to ceiling. Gilded inscriptions from the Qur'an, a photo of his staff with the Emir of Kano, and several poster-size photos of the doctor in the long white robes of a Muslim pilgrim performing the *hajj* hang on the walls. Like other successful healers in Kano working in the Islamic tradition of prophetic medicine, Dr. Inusa's parlor office is complete with carpet and plush couches. As is customary when entering someone's home, patients and other visitors remove their shoes at the door.

Dr. Inusa directs a well-established Islamic health center in central Kano, with branch offices in other northern cities and, more recently, an office opened in Lagos. He began consulting patients facing physical and spiritual afflictions decades ago and is recognized locally as an expert in Islamic prophetic medicine. With the pledged support of several state government officials and religious leaders, he plans to expand his Kano office from an outpatient operation into a larger, inpatient prophetic medicine hospital.

People seeking help at Dr. Inusa's center meet a receptionist in front of the

building, where they explain their problem and wait on wooden benches to see Dr. Inusa or another staff member. Painted in large letters on the wall behind the receptionist's desk, next to the pharmacy, a message in Hausa informs that the center helps people suffering from a range of illnesses: "Sorcery, madness, polio, epilepsy, spirit possession, high blood pressure, asthma, hemorrhoids, AIDS, liver disease, respiratory problems, erectile dysfunction, low sex drive, infertility, lack of breast milk, menstrual cramps, indigestion, et cetera."

Dr. Inusa is reserved the first time we meet but becomes increasingly oratorical over the course of our first interview. Explaining the focus of my research is HIV/AIDS, I ask what treatments he gives to people living with the disease:

We give them medicine that we make ourselves. We know the correct combinations. There are special herbs that we give them to eat, and we advise on a proper diet of vegetables to build their strength and increase the amount of blood in their bodies. If they have diarrhea, we give them herbs that will slow the problem and then stop it. Then we have another powerful medicine that helps us eliminate the virus, to make it leave the body.

Does this mean, I ask, that this powerful medicine is able to cure people of HIV completely? Dr. Inusa responds emphatically:

It can be cured completely! By the will of Allah, absolutely! In Islam, our belief is that there's no disease that doesn't have its medicine — absolutely. Allah sends the disease, and Allah does the curing. It's not people [who cure]. For Muslims, headaches, foot aches, stomachaches, typhoid, asthma, diabetes, Allah sent them all — and so too HIV/AIDS. Allah sent them, and He is the one that cures them. We don't agree that someone with a headache will be cured, someone with a foot problem will be cured, someone with a stomach problem will be cured, but someone with HIV can't be cured. We can't agree — because all cures are from Allah.

In deeply religious societies, religious discourses on illness and healing significantly shape practitioners' therapeutic approaches and patients' wellness-

seeking behaviors. This chapter is about the treatment of HIV/AIDS by *malamai* and other practitioners who work independently of—and in many ways compete with—the biomedical system. Situating my analysis within popular Nigerian debates and the broader medical anthropological literature on the role of African traditional healers in the AIDS epidemic, I pose the following questions: How has the resurgence of Islamic conservatism in Northern Nigeria affected healing practices, and to what extent has the region's therapeutic economy been reconfigured by these larger socio-religious developments? What etiological assumptions and therapeutic praxes do *malamai* working in prophetic traditions bring to HIV/AIDS? And how do Muslims living with HIV/AIDS and the practitioners who treat them evaluate different therapies with reference to scriptural pronouncements on illness and healing?

I argue that despite the recent and dramatic expansion of prophetic healing practices that have followed the formalization of Shari`a across Northern Nigeria, the authority of *malamai* to treat people living with HIV/AIDS has been put under considerable pressure by the massive influx of biomedical HIV therapies since 2004—a theme that continues into the next chapter about the U.S. President's Emergency Plan for AIDS Relief and biomedical approaches to HIV/AIDS. In response to these pressures, *malamai* assert the efficacy and safety of their treatments, premising these claims on the authority of widely agreed upon religious principles. These assertions pivot on a central tenet of Islamic faith: 'With every disease, Allah has also sent its cure'. Whereas, from the biomedical perspective, HIV is a disease from which one cannot be completely cured, many *malamai* claim that

their treatments cure HIV/AIDS because the omnipotent and infallible word of Allah makes it so. In so doing, they shore up their own religiously ordained authority and attempt to render biomedical strategies less authoritative.

Many *malamai* nevertheless draw upon biomedical idiom and quasi-clinical practice in efforts to remain relevant and intelligible in the shifting therapeutic economy of AIDS. Yet these attempts at therapeutic syncretism have yielded limited success in keeping clients, as HIV-positive Muslims have overwhelmingly migrated to antiretroviral therapy—at least, where these drugs have become available. Some *malamai* advocate that prophetic medicine and biomedicine be used complementarily, while others advocate for the rejection of biomedicine altogether—a position that biomedical practitioners and an increasing number of HIV positive Muslims consider dangerous. Mainstream Nigerian Islamic organizations and government have also increasingly disfavored prophetic treatments for HIV/AIDS, evincing a paradigmatic shift towards biomedical care. This chapter and the next on biomedical responses demonstrate that despite recent efforts in Nigeria to assert a unified Islamic perspective on HIV/AIDS, substantive disagreements persist over the causes, treatments, and curability of the disease.

Prophetic healing in Northern Nigeria

One aspect of the increasingly Islamic reorientation of Northern Nigerian society has been the marked expansion of religious-oriented healing practices. Since the early 2000s, classical Islamic modes of healing — with their focuses on the spiritual dimensions of illness, the power of prayer and Qur'anic recitation, and the

natural cures proscribed in the Qur'an and the *hadith* (the collected literature on the pronouncements and actions of the Prophet Mohammed) — have dramatically increased in prominence. Prophetic healing traditions have seen a renaissance throughout the northern states, even though governments have made few formal efforts to back them. As the expansion of ART and biomedical care for people with HIV/AIDS has occurred primarily in Nigeria's cities, so too the expansion of Islamic therapeutic strategies has been most pronounced in metropolitan Kano and other cities — reflecting the tendency of global flows of money and ideas of various origins to concentrate in urban centers (Appadurai 1996).

Muslim physicians and botanists of the medieval period made significant contributions to knowledge about the effects of plants, drugs, and foods on the human body, building on ancient Greek and Islamic prophetic traditions. By the thirteenth century, Andalusian-Arab botanist Abu al-Abbas al-Nabati introduced the experimental scientific method into this growing corpus of knowledge, and Islamic *materia medica* evolved into the science of pharmacology (Huff 2003). These contributions were foundational to the development of biomedicine as it exists today.

However, The Islamic therapeutic strategies most widely adopted in contemporary northern Nigeria lie within a long-established tradition in Islam known as the 'medicine of the Prophet' (Arabic: *Tibb-ul-Nabbi*) dating to the time of the Prophet Muhammad (Wall 1988). Ismail Abdalla argues that by the time Islam came to Northern Nigeria in the late 14th or early 15th century, Islamic medicine had lost its empirical approach to disease and cures. Rather, it became "impregnated

with religious and para-religious ideas that emphasized the curative property of divination, numerology, and prayer, especially prayer in traditions attributed to the Prophet Muhammad” (1997: 13). As opposed to the more scientific Greco-Islamic medicine developed centuries earlier in Baghdad, “Islamic medicine among the Hausa [has come] to be understood as nothing other than Prophetic medicine” (Abdalla, 1997: 35). In the following sections, I elaborate on the prophetic practices that predominate in contemporary Northern Nigeria.

Malamai

People living with HIV/AIDS have sought treatment by *malamai* since the disease's emergence in Nigeria in the mid 1980s, decades before the scale-up of ART. Despite the increasing dominance of ART in northern Nigeria's therapeutic economy, HIV-positive people continue to seek care from *malamai*, in addition to or in some cases instead of biomedical care. *Malamai* are trained, to various degrees, in Islamic knowledge and Arabic language. However, only about half of trained *malamai* teach. Other *malamai* work in government administration, religious procedure and ritual, medical practice, legal practice, and the formulation of public opinion (Paden 1973: 56). While only a portion of *malamai* work in the tradition of prophetic medicine, all those who practice prophetic medicine are considered *malamai*.

Malamai use their knowledge of the Qur'an and other Islamic texts to address afflictions both physical and spiritual. Traditionally, *malamai* have consulted patients from the parlors of their private homes or in mosques. While this home-

based and mosque-based approach continues today, in recent years some *malamai* have opened more elaborate 'Islamic health centers,' replete with fulltime staff, consultation rooms, and Islamic pharmacies. The *malam* is "a spiritual leader, an educator, political advisor, judge, secretary, and [medical] practitioner all in one" (Abdalla, 1997: 140), who, depending on what scholarly materials are at his disposal and according to his own personal inclinations, "may function as a counselor, diviner, astrologer, fortune-teller, spiritual adviser, pharmacist, and physician" (Wall, 1988: 232).

Malamai base their healing on the depth of their scholarly knowledge of the Qur'an and the mystically charged symbols of Islam, and they "are expected to be Islamic scholars or students and to work within an Islamically orthodox framework" (Last, 2007: 3). Indeed, because it is considered to be the direct and infallible word of God in Islam, *malamai* tap the Qur'an itself for its curative properties (Wall: 1988). As Clifford Geertz argued, the Qur'an "differs from the other major scriptures of the world in that it contains not reports about God by a prophet or his disciples, but His direct speech, the syllables, words, and sentences of Allah. Like Allah, it is eternal and uncreated" (1976: 1489).

One well-known *malam* in Kano referred me to a passage in *Medicine of the Prophet*, a well-known 14th century text on prophetic medicine, to explain the centrality of the Qur'an to his healing practice:

The Qur'an is the complete healing for all illnesses of heart and body and ills of this world and the next. Not everyone is given the qualification or the success to seek healing thereby. When the sick person is able to treat himself with it, and uses it for his illnesses with trust and faith and complete acceptance and certain belief, fulfilling the right conditions, the illness can

never resist it. For how could any illness resist the Word of the Lord of Earth and Heaven, whose Word if sent down upon the mountains would shatter them, or upon the earth would flatten it? For whatever illness of heart or body, the Qur'an contains the way pointing to its Remedy, its cause, and protection from it, for whomsoever God grants understanding of His Book. (al-Jawziyya, 1998, p. 250).

As elaborated in the previous chapter, several anthropologists have made arguments for greater incorporation of traditional healers into HIV/AIDS care in Africa (e.g. Good 1988; Schoepf 1992; Green 1994). Yet there have been no significant attempts to incorporate practitioners of Islamic or other non-biomedical traditions into the Nigerian healthcare system. Practitioners working outside the biomedical system have been essentially excluded from the flood of donor money for HIV/AIDS entering the country. While global HIV/AIDS agencies and foreign donors like the U.S. PEPFAR program have often been keen to enlist faith-based organizations into their efforts, an implicit requirement of this involvement has been that such organizations ideologically support ARV-based treatment regimes over and above any faith-based or 'natural' healing approach.

Early Islamic *materia medica*: curing with natural substances

Prophetic medicine as practiced in contemporary Northern Nigeria has expanded in several interrelated and at times overlapping directions. Of these, the most ubiquitous have been the thousands of storefront Islamic chemists (pharmacies) that have opened for business over the last decade. Largely unregulated by government and possessing varying degrees of Islamic and medical expertise, these chemists dispense the *materia medica* (natural vegetal and mineral

treatments) proscribed in the Qur'an and *hadith*, among other items.

In Kano, Islamic chemists offer on-the-spot consultations and prescribe natural products indicated in classical Islamic medical exegesis, such as honey, holy water from the Well of Zamzam in Mecca, *habbatus sauda* (black seed), dates, garlic, olive oil and perfumes. Also frequently available are locally produced remedies indicated for those suffering from witchcraft and spiritual attacks, potions to attract a beloved's affections, and medicines to increase sexual excitement and performance.

The specific items for sale in each chemist's store are subject to some variability, determined both by the size of the operation but more especially the strictness with which a given proprietor adheres to classical Islamic texts. While some chemists carry products not necessarily prescribed by Islam and which are more properly considered of the pre-Islamic Hausa medicine tradition, more religiously orthodox operations sell only products and services that they believe to be clearly indicated by Islam. A sign posted at the shop of one *Izala* chemist is indicative of this approach: "Follow the ways of the Prophet, precisely! Studying the Qur'an and Hadith and applying them is the way to health for Muslims".¹⁷

Honey is considered by many to be especially effective for treating a variety of ailments, including HIV. Several HIV-positive people I knew who were on ART said that they always took their drugs with a spoonful of honey, believing that this

¹⁷ In the original Hausa: '*Sunna, Sak! Karatun Al-Qur'an da Hadisi da aiki da shi, shi ne sama lafiya ga Musulmi.*'

made the treatment more effective. Others told me they believed that anti-retrovirals contained honey. Insofar as patients stayed faithful to their ART, biomedical practitioners rarely discouraged incorporation of honey or other *materia medica* into one's daily routine, and sometimes tacitly encouraged it. *Malamai* who emphasize treatment with prophetic *materia medica* generally ascribe viral causality to HIV infection and adopt biomedical concepts such as 'viral load' and 'CD4 count' in discussions with HIV-positive clients.

Rukiyya: Talking with jinn

Dr. Zaberu began learning to communicate with spiritual beings when he was five years old. His mother inherited this vocation from her mother, and when Zaberu was still a child his mother began to enlist his help in treating people who had become possessed. He and his mother worked together up until her recent death. Now in middle age, he works from his modest home office in metropolitan Katsina and also travels throughout Northern Nigeria performing exorcisms.

Sitting together on a plastic mat in his office, Dr. Zaberu tells me, "You're a man. And just as I'm sitting and talking with you right now, that's how I can sit with jinn and communicate with them. I have treatment for all kinds of jinn." Black jinn, he explains, are more stubborn and difficult to treat than white ones; sometimes the black ones leave and come back, requiring multiple sessions. When I ask him what interested him about this line of work, he laughed. "It's not about there being a reason, or having interest. This is just my inheritance."

Known as *aljannu* in Hausa, jinn are supernatural creatures mentioned frequently in the Qur'an. Like humans, jinn can be good or evil, have free will, and maintain their own complex society. They usually remain invisible to humans, although they can interfere in human affairs and possess people. Some *malami*, like Dr. Zaberu, are known to communicate with and control jinn, exorcising them when they have possessed a human host.

Increasingly popular throughout northern Nigeria since the mid 1990s¹⁸, the performance of *rukiyya* involves a *malam*, or several *malamai*, loudly reciting passages from the Qur'an renowned for their healing powers into the ear of a spiritually afflicted person¹⁹. Sessions often last for hours and may be repeated several times until the jinn agree to leave the human host in peace. *Rukiyya* is conducted in a dark room because jinn are believed not to enter places of light. Patients typically break down emotionally during the sessions, speaking in the voices of the spirits that have possessed them and submitting themselves to vigorous praying as the malam pulls the spirit (*cire iskokì*) out of the afflicted person's body. As Susan O'Brien explains, *rukiyya* is frequently dramatic, even violent:

Islamic exorcists attempt to expel spirits from their human hosts through intimidation and dialogue. By shouting powerful Qur'anic verses into the right ear of the afflicted woman, malamai call the spirits and then engage in an angry dialogue with them, attempting to convert them to Islam and persuade them to leave the woman in peace. Powerful suras from the Qur'an

¹⁸ O'Brien (2001) and Casey (2009) associate the surging popularity of *rukiyya* with the unprecedented possession of around 200 girls at a Kano secondary school in 1995. Notably, *rukiyya* is more commonly performed on women than men.

¹⁹ While *rukiyya* is generally performed live, many *malamai* also sell audio recordings of themselves reciting *suras* for the afflicted to listen to at home.

are used to 'burn' intransigent spirits until they scream in pain and agree to the malamai's demands. The spirits' insolent or evasive responses often provoke malamai to physical violence in this dialogue, which includes slapping and punching the spirit hosts on the face, head, feet, and back. These sessions can thus be disturbing scenes as two or three malamai circle around the sick woman and smack, scream at, and insult her. (O'Brien 2001: 232)

Malamai who specialize in *rukiyya* are more likely to assert that HIV infection is symptomatic of an underlying spiritual affliction than attributing a viral causation. As Dr. Zaberu explained, "Of all people with AIDS²⁰, only 30% really have HIV from sexual or blood contact. The other 70%, while they do have HIV, they got it from a jinn." Before treating a patient for HIV, Dr. Zaberu refers the afflicted person to a biomedical facility for an HIV antibody test to confirm whether she is positive. If she is, he treats the patient with *rukiyya*, then sends her back for another blood test to confirm that she is now negative. Several *malamai* in Kano claimed that *rukiyya* has the power to cure HIV/AIDS — particularly if the illness is attributed to an underlying affliction by jinn.

While their etiological assumptions may be quite different than those of biomedical practitioners, *malamai* often draw nevertheless on biomedical concepts and processes in their healing practices. *Rukiyya*, for instance, has become institutionalized into clinical format, "with standardized fees and intake forms that documented the symptoms, treatment, and outcome of each patient's illness" (O'Brien 2001: 225). Moreover, the induced possession and dialogic communication with spirits that characterize *rukiyya* draw upon the pre-Islamic Hausa spirit

²⁰ He uses the older Hausa term *kanjamau* rather than 'HIV' or 'AIDS'. *Kanjamau*, which means simply AIDS in Hausa, comes from the Hausa verb *kanjam-*, 'to become thin or emaciated'. Many HIV-positive Hausa speakers take umbrage with the term *kanjamau*, finding it stigmatizing and preferring 'HIV' and 'AIDS'.

possession practice of *bori*, which has been effectively outlawed since the institutionalization of Shari`a (O'Brien 2001: 229). As this demonstrates, healing strategies may exhibit elements of syncretism, even as underlying assumptions about the causality of illness remain distinct.

Rubutun sha: Drinking the Qur'an

Malam Ismaila lives and works on the outskirts of a roadside town, twenty kilometers from metropolitan Kano. A HIV-positive acquaintance I knew from the hospital HIV clinic where I conducted research and who knew about my interest in different treatment approaches told me he had heard that Malam Ismaila reportedly cures HIV. A few days later, my research assistant Usman and I take a shared Peugeot mini bus taxi from Kano to the malam's town. We then take a short motorcycle taxi ride through millet fields and past an outdoor cement block operation to his residence.

Outside the entrance of the malam's walled family compound is a two-room building. In the first room, a dozen women wearing *hijab* sit on plastic mats, quietly talking together and waiting for the malam. In the second room, two men in all-white *babbar-riga* (the standard Hausa three-piece waxprint men's gowns) are sitting on plastic mats. Greeting the men and explaining that we have come to meet with the malam, they invite us to sit, saying that that the *malam* is on his way home. Hanging on the walls of the room are two poster-size color photos of *Masjid al-Haram* (the Holy Mosque) in Mecca, another of the *kaaba*, a black velvet hanging with the 99 names of Allah, and another large and colorful laminated Islamic prayer.

Also hanging from nails high on the wall are two embroidered leather *gafaka*, the satchels used by scholars to carry the Qur'an.

Stretched out on mats in front of the men are dozens of tall stacks of long white paper on which verses from the Qur'an (*ayoyi*) have been hand-written in Arabic in golden-brown ink, thirty repetitions per sheet. As we chat, the men work at collating eighteen sheets of inscribed paper at a time from the various stacks, rolling them tightly together, then tying these bundled pages inside thin black plastic bags. These verses, which the *malam* writes for many hours a day, are given to patients to cure them of their afflictions.

Literally, 'writing for drinking', *rubutun sha* is a practice whereby a *malam* writes verses from the Qur'an with non-toxic ink, either directly onto a wooden writing board (*allo*) or onto sheets of paper. The verses are then washed off the board with water, or rinsed off of the paper. The afflicted person drinks the resulting liquid, literally internalizing the potency of the verse. Alternatively, the liquid is applied by the afflicted all over her body as a wash.

As with *rukiyya*, *rubutun sha* involves using verses from the Qur'an to heal. Whereas in the practice of *rukiyya* the afflicted is penetrated by the Qur'an aurally through the medium of the malam's voice, in *rubutun sha* the afflicted literally ingests, or covers herself with, the power of Allah. Using verses from the Qur'an for healing purposes, whether recited or ingested, is a manifestation of prayer, an act of piety and devotion aimed at providing relief for the sick (Wall 1988: 237). Still popular among some Sufi-oriented *malamai*, *rubutun sha* has been criticized by anti-Sufi reformers as an innovation without proper scriptural basis.

Is it true, I ask the men as we wait, that the *malam* can cure HIV with *rubutun sha*? "Absolutely!" the men reply. The malam sees people with a variety of ailments, they tell us, but most of the people with HIV who come to see the malam are women; many of them widows.

A car pulls up outside, and Malam Ismaila emerges with three young men, each carrying giant zippered bags containing thousands more pages of hand-written verses. The malam is tall, commanding, and around 60 years old. He wears a well-embroidered gown, and his face is covered by a few days' growth of white whiskers. A long strand of plastic red prayer beads is wrapped around his right hand and hangs almost to the ground. We greet each other, and Usman explains that we are the people who had called the previous day to set up a meeting with him.

Malam Ismaila says with a smile that he is obsessed with the Qur'an—for decades he has spent many hours a day writing verses from the Qur'an. He also demonstrates for us how he divines with the Qur'an: asking a question, he balances two wires that come out from his Qur'an on his fingers, and discovers the answer to the question based on which way the Qur'an turns. Citing the Qur'an, the malam tells says that the word of Allah through the Prophet will cure HIV or any other illness—and that it is impossible that it cannot. I ask him what he tells HIV-positive people when they come to him seeking treatment. He responds:

*I tell them when they come, 'This one [antiretroviral therapy] is not a cure.'*²¹ Everyone knows it's not a cure. The drugs they give them in hospital are not a cure. Everyone knows that. So I tell them just to have faith in what I am

²¹ Malam Ismaila switched quickly between Hausa and English when he spoke, as is common among some bilingual speakers in Nigeria. I transcribe his Hausa utterances in italics and his English utterances in standard script.

giving you, because I am giving you medicine from the holy Qur'an, and [with the] holy Qur'an it is inevitable you are going to get cured. Have that faith and forget about the drugs in the hospital. A lot of them have taken the advice I gave them, they have avoided the modern medicine; a lot of them are cured. Those who have started [*rubutun sha*] early have been cured completely. *This one from Abuja* [a sick boy he had mentioned curing of HIV earlier in the interview], I gave him *this prayer one time*, and he drank it just only once, and that was it [he was cured]. But you know, people are different, and *however Allah wants to do things, if he shows me that 'this person will become cured, he will be cured. That's why, before I give it [rubutun sha] to someone, I ask: 'Allah, will this person become cured if I give him this rubutu? Will he be cured? Will this prayer work on him? If I see it is said [by Allah] that it will work, I'm certain it will work. I agree to it, and I'll give it to him. But if it's said [by Allah], [...] that this disease is going to kill [you], you know it's going to kill you, I'll be able to tell you the truth. I won't waste time to say 'That person's dying.' I'll say to them, 'It's not going to work.' But if it's going to work, I'll tell you it's going to work.*

Later in the interview, I ask Malam Ismaila to explain his understanding of the origin of HIV. In posing the question, I was curious whether, based on his treatment approach, he presumed that HIV had a viral or spiritual origin. Without expressly rejecting viral causation, his response emphasized the disease as a divine retribution for moral disobedience:

If you commit adultery, there are things that will happen. You know a lot of diseases are contracted from sex. So what's why [Allah] said, 'Don't commit adultery'. Don't even go near it. If you don't do it, if you don't go near it, you'll be spared. Lots of people think that they are going to be able to fool Allah: you're going to do it [adultery], you're going to just put on a condom, you're going to protect yourself. You cannot protect. Even with condom you can still get AIDS. [He addresses Allah:] Allah if that's how it is, Allah, cause this Qur'an here to turn, Mohammed peace be upon him²². [His Qur'an, balanced from wires on his two pointer fingers, turns to the right.] There's no escape. Go and use condom and think that you are protecting yourself, and God will say, 'Because you are defying my authority, contract this disease.' It's said that AIDS has been created in a laboratory. That is just nonsense. I don't believe in that. Nobody has created AIDS in laboratory. It is just one of those punishments that God has sent. Even after AIDS there will be another deadly disease that will come, much more deadly than AIDS.

²² 'Mohammed sallallahu 'alaihi wa sallam' in the Arabic.

The biomedical story of the origin of AIDS begins on the microbiological level, with the theory that simian immunodeficiency virus crossed into the human population in central Africa and mutated to become HIV. Certain sexual exchanges and other exchanges of bodily fluids are the modes through which viral transmission occurs, but standard biomedical etiology does not account for the moral status of the act that caused the viral transmission. Individual practitioners of and adherents to biomedicine are of course imbued with social judgments about the moral status of behaviors and individuals involved in disease transmission. But biomedical etiology, to the extent that it exists independently of moral-normative beliefs of individuals and societies, does not consider the morality of the act or actors relevant to transmission.

By contrast, Malam Ismaila's understanding of the origin of AIDS is rooted in the transgression of conservative sexual morality and divine punishment. In his account—and it is an account that is common in Nigeria—human deviance from God's scriptural mandates brought about the AIDS pandemic. For Muslims who assert that AIDS is foremost brought about by human distance from scriptural mandates, and who furthermore believe that the Qur'an is unmediated perfection, practices such as *rukiyya* and *rubutun sha* are necessarily efficacious forms of therapy. By literally imbibing the word of the Qur'an through *rubutun sha*, or through aural penetration of the Qur'an in the practice of *rukiyya*, the sufferer/sinner is brought back to wellness and back into the moral fold. Malam Ismaila's perspective that AIDS is a divine punishment is made even clearer by his

insistence that condoms are an ineffective means of prevention. Condoms, according to this line of reasoning, do not efface the underlying sin that is the *true* origin of one's infection.

In summary, Islamic healing in contemporary Northern Nigeria encompasses a range of herbal and spiritual approaches centering on the traditions of prophetic medicine and on more heterodox methods such as *rubutun sha*. Promulgated by both Sufi-oriented and anti-Sufi reformers, prophetic medicine is the first resort to care for many Northern Nigerian Muslims with a variety of physical and spiritual complaints. Compared to the impersonal atmosphere and frequently curt service provided at government health facilities, the “amicable, intimate, elaborate and often ritualistic approach” of the *malamai* makes Islamic healing a comparatively attractive option (Abdalla 1997: 30).

Despite their popularity, Islamic healing practices are both largely unregulated and largely unsupported by the ministries of health in the northern states. Of the estimated 30,000 Islamic medical centers, Islamic chemists, and other traditional medical practitioners in Kano State, as of 2010 only seven were registered with the Kano State Ministry of Health's Private Health Institutions Registration Unit. On the one hand, if state health ministries support and recognise Islamic medicine and other traditional practitioners, they risk a reproach from the biomedical establishment. If, on the other hand, they more strongly censure Islamic health centers and Islamic chemists—when, for instance, individuals claim to be able to cure HIV—they risk being branded as un-Islamic. The compromise they

strike seems to be not licensing such practitioners but allowing them to operate.

Medical syncretism and the therapeutic economy of HIV/AIDS

Nigeria is an undeniably medically pluralistic society. When Nigerians become ill there are many sources from which they seek healing, including a wide range of 'traditional' healers, spiritual churches, Islamic healers, herbal stores, and street hawkers, in addition to Western-style hospitals, clinics and pharmacies. Patients frequently 'shop around' among different healing options in attempts to find affordable solutions to their problems (Oyebola 1986). In Northern Nigeria, as Abdalla stated, "even among the educated there are many who see no contradiction in consulting a traditional practitioner in the evening and seeing a Western-trained physician in the morning" (1997: 30).

Vinh-Kim Nguyen's concept of 'therapeutic economy', is useful for conceptualizing HIV/AIDS treatment in Northern Nigeria. Nguyen defines the term as "the totality of therapeutic options in a given location, as well as the rationale underlying the patterns of resort by which these therapies are accessed", and the "practices, practitioners, and forms of knowledge that sufferers resort to in order to heal affliction" (2005: 126). *Malamai* and other neo-traditional medical practitioners and systems have not only reacted against competition from biomedicine by rejecting it forthrightly; they have also adopted elements of biomedical practice and discourse. This suggests not only medical pluralism, but also widespread syncretism in Northern Nigeria's therapeutic economy of AIDS.

Harry West argues that "so-called traditional healers" in Mozambique "situated themselves at borders between the traditional and modern, between the indigenous and the scientific, between the familiar and the foreign, between the local and the global, between this world and a dimly perceived other world, and even between good and evil" (2006: 24). Similar dynamics are at play with many *malamai* and herbalists working in prophetic traditions. Somewhat paradoxically, as in many senses they are in competition with each other for patients and funds, the authority of prophetic and biomedical practitioners is mutually constitutive in Northern Nigeria. That is, practitioners of both of these broad classes of healing tradition draw upon the other system when interacting with patients. Muslims in Northern Nigeria generally disapprove of and disparage religious "innovation", believing that the incorporation of other practices is tantamount to a betrayal of faith. But as Ferdinando (1995) notes, syncretism is particularly likely to manifest itself in the context of sickness and suffering.

In January 2001, the Infectious Disease Hospital (IDH) in Kano submitted a *Preliminary Report on the Use of Sujuud Foundation's Preparation in the Management of HIV/AIDS Patients* to the Kano State House of Assembly.²³ The three members of Sujuud Foundation, described in the report as "well known to the Hospital", "indigenes of Kano State", and "practicing Muslims", visited the Medical Director of IDH in 2000 to inform him that they had "found a cure for HIV/AIDS". Furthermore, the Foundation wished to conduct a clinical trial on HIV-positive patients being seen

²³ Sujuud, also spelled 'sujood' in English, is the Arabic word for 'prostration', as in prayer to Allah.

at IDH to prove that their treatments did in fact cure the disease. IDH authorities referred Sujuud Foundation to the State Ministry of Health, who in turn directed IDH authorities "to collect and use the preparation on willing patients". On their visit to IDH on 6 October 2000, the Honourable Speaker and several Honourable Members of the State House of Assembly visited IDH to observe the conduct of the trial, and told IDH to furnish the Ministry of Health and State House of Assembly with a full report.

Sujuud's preparation, the report continues, consists of "Rain water, Pomade (vaseline), The holy water of Zam - Zam, and Pure, unadulterated Honey." Taken together, these items "are mixed with some portion of the Holy Quran (the portims [sic] are written on a slate then washed and the solution mixed with the 4 items) = (RUBUTU)." Patients were instructed to first "wash the whole body including all crevices, all orifices, the palms and soles etc." with rainwater, then to rub the pomade all over the body in the same fashion. Three tablespoons of Zamzam water were then to be swallowed at intervals three times over a period of six hours. And finally, a tablespoon or teaspoon of honey was to be consumed first thing every morning for the next 16-21 consecutive days, with "no further treatment after 21 days unless otherwise indicated." During the trial, Sujuud Foundation's preparations were given free of charge to willing patients; the foundation also paid for "about 75%" of labs for testing patients' pre-treatment CD4+ cell count.

59 HIV-positive patients were recruited into the trial, 28 with asymptomatic HIV infection and 31 with "recognized signs and symptoms of AIDS/ARC." Each patients' weight and CD4+ cell count were measured prior to beginning the Sujuud

regimen, again after the full 21 day course, and "in a few cases" again 50 to 60 days after the start of treatment. The report notes that of the 28 asymptomatic patients enrolled, 15 (53%) had their CD4+ cell count measured again. Of these 15, 10 (66%) showed "a remarkable improvement", while the remaining 5 had their CD4+ counts fall. (It is unexplained in the report why the other 14 patients who were initially enrolled were not tested again at the conclusion of the 21-day regimen.)

In the 31 patients initially enrolled in the trial who were already diagnosed with AIDS/ARC, 11 were lost to follow-up. Of the remaining 20, "only 6 had an increase in their CD4+ cell count while 14 of them died." The report concludes: "Based on the post-treatment CD4 + cell count level we may safely assume that the SUJUUD PREPARATION is effective in offering relief to HIV/AIDS patients. However, the efficacy of the preparation in curing HIV/AIDS is not proven by this trial. More research should be conducted on the preparation so as to improve its efficacy."

Sujuud Foundation's owners did not explicitly explain the mechanism that lead to increased CD4+ counts in those patients who experienced them, but the implication was that they had discovered, through quasi-scientific means, the precise combinations and timings of prophetic treatments. Sujuud treatments come in plastic containers of standard sizes. On each bottle, along with the name, address and logo of the business²⁴, are dosing instructions. Moreover, the Foundation keeps

²⁴ While the Sujuud Foundation indeed calls itself a foundation, implying some sort of non-profit and charitable endeavor, it is indeed a for-profit business. This point became particularly clear to me when I asked the founders how many patients they had near their start before the arrival of ARVs, and in 2010, six years after ARVs became much more widely available. Rather than state a number of patients, they

patient records in files that are remarkably similar to those found at biomedical facilities. While the treatments are an amalgamation of different prophetic remedies, the specificity of the dosing guidelines, patient record keeping format, and quasi-clinical trials are indicative of the incorporation of biomedical reasoning.

Elisha Renne argues in her ethnography of the Northern Nigerian response to the Global Polio Eradication Initiative that, "when the situation warrants, both "modern" Western and "traditional" Hausa medications may be seen as appropriate. The reception of Western medicine also depended on circumstances. During epidemics, people were more amenable to trying Western care, particularly when local medicines and treatments were ineffective" (2010: 19). A similar dynamic has been developing with HIV treatment. As biomedical therapies have become more widely available, many fewer people have come to seek care in recent years from *malamai* and herbalists. As I explain in the next chapter, a sizable technocratic infrastructure has been installed to manage patients in biomedical care. Most importantly, this treatment migration in HIV care is related to the perceived efficacy of biomedical care.

'Every disease has its cure'

In many Muslim societies, "ordinary conversation is laced with Quranic formulae to the point where even the most mundane subjects seem set in a sacred frame" (Geertz 1976: 1491). Muslims in Northern Nigeria regularly quote from the

responded by saying how much money they had made in a month when they began their operation and now. It was clear that business had been decimated.

Qur'an and hadith in everyday discourse to express and affirm guiding principles of social life. This practice is especially common when discussing central concerns, such as life and death, right and wrong, humankind's relation to Allah, and humankind's place in the wider world.

In conversations pertaining to health, by far the most consistently articulated proverb is: 'For every disease that God has sent to humankind, He has also sent its remedy'. Attributed to the Prophet Mohammad in several often-quoted *hadith*, this proposition is foundational to Muslim ideas about illness and healing (al-Jawziyya, 1998: 9–10). In everyday conversation, the proverb is expressed with the more succinct Hausa phrase, 'Every disease has its cure' (*Kowace cutar da maganinta*). In addition to being a frequent conversational utterance, the proverb is seen in the advertisements and signboards of prophetic medicine practitioners, and even written on the back of public buses.

The affirmation that Allah sends a cure with every disease is also common in discussions of HIV/AIDS.²⁵ This sentiment offers hope in the midst of a devastating public health crisis; it also has the potential to unify the Muslim community's response to the epidemic. But from another perspective, the proposition that every disease has a cure can be seen as inappropriate and even dangerous when applied to HIV/AIDS. In the dominant biomedical understanding of HIV, the virus presently has no cure. Where ART has been the standard of care since its rollout in 1996 (particularly, that is, in the world's richest countries), HIV infection is now widely

²⁵ This has been true for other Muslim communities in Africa too. See, for instance, Svensson (2009) on Muslims in Kisumu, Kenya.

considered a manageable, chronic disease. The goal of ART is not to eliminate the virus, but to suppress it as much as possible, thereby forestalling indefinitely its progression to AIDS. From the biomedical perspective, HIV cure claims have generally been interpreted as the self-serving assertions of denialists and profiteers.

Many *malamai* insist that HIV can be completely cured by faith in the supernatural power of the Qur'an and proper combinations of *materia medica* prescribed in Islamic texts. The ability to completely cure HIV/AIDS (or, more precisely, to serving Allah's will in manifesting the cure) is professed in advertisements, radio broadcasts, and other forums where *malamai* discuss the disease. Dr. Inusa, with whom I began this chapter, was among the most passionate of the *malamai* I interviewed in articulating his ability to cure HIV, but was far from alone in asserting that Allah reveals the cure to dedicated Islamic scholars. Such assertions constitute a response to the increasing therapeutic hegemony of ART in Nigeria. Taken further, those who profess that HIV/AIDS can be cured by prophetic medicine confirm the omnipotence of Allah and the inferiority of secular (and hence fallibly human) biomedicine.

Without falsifying the proposition that a divine cure for HIV exists, many Muslim patients on ART and the predominantly Muslim biomedical staff who treat them express skepticism about whether Allah has yet to reveal the cure to humans. The growing numbers of HIV-positive Muslims who consume ART, some of whom simultaneously pursue forms of Islamic healing, are therefore positioned somewhere at the intersection of two different cultural-institutional understandings of HIV and its treatment. As Van der Geest and Hardon (2006) point out, "neo-

traditional" drugs for preventing and treating AIDS developed without competition from ART. Whereas health workers advise patients today against neo-traditional treatments out of concern for pharmacological interactions with ART, patients may consider neo-traditional medicines as complementary or even alternative to modern pharmaceuticals.

With the exception of those who claim that ART is inferior to Islamic remedies or too toxic, some *malamai* consider ART to be beneficial, even advising complimentary therapy with Islamic treatments. Many patients on ART, and the biomedical staff who care for them, praise ART for the frequently transformative effects these drugs have in the lives of HIV-positive people. No one I spoke with said they believed ART constitutes a cure. ART is conceptually distinct from the notion of a 'cure' — which, from the Islamic perspective, is the sole providence of Allah.

On the one hand, Islamic approaches to health emphasize the will of Allah, attending to not only the physical but also to spiritual components of health and disease. Standard biomedical etiology and treatment, on the other hand, focus nearly exclusively on measurable changes to individual bodies, denying the importance or even the existence of spiritual aspects of wellness and illness, and categorically denying the existence of a cure for HIV. In what follows, I highlight how different people in Northern Nigeria talk about ART, cures, and negotiate these two conceptually distinct aspects of the therapeutic economy of HIV.

Isa is in his late twenties, has been HIV-positive for three years, and is a member of a hospital-affiliated support group for people with HIV. While he is enrolled as a patient at a hospital HIV clinic, his doctor has told him that his CD4 cell

count is high enough that he does not yet qualify for ART. When I asked him to explain what he thought about HIV treatment, he responded: “As a Muslim, I agree that God has never made a disease for which He has not also sent its medicine. So even if we don’t have the cure [for HIV] now, it’s here. We just need to find it, because God has sent it down to us. We just haven’t reached the time yet when we can say, here’s the medicine; drink it and you’re cured.” Here, Isa offers an interpretation of the *hadith* that is common among HIV patients and practitioners operating in the biomedical system: that a cure for HIV exists *somewhere* in the world, but human beings have not yet discovered it. This interpretation does not falsify the *hadith*, which would be considered blasphemous, but proposes instead that revelation of the cure to human beings is forthcoming.

In *Medicine of the Prophet*, al-Jawziyya (1998: 10) considers a similar interpretation: “It is also possible that [Muhammad’s] actual words were: ‘For every disease there is a remedy,’ to be taken in a general sense, so as to encompass fatal illnesses and those which no physician can cure. In that case, God the Most Glorious has appointed remedies to cure them but has concealed the knowledge of such remedies from humankind, and has not given man the means to find out. For created beings have no knowledge except that which God has taught them.” From this perspective, Allah — source of everything in the universe, including human knowledge — has not yet revealed the cure for HIV to people. The cure is, as it were, hidden in our midst.

Ali, a member of the same HIV support group, is a businessman in his mid-thirties who fell seriously ill before testing HIV-positive a year before starting on

ART. Having spent over two million naira (about US\$14,000) of his own money trying to cure himself with a variety of herbal treatments, he expressed gratitude to the staff of the hospital HIV clinic—where, he pointed out, the ART was even free. Ali compared his life before and after being on ART:

I'm not afraid to tell anyone, now, that I have this disease. Before, if you got HIV, you had to hide it because there was no medicine. But I've never been fatter than I am now—I feel strength in my body. Since I've started ART I've never had a headache or malaria. I have a mosquito net, I eat regularly, and I don't mess around with taking my meds at the proper time [...] Before I was enlightened [about HIV], I told you, once someone told me that they would give me a treatment that would cure me—what do they call them, 'native doctors'? I went to Ilorin, I went to Lagos, I went to Kaduna, and I even went out into the bush to seek out a treatment, buy it with my own money, to get healthy and cure myself completely. But now I know it's a lie. People say they have a cure, but they never explain how it works. They say, 'We understand this disease, we know how to eliminate it from someone's body. Just take this treatment once and you'll be cured.' But if you don't mess around with taking your real medicine [i.e., ART], you won't have problems.

The costs of treatments provided by practitioners of prophetic medicine vary based on the form and duration of treatment, the practitioner, and the financial situation of the patient. In Nigeria, where the price of most goods and services is negotiated, *malamai* commonly say that they 'show mercy' in pricing their remedies for poorer patients. That being said, it is not uncommon for treatments to cost upwards of the equivalent of US\$100 a month for several months—a significant financial investment for most Nigerians. In narrating his therapeutic migration from cure seeking to ART, Ali reflects on his pursuit of a cure as futile and unenlightened. He attributes the major improvements in his health to a strict adherence to his ART and other health promoting habits, such as eating properly and using a mosquito net. He criticizes in no uncertain terms those who claim they can cure HIV on the

grounds that they do not explain how these alleged cures work. Like many patients now on ART, Ali's enthusiasm for ARV drugs are associated with the physical, financial, and emotional costs he suffered before he started taking them.

Dauda, an HIV-positive man in his early thirties who is employed as an ART adherence counselor at a PEPFAR-funded HIV clinic in Kano, expressed similar frustration about those who claim they have a cure, namely because they are not forthcoming about the curative mechanism. When I asked about the difference between the hospital clinic where he worked and a nearby Islamic health center, he said:

Some people approve of this [prophetic] type of medicine and some don't. There are differing opinions, and the relationship [between prophetic practitioners and biomedical practitioners] isn't always very good. Do you see what I mean? Some [*malamai*] are just doing it to be in the market, to make money. They think that we [at the HIV clinic] are trying to encroach on their business, and they're not happy about it.

Highlighting the economic element of the therapeutic economy of HIV, Dauda makes the case that *malamai* working in the prophetic tradition are displeased with biomedical practitioners and their provision of ART because this competition encroaches on their business. He also posits a larger mutual distrust between biomedical and prophetic healers. Dr. Inusa responded similarly to Dauda when I asked him about the relationship between prophetic and biomedical practitioners:

There's a good relationship among those of us who practice Islamic medicine, those who practice traditional medicine. We have a mutual understanding. We even meet together to exchange views and help each other. Every medicine, if it's not Western, it gets called traditional by Westerners. [He chuckles]. Westerners don't concern themselves with Islamic medicine. Every medicine that's not Western is "traditional" to them. So because of that, we [non-biomedical practitioners] unite to help each other out.

Masu maganin gargajiya (traditional healers), the larger category with which many healers working in Islamic traditions align themselves²⁶, consider themselves to be distinct and largely at odds with practitioners of *maganin Turawa* (Western biomedicine). There are several national, state, and local associations in Nigeria for herbalists, traditional doctors, and other non-biomedical practitioners. While *masu maganin gargajiya* are in some ways in competition with each other for patients, and often advertise their practices in a variety of media, they tend to view biomedicine as a much more serious source of competition. *Masu maganin gargajiya* frequently decry their lack of support by the Nigerian government, despite the fact that they are many Nigerians' first resort to care. Dr. Inusa's accusation that Westerners lack respect for other healing systems is a frequent refrain among those who work outside the biomedical system. He continued:

There's a *hadith* that says — Look for your medicine with Allah. God has never sent a disease for which he has not sent its medicine — it's a *hadith*. And another *hadith* says — The one who knows the proper cure for something knows it, and the one who doesn't know it doesn't know it. The one who doesn't know the cure, he shouldn't say it doesn't exist. Rather, he should simply say he doesn't know it. We Muslims don't agree that there's a disease that can't be cured. We don't agree. That's why at this health center we cure our patients. We've even had witnesses come visit and see that the cure is real; they've seen the [blood] test results. You see this gift. Our faith doesn't allow that there is no cure. We give medicine out in the open, and

²⁶ However, a few Islamic healers also told me in interviews, *'I am not a traditional healer'* (*'Ni ba mai maganin gargajiya ba ne'*), in order to emphasise the Islamic foundations of their practices and distinguish themselves from herbalists and spiritually based healers who do not adhere as closely, or at all, to Islamic precepts. Hundreds of traditional healers not operating under the rubric of prophetic medicine also exist in Kano; they tend to be found in or near Sabon Gari, Kano's primarily Christian neighbourhood, where many southern Nigerians live and work. While some of these produce and sell herbal 'immune boosters' that are of interest to some people living with HIV, I have never heard these individuals claiming that they can cure HIV.

people are cured — praise be to Allah.

Dr. Inusa's repeated insistence that he is able to cure HIV is based on what might be considered a literalist exegesis of Islamic texts. According to him, the *hadith* on diseases and their cures imply not only that all diseases are potentially curable, but that they are necessarily curable now. Addressing critics who doubt the presence of a cure, he rhetorically reframes their skepticism into an agnostic suspension of judgment: How can these critics be so certain that there isn't a known cure? And if they cannot be absolutely certain, shouldn't they say that they are uncertain, rather than saying that there is no known cure? Dr. Inusa's insistence that his Islamic center provides cures for patients with HIV, whereas biomedical facilities provide only non-curative treatments, finds some rhetorical support from another passage from *Medicine of the Prophet* concerning the efficacy of prophetic medicine: "Religious and Prophetic medicines heal certain illnesses that even the minds of great physicians cannot grasp, and which their science, experiments and analogical deductions cannot reach" (al-Jawziyya, 1998: 8).²⁷

Another *malam*, who like Dr. Inusa was one of the few *malamai* officially registered with the Kano State Ministry of Health's Private Health Institutions Registration Unit, advertised in a popular weekly Hausa-language newspaper, saying that at his center: "HIV/AIDS is completely cured [holistically]"²⁸ Another,

²⁷ Nor has this assertion been limited to either Nigeria or Muslim Prophetic medicine. West recounts a government official in Mozambique (presumably a Christian, although this is not stated) telling him proudly that, "traditional healers know cures for diseases that Western medicine cannot heal. They even know cures for diseases that Western medicine has not yet diagnosed." (2006: 21)

²⁸ In the original Hausa: '*HIV/AIDS warkewa ake gaba daya [holistically].*'

advertising in the same newspaper, says perhaps more subtly that “Every disease has its medicine... we have medicines [*magani*] for uncontrollable diseases like high blood pressure, AIDS, ulcer, typhoid fever, and the rest.”²⁹ The Hausa word '*magani*' is typically translated into English as 'medicine,' but also carries the connotation of 'cure.' Thus, when someone professes to have '*magani*' for an illness, he is at least claiming to have medicine for it — although in Hausa, this is conceptually linked with the concept of a cure.³⁰

At any rate, since concepts of 'relief' and 'cure' are often highly subjective, healers have vested interests in defining these terms in ways that are favorable to themselves (Wall 1988). When pressed on how they know whether they have succeeded in curing a patient of his or her HIV infection, some *malamai* insist that a patient's general physical and emotional improvement evinces the cure. Those who adopt a perspective of HIV as a virus often profess that a substantially improved CD4 cell count is evidence that their treatments have worked — thus adopting the main marker of ART efficacy in Nigeria.³¹ Some insist that patients they have cured of HIV subsequently test negative for HIV antibodies, but that the Nigerian government and media suppress news of such HIV-positive to HIV-negative sero-

²⁹ In the original Hausa: '*Kowace cuta tana da magani...muna da magungunan gagararrun cututtuka kamar hawan jini, AIDS, gyambon ciki wato ulcer, zazza'bin taifod da sauransu.*'

³⁰ An HIV-positive man in a support group whom I knew was on ART once asked me: '*Me ya sa har yanzu ba mu da maganin HIV?*' ('*Why do we still not have magani for HIV?*'); I interpreted him to be asking why there was still no cure for HIV — despite the fact that ART constitutes a form of medicine for the disease.

³¹ Since it is a much more expensive diagnostic measure than a CD4 cell count, viral load is generally only measured in Nigeria when a patient experiences a substantial drop in their CD4 count despite being on ART.

conversions.

Back at the hospital HIV clinic I mentioned to Dauda, the ARV adherence counselor, that I had been surprised the day before when Dr. Inusa told me that he had devised a cure for HIV. To this Dauda responded:

Yes, there are people who say that they have a cure, and people drink it. Our Islamic belief is that every disease has its cure—except that we might not know it yet. Surely someone will be able to know the cure. But anyone who says they have the cure, it would be better and helpful if he comes out with it, shows it, makes a lot of it, so that we can give it to people to make them well. But if you have the cure and you keep it hidden under your bed—if you only give it to people who pay you a lot of money—that's not help. If you have the cure, people have to know.

In other words, given the extreme suffering brought about by HIV/AIDS, if someone has truly devised a cure then he is morally obligated to make it publically available rather than use it for his own profit. What is striking about this humanitarian position is that it parallels an argument several *malamai* have joined HIV treatment activists in making against Western drug companies who develop and sell ART: rather than keeping these treatments metaphorically hidden by intellectual property protections and prices that render them inaccessible to the vast majority of people with HIV, those who manufacture these the treatments have the moral responsibility to make them widely available.

Dr. Salisu, a Muslim biomedical doctor who works at the HIV clinic in Kano where I conducted fieldwork, offered this succinct opinion when I asked his opinion of those who profess they have a cure for HIV: "If they want to treat HIV patients with holy water, honey, and prayer, I don't have a problem with it. But to tell patients that they are cured and should stop taking their ART completely? It's a

crime." Dr. Salisu's statement might be interpreted to mean that he believes Islamic treatments offer some net spiritual benefit to HIV-positive patients, or that they at least pose no serious harm to them. He might also be conceding to the realities of practicing within the pluralistic therapeutic economy of HIV in Northern Nigeria. But by stating that it's criminal to tell patients to stop taking ART, he clearly indexes his doubt about the existence of a known cure.

Such a position finds justification in another *hadith* attributed to the Prophet Muhammad: "If anyone carries out medical treatment, yet previously he was not known as a medical man, then he takes responsibility" (al-Jawziyya 1998: 105). Al-Jawziyya points out that in this *hadith* that the Prophet did not say 'whoever is a physician,' but rather 'whoever practices medicine'; this indicates that the Prophet Muhammad ascribed legitimacy to a range of practitioners, not just established 'medical men.' But, al-Jawziyya (1998: 105) continues: "When a person carrying out treatment transgresses the limits of his knowledge and expertise and causes harm to the patient, he should be held responsible. One who lays claim to knowledge or practice which he does not have is an impostor."

When I asked him how he responds to those who remain skeptical or suspicious of ART and base the sentiment on Islamic grounds, Dr. Salisu said he appeals to the proposition—found not only in Islamic teaching, but common to several religious systems—that everything good is God's blessing:

I tell them that both Muslims and non-Muslims are created by God; Westerners—that is Europeans and Americans, developed societies—are created by God, just like we are. And God's mercy can come through both Muslims and non-Muslims. Just like we receive medication and treatment for other ailments apart from HIV through the Western society, just like we

receive good food, better than ours, just like we import vehicles and use planes produced by Western society to go for pilgrimage. So it's a blessing from God almighty, but it's coming through his creations who have different culture and religion than ours. You can't say that Western society is not the creation of the Almighty. So, the same way, if we have a disease, whether global or restricted to our society, the treatment or the cure may eventually come through any of God's creations, or any of God's doing, whether in the Western society or here. And I used to tell them that having treatment for HIV which suppresses the virus and makes someone to live well and longer is also a mercy of God, coming through Western scientists. Ok? We learn from what you [Western] people develop and transfer that mercy of God to our people. And you can't deny the impact of other interventions by Westerners in our health system. Would they [people critical of ART] then say that it's not the mercy of God?

Conclusion: A paradigm shift

In 2009, Nigeria's largest single Islamic organization, the Nigerian Supreme Council for Islamic Affairs (NSCIA), released a national Islamic policy on HIV/AIDS in an effort to unify the Muslim response to HIV and AIDS in Nigeria. In the policy's forward (NSCIA 2009: iv), His Eminence Muhammad Sa'ad Abubakar III, The Sultan of Sokoto and President-General of the Council, writes: "The Policy is based on the Teachings of The Glorious Qur'an and the Traditions of the Holy Prophet (SAW)³²" — a statement that is repeated several times throughout the 31-page document. Indeed, every page of the policy includes passages from the Qur'an.

Furthermore, the policy asserts, "Muslims...are committed to ensuring that persons infected or affected by HIV/AIDS including orphans and vulnerable children receive appropriate treatment, care and support in line with the National Guidelines for treatment of HIV and AIDS in adults and adolescents as well as the National

³² 'SAW' is an abbreviation for the Arabic phrase '*Sallallahu Alaihi Wasallam*' ('Peace be upon him'), and commonly follows mention of the Prophet Mohammad in Islamic texts.

Guidelines for pediatric HIV and AIDS treatment and care. To achieve this, access to quality healthcare and referral systems shall be encouraged with focus on ART, palliative care and establishment of support groups" (NSCIA 2009: 15). By emphasizing ART, NSCIA aligns itself with the national treatment guidelines established by the National Agency for the Control of AIDS (NACA), which itself follows UNAIDS's biomedical focus on ART as the currently accepted treatment for HIV. No mention is made in the policy of the existence of a cure for HIV, or of treating HIV/AIDS with *materia medica*, or of spiritual causes of HIV infection.

The policy states that Nigeria's Islamic HIV/AIDS policy "shall be based on the injunctions of the Glorious Qur'an and Sunnah of the Prophet (SAW)" (NSCIA 2009: 6), without further stating that the Qur'an *itself* be the primary medicinal agent (as it is in the practices of *rukiyya* and *rubutun sha*). In its assertion of a unified Muslim position that is closely aligned with mainstream biomedical approaches to treating HIV/AIDS, the policy makes no mention of a range of common practices and perspectives on the disease among Northern Nigerian Muslims who find their inspiration not from the policies of programs like UNAIDS or PEPFAR, but from classic Islamic texts. Similar to West's finding in Mozambique, policymakers and health officials "have not been prepared to conceive of traditional healers fully as colleagues, whether in the realm of medical research or health care. To do so would be to undermine their status as the authoritative guardians of vital therapeutic knowledge and resources" (2006:24).

Aside from being Islamic, what Islamic treatments share is a deep history not associated with ART. From the perspective of nonbelievers, Islamic prophetic

medicine may seem supernatural and unconnected to scientific reasoning. For many people I spoke with in Northern Nigeria, however, the curative mechanisms of ART are similarly shrouded in the unknown. And while some patients found little contradiction in consulting both biomedical and prophetic Islamic care for their treatments, the practitioners themselves were much more likely to express ill will towards the other system and its practitioners. This was particularly true to the extent that it was felt the other system disrespected one's own, harmed one's business, or put patients at risk.

In her research on the polio eradication initiative in northern Nigeria, Elisha Renne (2010) has demonstrated that there is no monolithic Islamic view on the value, effectiveness, and safety of the polio vaccine. Rather, parents' decisions about whether or not to have their children vaccinated against polio or other childhood diseases depends on education and social class, as well as particular understandings of the Qur'an and *hadith*. Felicitas Becker (2009) found similarly that Tanzanian Muslims' attitudes towards AIDS and ART are less predetermined by restrictive religious notions than they are influenced by the political process and different kinds of knowledge, reminding that Islam (like all religions) is lived in socially, politically, and culturally specific contexts. In a similar vein, I have argued in this chapter that a multiplicity of perceptions and values are expressed about prophetic medicine and other treatments for HIV in Northern Nigeria. Recent moves by Nigerian Supreme Council on Islamic Affairs to emphasise ART as the singular appropriate treatment for HIV/AIDS reflect how religious organisations often align themselves with broader secular, national and international donor policies on HIV

treatment. But despite the surety of language in the *National Islamic Policy on HIV/AIDS*, and in light of Islamic beliefs about healing and treatment efficacy, there is far from any consensus yet among Northern Nigerian Muslims on what constitutes the most efficacious or Islamically required treatment for HIV/AIDS.

Chapter 3:

The New Orthodoxy: PEPFAR and the Islamification of Antiretroviral Therapy

Introduction

The preceding chapter concerned the role of Islamic prophetic medicine in the therapeutic economy of AIDS in Northern Nigeria. I argued that in a region where many people use biomedical, prophetic, and naturopathic therapies in consort, which treatment strategies one pursues depends on a host of factors: availability, affordability, claims and beliefs about efficacy and harm, and assumptions about the origins of illness. In the pluralist therapeutic landscape of Northern Nigeria, different moral-medical systems have been subject to suspicion and derision by adherents and practitioners of other systems. In the case of AIDS, I demonstrated the harsh criticisms that some practitioners working in the Islamic prophetic tradition have levied against antiretroviral therapy (ART) and the biomedical establishment that undergirds it, and conversely the denunciations that biomedical patients and practitioners have issued against *malamai* who claim to cure HIV/AIDS.

This chapter addresses the rapid and overwhelming therapeutic migration from prophetic and naturopathic treatment of HIV/AIDS to ART-based biomedical treatment over the last decade. This migration has followed a massive influx of ART to Nigeria through the U.S. President's Emergency Plan For AIDS Relief (PEPFAR), the most expensive bilateral program to address a single disease in history. While

the PEPFAR program laid the groundwork for this migration, the perceived need, efficacy, and acceptability of ART have also been necessary conditions. I argue that the movement towards the biomedical care of AIDS has involved a discursive process I call the 'Islamification of ART': international organizations, national Muslim groups, biomedical practitioners, and patients' groups have come to frame ART as the Islamically acceptable treatment for HIV/AIDS

Ethnographically I focus on a PEPFAR-funded clinic in metropolitan Kano where over 10,000 people access ART and other biomedical therapies to manage their HIV. My aim is twofold: first, to examine the ideological and political economic underpinnings of PEPFAR, positioning the program in the larger context of Nigerian-U.S. relations. Secondly, I provide an account of how the program is experienced by Muslims living with HIV/AIDS and the biomedical practitioners who care for them.

The central questions addressed in this chapter are: 1) Through which processes, discourses, and institutions has ART-based treatment come to dominate the therapeutic economy of AIDS? 2) How has the expansion of ART-based care affected the lives of HIV-positive Muslims in Kano, and to what extent do men and women experience treatment differently? 3) What is the position of the PEPFAR program within the broader political-economic context of U.S.-Nigerian relations? 4) Given suspicion and rejection by some Northern Nigerian Muslims of drugs distributed for "free" by Western governments and international organizations in recent years, to what extent has the reception of ARV drugs followed, or bucked, this trend?

In addressing these questions I contribute to three strands of anthropological scholarship. The first strand is the critical medical anthropology of global health policies and programs, introduced by Judith Justice's 1986 account of foreign health assistance in Nepal and advanced comparatively by a growing corpus of anthropological scholarship over the last quarter century. Second, this chapter contributes to the scholarship on African nations' positions in the global political economy, and the effects of this structural position on governance and well being on the continent (e.g. Ferguson 2006; Mbembe 2001; Cooper 2002; Moore 2005; Watts 1994; Bayert 1999; Peterson 2012). Third, I synthesize Michel Foucault's concept of biopower (1973), Vinh-Kim Nguyen's concept of therapeutic citizenship (2005; 2010), and Paul Rabinow's concept of biosociality to theorize HIV patients' positions in today's PEPFAR-dominant landscape of biomedical AIDS care in Nigeria.

Patienthood as Observant Participation

Monday 19 July 2010: A shared taxi drops me at the main entrance gate and I snake my way on foot through the covered outdoor corridors to the HIV clinic at the far end of the hospital campus. The nationwide resident doctor strike is now in its fifth week and the hospital has been largely emptied of doctors and their patients. I arrive at the clinic at 8:08am, a few minutes past the 8am opening and later than I had wanted. Already about 14 male patients and 40 female patients are sitting on their respective sides of the waiting room. Several of the women have small children and babies in tow. I now know enough to look for the pile of salmon-colored patient registration cards; I see it on the floor outside the patient registration room to the

left of the clinic entrance. I open my card and place it face up on top of the stack. The first patients likely arrived by 7am or earlier, hoping for a shorter day at the clinic.

The 12 seats of the men's side near on the entrance level, near the TV, are already full. I take a seat in the front row of the shaded, open-air courtyard waiting area that's surrounded by the rest of the clinic. I choose a seat in the path of the large floor fan; even at this early hour it's already getting humid-hot. A chubby-faced orderly in his blue short-sleeve uniform works past with a wet mop. As I lift my feet to let him mop under me I hear a loud squeak as the window of the nurses' consulting room is opened. Farouk, a patient who volunteers³³ at the clinic and whom I interviewed last week, is looking out at me from the window with his impish grin. I walk up to greet him: *Ina kwana?* We exchange a few more standard morning greetings and he asks if I've come today to do research. No, I tell him, I'm here today to collect my drugs.³⁴ "Well, anyway," he says, "come in here. I want to talk to you about something." I walk around and come inside the room. "*Wallahi*", he begins, "since the day we did that interview last week I've been feeling terrible. Dr. Aminu gave me this prescription to get an injection, but I haven't had enough money." He pulls a folded script out of his wallet and hands it to me. The doctor's

³³ While his status in the clinic is that of a volunteer (in addition to being a patient), he is unofficially remunerated by patients for using his connections with staff to expedite patients' passage through the busy clinic, and by staff for doing various non-medical tasks. Informal, "intermediary" labor of this type is common in many settings throughout Nigeria, from transit centers to markets to government offices.

³⁴ While I had no intention to be deceptive, I see upon reflection that my answer Farouk was not accurate: although I was not conducting interviews or surveys in the clinic that day, I was writing fieldnotes. As discussed in Chapter 1, my dual position as researcher and patient in the clinic, and as researcher and support group member (as elaborated in Chapter 4) resulted in certain ambiguities.

scribble is too messy to make out, except for the price of the injection, 1800 naira (about US\$12). "I didn't even sleep last night," he continues. "I was throwing up. And my body itches." He scratches his wrist. "See here?" He pulls down his shirt collar to expose his collarbone. I can't really see anything in the unlit room, but I nod in sympathy. "And every time I stand up I feel like I'm going to fall down. Maybe it's my drugs."

"That's terrible!" I say. "How long have you been on your meds?" "Almost two years", Farouk replies. "So why should it be giving me this problem now?" "That's what I'm wondering," I say. "May God make it better." "Amin. My problem is I don't have enough for this injection. I only have 800 naira." He pauses, shakes his head, looks at me, lowers his eyes; I infer that he's subtly asking for my help. "Here, take this", I say, pulling a 1000 naira note out of the pocket of my *dogon riga* and putting it in his palm with a handshake. His eyes widen. "Oh, thank you. Thank you," he says. "It's no problem," I reply. " May God make it better."

I return to the courtyard waiting area. By 8:45am the number of female patients has doubled, and the number of men has increased by half. Most of the men seem to be in their late 30s or older; a few wear jeans and button down shirts but most are wearing locally tailored gowns in white or salmon color with matching hats. The female patients seem to be five to ten years younger than the men on average. The women chat much more amongst themselves, whereas the men sit mostly quietly, sometimes taking calls on their cell phones. The power cuts, the fan stops blowing, and after a minute I'm feeling sticky from the humidity. A woman brings a two-year-old girl and leaves her in front of the man sitting next to me, then

returns to the female section. They don't speak, but I infer that they are the married parents of the girl.

At 9am the clinic is an overcrowded buzz of activity. Danladi, the handsome young man who works in the patient registration office comes out with the stack of patient cards and begins calling names in twos, and the patients follow him off. Then another man from registration begins calling patients. The power comes back on; the fan starts blowing again. "The doctors are still striking," the man next to me says with a slow shake of his head, daughter on his lap. "It's awful," I say. He replies, "Doctors on strike for five weeks, and the president does nothing but go to convocations." He is chewing the twig of a *dogon yaro* tree. When his daughter starts getting restless he stands her on the ground and tells her, "Ok, time for you to go back to your mother." She toddles off to the women's section.

Eventually Danladi from patient records calls my name and I walk up to him. He looks down at my patient card, then up at me. "You are supposed to come back on the 23rd of the month," he tells me, frowning. "I know, but I'll be traveling then," I reply. "Wait for me up there," he says sternly, pointing to a clump of five other patients standing near the clinic entrance. After a few moments, the situation gets a bit tense. Sylvia, an HIV-positive woman who works at the clinic as a nurse's assistant, raises her voice at Danladi: "All these patients need to sit down!" Sylvia and Danladi argue, and we six patients are stuck in limbo, watching. "I'll knock your hat off!" she threatens, with what I hope is a sense of playfulness. Eventually Sylvia backs down and walks away. Danladi, still worked up from his altercation, admonishes us six patients for coming to clinic on the wrong day. "I know I'm

supposed to come on Friday, but I'm traveling out of town tomorrow and my pills are almost gone," I say calmly, trying to diffuse the situation and explain myself. Danladi shoots me a look that I register as somewhere between frustration and disgust. "Fine, go talk to Aziz", he tells me, handing me my patient card. "Which Aziz?" I ask. "The tall one that works with us," he replies, and walks off.

I guess he might mean someone who works in records, so I go to the records office. There is a man sitting at the desk. "Aziz?" I ask. "No, he's not here," the man replies. I look for Danladi and tell him I couldn't find Aziz in the office. "Well, wait for him!" he barks at me. I go back to the records office and wait by the door. After ten minutes the person I think is Aziz enters the office. I explain that I was supposed to come to clinic on Friday but need to travel tomorrow. "Ok, no problem" he says. "So I should go sit back down?" I venture. "Yes." I sit down again. Babies are crying, at least four staff members are calling out the names of patients, and people are moving in all directions. After 20 minutes, Aziz comes out and signals to me. "Your file's not here," he tells me. "Oh. It's not here?" I say, surprised. "He looks again at my card, and notices that I've also had appointments in rheumatology for gout. "Maybe your file is with rheumatology." I had assumed that each clinic had its own file for each patient; apparently not. Not clear whether I was being asked to go find it myself at the rheumatology clinic, I ask if I should go there to look. "No, just sit down again", he tells me.

After another 20 minutes, Nurse Kareem slides the window to his office open with a loud, high-pitched squeak, and signals for me to come to his office. "There's a problem," he says. "We can't find your file. Are you just here to collect your

medicine?³⁵ I tell him that I am. I return to the waiting area, concerned that I might not be able to get my drugs today after all. After another 30 minutes, I'm called back to wait outside Kareem's office. When the young woman seeing him before me comes out, I go in and sit in front of his desk. We greet warmly this time. He asks about my health, which I say is fine; no problems with my medications. He tells me I'll have blood drawn to check for renal failure today, since one of the meds I'm on can cause kidney problems. "Where do I go from here?" I ask. (I'm still learning how to be a patient here, and what offices I need to go through and in what order to follow the protocol.) Kareem explains that next I will go to TSS (Treatment Support Services), then to the registration office, then to the Adherence office, then drop my forms signed by TSS and Adherence at the pharmacy, then go to blood draw, then wait back at pharmacy to be called to collect my medications.

There is a big cluster outside of the TSS office³⁶. 10 people are waiting to get in. When one woman enters the office, another woman waiting says to a third woman rather aggressively, "You're not after her, *I'm* after her." I wait my turn, hoping that I and the other patients waiting will be able to keep track of the order of the queue. I see Farouk lying down in the patient day care room across the hallway,

³⁵ Even when doctors are not on strike, few but the sickest patients will see a doctor each time they come for an appointment. However, even during appointments where one is not seeing a doctor but "just" collecting one's medications, the process is tortuous because of the many bureaucratic steps one must pass through and the crowded nature of the clinic.

³⁶ The four full-time, paid staff of TSS are HIV-positive people tasked with providing peer education to patients, especially in relation to their treatment. While I did see this sort of peer education happening in TSS, my impression was that this intended peer dynamic was lost on most patients. Instead, TSS was perceived as a place to collect a signature--another step towards making it through the clinic bureaucracy and getting one's medications.

so I go in to ask how he's feeling. He looks slightly dazed but says he's feeling ok. Another 20-odd minutes pass and it's my turn to enter the small office. I sit in front of Hajiya Jamila and hand her my form and patient card. Checking my patient registration number³⁷, she calls out to the other staff which of the 30-odd volumes of patient records books she needs for me, and El Haji Sinusi passes it over from his desk. "Any problems?" she asks without looking up at me as she fills in some data and assigns me a 15 October return date for my next appointment. I say no. She tells me to return to the registration office.

I see Danladi again and give him my patient card. He writes 15 October in his ledger as my next appointment date. "From now on you must try to keep to your appointment," he tells me, more evenly than before. I nod, contemplating whether I should try explaining again that it's only because I have to travel for a conference that I came today rather than Friday. I decide to let it pass.

Next I'm off to the Adherence office, where the adherence officer Dauda is talking to another patient when I enter. We greet, I hand him my form, he signs it, records something in his ledger, and I'm done. (We certainly don't discuss any issues related to my adherence.) Having obtained the necessary signatures from the nurse, TSS, and Adherence, I walk back to the front of clinic to drop my completed form on the pile outside the pharmacy³⁸.

³⁷ Patient numbers are assigned sequentially, based on one's appointment in the clinic.

³⁸ Although called the 'Pharmacy', it's more of a dispensary given the limited number of medications that patients can obtain in the clinic.

Then I'm off to blood draw, at the back of the clinic. I walk in, blood draw form in hand, not knowing really what to do. I stand in the entrance of the small room and after a few moments a technician holds out his hand for my form. Another says, "Sir, sit," and I sit on his stool. "What am I doing for you?" he asks me. I look blankly at him, not sure what to say. "Chemistry," the other technician tells him. He finds a vein in my left forearm and draws a vial of blood. When he's taken what he needs, he hands me a tissue to press on my arm where he stuck me and puts the vial of blood inside a centrifuge machine on the counter. The machine has a sticker with the PEPFAR, CDC, and USAID logos and reads, "From the people and government of the United States of America."

I return to wait near the pharmacy. Two young girls wearing hijab and trousers, perhaps seven and ten years old, turn and stare at me. It's now 11:30am. A woman nearby--I wonder whether she's a patient too?--is selling small meat and potato pies out of a large plastic bucket for 50 naira (US\$0.33) a piece. I buy three pies and wolf them down. It's my first food of the day, and getting blood drawn always makes me a bit queasy.

Suddenly, and rather loudly, I hear a woman's voice: "Go fuck your mother!"³⁹ I turn and see a woman, fully veiled except for her eyes, coming out of the pharmacy in a huff. "Who is it?" another female patient asks her. "That useless short one!" the woman replies, referring to the man at the pharmacy office who has been calling patients up to collect their medicines. In a more hushed tone, and speaking in Hausa so fast that I can barely follow, she continues to insult the man.

³⁹ *Ka ci uwarka*, a common Hausa insult.

The other women sitting nearby turn to listen as she lays out her complaint against the man.

The pharmacy is the final step towards getting through the clinic and is always particularly bottlenecked and stress inducing. The wait seems to stretch on and on, not only because it *is* a long wait but because patients have already been waiting for a total of several hours just to make it to the pharmacy. The pharmacy office is off of the women's side of the clinic waiting area; male patients must strain to hear their names being called from inside the office from across the crowded courtyard. After an hour my name is called and I'm told to wait behind a woman in a line of about 10 patients waiting to collect drugs in the inner room of the pharmacy.

As I'm waiting in line, a man around my age in a light pink *tazarce* gown with some papers in his hand approaches me and addresses me in halting English. He hands me the papers, written in a combination of Japanese, English, and French. Looking through them I piece together that he is applying to do an engineering course as an exchange student at a Japanese university. His concern, he tells me, switching to Hausa, is whether he'll be able to get ARVs in Japan. I look through the health evaluation form he must submit with his application and do not see any question asking his HIV status. "There's HIV in Japan, so I imagine that if they accept you as a student you should have access to your drugs", I tell him. "But I think you should ask the advice of your HIV doctor." "I did", he tells me. "He told me the same thing you did." "I think you'll be fine", I say, smiling. "Like me, I'm an American studying here in Nigeria and I get my drugs here at this clinic. I was worried too

about whether I'd be able to get them here, but it's worked out fine." He thanks me, and we exchange names, phone numbers, and shake hands.

It's my turn to enter what I think of as the 'inner sanctum' of the clinic: the small drug disbursement room. Inside, two men sit behind their respective desks, each with a computer. Behind them, covering the wall, are tall cabinets full of ARVs and other drugs. As a patient rises I sit down in front of the open desk. "Your name?" the pharmacist asks. I tell him. "Which drugs do you take?" I struggle to remember the multisyllabic names of my medications. "What color are the pills?" Yellow; white. "And how do you take them?" Once a day, one of each, with dinner at 8pm. "Ok, here they are." He hands me six bottles of pills each in a small box, manufactured by an Indian pharmaceutical company. I put them into the black plastic bag I brought with me, having remembered the last time I collected my drugs and had to awkwardly carry the six boxes across the hospital campus in my hands.

I walk back to the day care room to check on Farouk, who is lying down and still looking rather dazed. I ask him if I can bring him something to eat and he says he'll take whatever I bring him.⁴⁰ I exit the clinic and walk to the nearest commissary hut and buy him some meat pies, donuts, and a malt beverage. On my way back, a woman who looks to be in her late 20s with her braided hair uncovered standing outside the clinic entrance tells me in English, "Please, I want to speak with you." "Ok, I'm coming back out," I tell her, suspecting that perhaps I am about to be

⁴⁰ Food is usually not provided to patients in Nigerian hospitals. This necessitates family and friends bringing food to patients, even for long hospitalizations. Patients must also purchase their own medical supplies and other sundries like toilet paper and soap, or are billed for them at the conclusion of their hospitalization.

asked out on a date. I bring Farouk the food, say goodbye, and tell him I'll call tomorrow to check on him. Walking outside I meet Nurse Kareem who is walking out with his prayer rug for the second prayer of the day, which male staff and patients perform at the entrance of the clinic. The woman, seeing me with Kareem, tells me, "Please, I hope you are not offended. I need transport fare to get home." "No problem," I say. "Where do you live?" "Sabon Gari" she replies, Kano's predominantly Christian neighborhood. I give her a 200-naira bill, and she thanks me. As we're walking away, Kareem tells me with a glint in his eye, "I have a feeling that she wanted to ask you something else, but because I was there she asked you for the money instead." He smiles.

Biomedicine in Northern Nigeria

The arrival of biomedicine in Northern Nigeria was recent, relative to other healing traditions. Nineteenth century European explorers occasionally gave medicines upon request and as gifts to members of the ruling elite (Lockhart and Lovejoy 2005: 520-21, cited in Renne 2010: 19), but European medicines remained unknown to most people in the region prior to the formalization of British colonial administration in 1903. Even during the colonial era, biomedical clinics, hospitals, and public health programs were few in Northern Nigeria, relative to other African regions under British colonial rule (Schram 1971).

The main reason for this relative lack of biomedical intervention was the indirect form of rule that the British pursued in the politically powerful and hierarchically organized Hausa-Fulani emirates and surrounding areas before

Nigerian independence in 1960. Believing the Hausa-Fulani to be more advanced than the peoples of the "pagan" chieftaincies and stateless tribes of the south, British administrators decided to operate through the established political structures of the emirates. This approach allowed the British to curtail spending, triage administrative efforts to other regions of its vast colonial empire, and minimize the perception that they were undermining the Islamic authority and political legitimacy of the emirs (Adamu 1978).

The British administration furthermore prohibited Christian missionaries from operating in Muslim areas of Northern Nigeria (Wall 1988: 125; Schram 1971). This was significant because throughout most of the colonial period and throughout most of Africa, Christian missions provided vastly more medical care than did colonial states (Vaughan 1991: 56). Moreover, and unlike elsewhere under colonial regimes where "native" healing practices were outlawed, Hausa medical and surgical procedures and methods for controlling mental illness remained legal and were not suppressed by the British (Last 2004: 719). To the extent that it was practiced, biomedicine in the colonial era was most evident in the form of public health campaigns to control the spread of infectious diseases, such as smallpox and meningitis. However, the vastness of the Northern region, poor roads, lack of trained staff, and limited infrastructure and resources made even these efforts immensely challenging (Renne 2010: 32).

Political and economic motivations were main drivers of biomedical expansion in colonial African societies (Vaughan 1991; Lock and Nguyen 2010: 154), Nigeria inclusive. This is not to say that the expansion of biomedicine was

motivated by the goal of resource extraction in any one-dimensional way. Rather, the distribution of medicine was a means of forging and solidifying political-economic alliances in the (decidedly non-egalitarian) terms of Nigerian-British colonial engagement. Furthermore, colonial-era Nigerians generally viewed British medical interventions as beneficial. In what follows, I argue that similar dynamics persist today in the postcolonial era: Those countries with interests in Nigeria's oil resource are overwhelmingly those that fund public health initiatives in Nigeria. The PEPFAR program epitomizes this dynamic.

The availability of biomedical care in Nigeria today is highly stratified by wealth, and relatedly by rural/urban location. Despite having the second-largest economy in sub-Saharan Africa, government expenditure on healthcare is very low. The Nigerian government spends about US\$25 per citizen on healthcare annually, ranking Nigeria among the countries with the lowest per-capita spending on healthcare in the world (World Health Organization, 2012). The WHO has ranked Nigeria's health system 187th out of 191 nations (World Health Organization 2000).⁴¹

Nigeria has a three-tiered government health system: the country's 774 Local Government Areas (LGAs) are responsible for primary health care (with some funding and regulation from the state and federal levels); the 36 states manage secondary-level general hospitals; and the federal government coordinates the

⁴¹ I hesitate to include this ranking as the research itself has been criticized for methodological problems (e.g. Coyne and Hilsenrath 2002). That Nigeria was ranked anywhere near the worst in the world, despite its sizable economy, at least gives some indication of the state of health care in the country.

tertiary-level university teaching hospitals and Federal Medical Centres. The biomedical health system in Nigeria is underfunded, understaffed, and inadequate to the size of the country's population at all levels. Government hospitals and clinics are overcrowded and understaffed, often lack drugs, and medical equipment is often out of operation. Nigeria's worsening shortages of electricity and municipal water further affect not only hygiene and medical safety, but also compromise Nigerians' faith in their nation's medical system (Last, 2004). These problems have been particularly acute in the vast northern region.

Primary care clinics are particularly inadequate. Deterioration in government facilities, low salaries and poor working conditions had resulted in a mass exodus of professionals from primary health care in Nigeria, a problem which has been particularly acute in rural areas (Abdulraheem 2012). In some LGAs, clinics have few or no staff and sit shuttered much or all of the time.⁴² Rural populations are especially underserved: not only is primary health care in a deplorable state, but the distance and uncertain transportation from rural villages to state-level and federal hospitals make hospitals effectively inaccessible for many rural people.

In the absence of a reliable government health system, and in addition to seeking care from a variety of neo-traditional and faith-based healers, Nigerians pursue biomedical treatments on the open market. In effect, one's ability to access a

⁴² In June 1990 responsibility for primary health care services in Nigeria was transferred to the Local Government Areas, a decision that followed the International Monetary Fund structural adjustment program requirement that the federal government curtails spending on social services (Anonymous 1990, cited in Renne 2010).

standard of healthcare that most Nigerians (and organizations including WHO) would deem acceptable is predicated on one's ability to afford care privately. Wealthy Nigerians seek medical care at private clinics and hospitals, and outside the country. For the vast majority of Nigerians who cannot afford such private health care, seeking care 'on the market' most often entails going to a literal market, where merchants--the majority of whom have no formal medical or pharmaceutical training--provide on-the-spot consultations and sell specific drugs at patient request.

More established pharmacies, where drugs are ostensibly less likely to be counterfeit and merchants have more pharmacological knowledge, are concentrated in urban centers. Yet the profession of pharmacy, once held in esteem, has been increasingly denigrated in Nigeria as a result of an inhospitable climate of drug distribution and competition with black market sellers (Peterson 2012: 146). The Nigerian National Agency for Food and Drug Administration and Control (NAFDAC), established in 1993, is tasked with regulating the importation, manufacture, and sale of drugs. However, NAFDAC's efforts have been overwhelmed by the enormity of the problem, and fake and expired drugs continue to comprise a sizable portion of the Nigerian market. As a result, Nigerians adopt a cautious stance towards pharmaceuticals.

How did biomedical care in Nigeria get to this point? One answer commonly proffered by Nigerians and other observers is corruption. Stories of LGA Chairmen "chopping" (embezzling) funds earmarked for primary health care are legion. The paltry sums spent by the federal government on health care indicate at minimum

that health is insufficiently prioritized, but to most Nigerians this neglect is emblematic of the systemic corruption that diverts revenue from public services and into the private bank accounts of government elites.

As Daniel Smith asserts, "[f]or Nigerians, the state and corruption are synonymous" (2007: 15). The inadequacy of Nigeria's health care system is one aspect of a much larger failure of all levels of government to provide the services expected of modern nations. These failures affect every aspect of life in Nigeria and are particularly noticeable in densely populated urban centers. We were lucky to have electricity for one hour a day in the middle-class neighborhood where I resided in Kano. Water would stop coming out of the tap for days, and sometimes weeks, on end. There was no trash collection, malaria-carrying mosquitoes thrive in the open raw sewage, and traffic control is grossly inadequate.

Nigerians have thus grown accustomed to what Ebenezer Obadare (2012) calls the "counterfeit modernity" of postcolonial Nigeria. In the absence of reliable electricity, loud petrol-burning generators sputter smoke outside of homes and businesses. Young men push heavy jerry cans of water through the scorching sun to sell water when the municipal supply cuts out, and sell plastic bags of "pure water" for drinking. Trash is burned, or carted and dumped in an open neighborhood heap. All Nigerians bear the effects of absent and ineffective government services. However, wealthy Nigerians are able to partially mitigate these effects by living in gated compounds with massive generators and water tanks, and by traveling overseas for health care.

The corruption explanation for poor health system performance--and poor

service provision more generally--begs many further questions about the nature and causes of corruption in Nigeria. One common pitfall in explanations based on corruption is the tendency to attribute corruption to timeless cultural tradition or innate national character. Such negative stereotypes about the aggregate corrupt Nigerian character are common enough.⁴³ The problem with such attributions, as Smith argues, are the ways they "obscure the extent to which the relationship between corruption and culture in places like Nigeria can only be understood in the context of larger historical patterns of political and economic inequality (Smith 2007:26). I return to address Nigeria's propulsion towards corruption in the context of global capitalism later in this chapter.

Biomedical interventions of Western origin have found partial acceptance among Northern Nigerian Muslims, to the extent that they are effective, available, affordable, and considered legitimate and in accordance with Muslim teachings. In recent years, however, they have at times been met with suspicion and rejection. This has been particularly true of drugs distributed for diseases that are not considered to be major health problems, raising suspicions of hidden motives--for instance, that outsiders are trying to curtail Muslim fertility. Such distrust has been particularly acute in the case of the ongoing polio eradication initiative led by the World Health Organization. In October 2003, Kano's former state governor, Ibrahim Shekarau, led a boycott of the distribution of the oral polio vaccination

⁴³ As evinced, for instance, by the portrayal of Nigerians as criminals and cannibals in the hit feature film *District 9* (Blomkamp 2009); disparaging public comments that follow Internet news articles about social problems in Nigeria; and the association of Nigeria with email scams.

based on suspicions that the vaccine contained an anti-fertility agent or was otherwise unsafe (Renne 2010). This mistrust of Western medical interventions among some in Northern Nigeria has been exacerbated by international conflicts and perceptions of Western aggression in the Muslim world, most notably the 2003 American-led invasion of Iraq. Moreover, such reactions should be understood as one facet of a legacy of resistance to the Westernizing forces of British colonial occupation, and the subsequent threat to autonomy posed by incorporation into the secular Nigerian state (Barkindo 1993).

Biomedical responses to AIDS in Nigeria: 1986-2003

One aspect of the Nigerian government's poor provision of healthcare more generally has been a weak response to HIV/AIDS. The country's first AIDS diagnosis was reported in 1986. By 1991, prevalence was 1.8%; ten years later in 2001, prevalence had risen to 5.8% (Federal Republic of Nigeria 2012: 26). Nigerian physicians could do little more than physicians elsewhere in the world could do in the early years of the epidemic: provide palliative care for those infected by the virus as they became increasingly immune-compromised, developed AIDS, and died.

Although a few antiretroviral medications were developed in the 1980s and early 1990s, these early therapies did little to curtail HIV-related morbidity and mortality. The watershed in AIDS treatment came in 1996: for the first time, there was evidence that combinations of different antiretroviral drugs could dramatically slow the reproduction of HIV. 'Highly active antiretroviral therapy' (HAART;

hereafter abbreviated more simply ART⁴⁴) was so effective that even patients so immune-compromised that they were on the brink of death bounced back to virtually full health when started on the new drug regimens. So powerful and dramatic were the effects of the new drug regimens that clinicians and patients referred to it as 'the Lazarus effect'. In the wealthy countries where ART became widely available around 1996, mortality from AIDS plummeted and quality of life for HIV-positive people on ART increased dramatically. In short, ART has changed HIV/AIDS from highly fatal to a highly manageable chronic disease—at least for those who have access to the expensive drug regimens.

In 2002, then-president of Nigeria Chief Olusegun Obasanjo launched the Nigerian Antiretroviral Program, which started with the delivery of generic antiretroviral drugs to 10,000 Nigerians living with HIV/AIDS. Distribution took place through twenty-five tertiary federal teaching hospitals across the country with the most severely ill and pregnant women given priority. But the extremely limited supply of the drugs meant that thousands of very ill people at each site were still without access to ART, and AIDS mortality rates were little reduced by the program (Idoko 2012: 1423). Nigeria's HIV prevalence rate at the time was estimated to be 5.8%, comprising more than four million people (Joint United Nations Programme on HIV/AIDS 2004); as such, six years after the introduction of ART only a quarter of one percent of HIV-positive Nigerians had access. In 2003, seven times as many

⁴⁴ HAART and ART are now terminologically equivalent. 'HAART' was originally used to distinguish from earlier one- and two-drug antiretroviral regimens that were much less effective at slowing HIV replication. Today, all approved uses of ART are 'highly active' in the clinical sense.

Nigerians died of AIDS-related illnesses as were on ART (National Population Commission 2003: 169).

The Nigerian Antiretroviral Program expanded slowly; by 2004 about 50,000 HIV-positive Nigerians were on ART. However, these 50,000 represented less than 3% of the HIV-positive Nigerians who needed ART according to clinical guidelines at the time (Osotimehin 2004). The sheer number of patients needing care overwhelmed clinical infrastructure and staffing in a country where biomedical healthcare was already in a deplorable state.

Maintaining steady supplies of drugs was also highly problematic in the early days of the Nigerian Antiretroviral Program. In April 2003, drugs ceased to reach the clinics, the result of a hastily assembled procurement system that had not set aside a reserve of drugs to accommodate supply disruption (Idoko 2012: 1423). Although supply was restored after a month, the interruption was medically dangerous for the patients who had started on ARVs and risked relapsing to serious immunocompromise. Such disruptions also risk the mutation of drug-resistant strains of HIV, which poses a risk of potentially great magnitude for the global pandemic.

In sum, the biomedical treatment response to HIV/AIDS in Nigeria prior to 2004 was grossly inadequate to the country's growing epidemic. Nigeria was thus typical of the position sub-Saharan African nations prior to the mid-2000s: rising HIV prevalence, rising AIDS mortality, and lacking the health infrastructure and financial resources to adequately address the mounting crisis.

The roll-out of PEPFAR

As in many sub-Saharan African countries, Nigeria has experienced a rapid scale-up of biomedical HIV/AIDS care since 2004, with new clinics, new laboratories, newly trained and employed medical staff, and newly available ART. According to WHO recommendations, ART coverage for HIV-positive adults in Nigeria who should be on treatment today is 26%^{45,46} (World Health Organization 2012). Given the scale of the country's epidemic this means that over a million Nigerians who should be on ART are still without access. However, in a hopeful trend, nearly 360,000 Nigerians were on ART by the end of 2010 (NACA 2011), a more than seven-fold increase in coverage since 2004. Even as AIDS mortality remains high, hundreds of thousands of people have averted HIV-related illness and death.

These changes have overwhelmingly been the result of PEPFAR. The U.S. Congress authorized PEPFAR in May 2003 with goals of supporting the prevention

⁴⁵ The most recent WHO guidelines recommend initiation of ART for all HIV-positive individuals with a CD4 count of ≤ 350 cells/mm³ (WHO 2010). The 2006 guidelines recommended ART initiation with a CD4 count of ≤ 200 cells/mm³. Thus while treatment in Nigeria and other countries has expanded considerably in recent years, the new WHO clinical recommendations on treatment initiation have meant that a smaller percentage those who should be on treatment actually are, even as absolute numbers on ART have risen.

⁴⁶ Estimated rates of ART coverage in Nigeria vary. For instance, the U.S./Nigerian *Partnership Framework on HIV/AIDS, 2010-2015* puts the figure at approximately 34% (PEPFAR 2010: 50), citing the *United Nations General Assembly Special Session (UNGASS) Country Progress Report, Nigeria* (National Agency for the Control of AIDS 2010: 31), which itself cites the *National HIV/AIDS and Reproductive Health Surveillance Survey* (Federal Ministry of Health: 2009). I cite the WHO estimate of a 26% ART treatment rate, recognizing that 1) there is no clear consensus on the treatment provision rate, and 2) certain entities have a reputational interests in proposing a higher rate.

of HIV infection, the treatment of people living with HIV, and the care of families affected by HIV in fifteen 'focus countries' with among the highest rates in the developing world. President George W. Bush requested \$15 billion from Congress over a five-year period for PEPFAR, arguing in part that the United States had a security interest in curtailing the pandemic. The funding was primarily focused on HIV/AIDS but also covered tuberculosis and malaria. PEPFAR's initial goals were to support the care of ten million of the people then living with HIV/AIDS; provide antiretroviral treatment for two million of the people infected with HIV; and support efforts to prevent seven million new HIV infections. Those goals were exceeded, and in 2008 the U.S. Congress reauthorized PEPFAR with a five-year allocation of \$48 billion. By September 2011 nearly 13 million people around the world were receiving HIV/AIDS-related care through PEPFAR, and 3.9 million were receiving antiretroviral treatment. AIDS-related mortality in countries that received PEPFAR-funded assistance decreased by more than 10 percent between 2004 and 2007, compared to countries without PEPFAR funds; this achievement translated into 1.2 million lives saved (Vantekesh et al 2012: 1429).

The expansion of ART in Nigeria is overwhelmingly attributable to a massive influx of international donor funding and organizational oversight. By 2008, less than 8% of the country's total HIV/ AIDS budget came from domestic sources, whereas 48% came from PEPFAR and 33% came from the United Nations' Global Fund to Fight AIDS, Tuberculosis and Malaria (Resch *et al.*, 2009). As one of fifteen

PEPFAR 'focus countries'⁴⁷, Nigeria has received over \$2.5 billion to date from the United States for HIV/AIDS prevention, treatment and care programs, with the majority of this money going to ART services and palliative care for HIV-positive people (United States Diplomatic Mission to Nigeria, 2012). By 2007, PEPFAR supported 83% of all ART provision in Nigeria (Resch *et al.*, 2009), with much of the remainder supported by The Global Fund. In sum, Nigeria is heavily reliant on donor funding for implementing HIV/AIDS services, and far and away this reliance is greatest on the United States. Well over 90% of funding for clinical HIV/AIDS treatment in Nigeria comes from outside the country, and the United States government contributes about 80% of the total resources for HIV/AIDS that are expected to be available in Nigeria through 2014 (Resch *et al.* 2009: 66).⁴⁸

While the need for ART-based HIV/AIDS care in poor, high-prevalence countries like Nigeria continues to grow, the commitments of wealthier donor countries including the United States to long-term AIDS funding internationally are waning. In a 2008 commentary (along with lead author Colleen Denny), Dr. Ezekiel Emanuel, a healthcare advisor to newly elected U.S. President Barack Obama,

⁴⁷ Twelve of fifteen focus countries are in sub-Saharan Africa. Criteria for selecting these focus countries were not explicit, however. Bendavid and Bhattacharya propose that the criteria, "were related the burden of disease, the focus countries' governmental commitment to fighting HIV, administrative capacity, and a willingness to partner with the US government" (2009: 668). How these criteria were measured and ranked, and the extent to which U.S. economic and security interests contributed to the decisions, are unclear.

⁴⁸ Resch and colleagues further assert, however, that it is not possible to get a comprehensive picture of how and where resources are being expended on AIDS in Nigeria because the planning documents of "donors, sub-recipients, and implementing partners [...] rarely describe costing methods, calculations, or assumptions to justify the amounts requested, budgeted or disbursed to support planned activities." (2009: 14)

signaled a policy shift away from PEPFAR and towards "simple but more deadly diseases, such as respiratory and diarrheal illnesses", on the grounds that initiatives to address fundamental sanitation and hygiene problems would save more lives, younger lives, and use finite resources most effectively (2008: 2048-49).

This shift is apparent in the *Partnership Framework on HIV/AIDS, 2010-2015: A Memorandum of Understanding between the Government of Nigeria and the United States Government to Fight HIV/AIDS in Nigeria*, a non-binding bilateral arrangement. Among the framework's stated goals are increasing ART access to 80% by 2015, while increasing the Nigerian government's financing of the national HIV/AIDS response from 7% to 50% by 2015 (PEPFAR 2010: 6). A separate analysis of Nigeria's HIV/AIDS response commissioned in 2009 by the Nigerian Agency for the Control of AIDS found that, "The size of the gap between the resources required and the expected level of available domestic funds for HIV/AIDS suggests that substantial innovation in health system design and health financing will be needed to mobilize domestic resources, increase operational efficiency, and ultimately reduce Nigeria's reliance on external funders of its HIV/AIDS response." (Resch et al 2009: 13)

Even with current PEPFAR funding, Nigeria's HIV treatment provision rate⁴⁹ of 26% is by far the lowest of the 15 PEPFAR focus countries (World Health Organization 2012). This reflects the enormity of the problem both in terms of how

⁴⁹ Treatment provision rate is calculated by dividing the number of people who are on treatment by the number of people who need it, according to current WHO guidelines. For Nigeria in December 2010 this was 359,181/1400000, or approximately 26% ART coverage.

many people are infected and need treatment, and in terms of the still-incommensurate response on the part of the Nigerian government and its donors. In light of the Nigerian government's deplorable track record providing for the health of its citizens, it is difficult to imagine that the simultaneous goals of dramatically increasing ART access while dramatically increasing the government's financial contribution to the AIDS response, as laid out in the U.S.-Nigerian *Partnership Framework*, will be realized.

PEPFAR in context: U.S.-Nigerian relations and the neo-liberal world order

Why has the United States government invested so heavily in AIDS treatment intervention in Nigeria? How should PEPFAR be understood within the broader political-economic context of U.S.-Nigerian relations? Without denying that altruism and humanitarianism partly explain American intervention in Nigeria's AIDS epidemic, in this section I propose that analyses of African marginality in the neo-liberal world order offer a more comprehensive explanation.

Walter Rodney's (1972) Marxist reading is perhaps the most vigorous indictment of the European extraction of African resources and reconfiguration of geo-politics, but many subsequent scholars have traced the poor governance, corruption, underdevelopment, and civil war that have plagued so many postcolonial African states to the pernicious long-term effects of colonialism on contemporary African life. Colonialism, Rodney argued, set the ground for corruption and the accumulation of illegitimate social capital. Colonial systems of resource extraction that had benefited European imperialism were appropriated by

the African elites who inherited control of new states, to the extent that today, “African societies are characterized less by their communalism than by [their] almost frenetic individualism” (Bayart 1999: 34).

As various indicators of growing economic inequality make clear, average Africans have largely failed to benefit from the wealth created by natural resources under this arrangement. Whereas classical analyses of state societies have posited that the concentration of wealth leads to unequal political power, scholars of contemporary African states have tended to argue the inverse: that in postcolonial Africa political power is the means to wealth, and control of the state is the surest means to controlling the state’s resources. Following political theorist Jean-François Bayart’s argument, Frederick Cooper explains this as symptomatic of the ‘extroversion’ that has characterized post-colonial Africa: “a relationship between outside corporations and a state elite that guarded the interface between national resources and world markets” (2002: 105).

Bayart’s concept of the “reciprocal assimilation of elites” explains how state power and resources become concentrated in the hands of the few. In post-colonial Africa, intra-national and intra-continental socio-political ties among the ruling elite transcend the old geographical and family divisions, to the extent that “today, endogamy [among the political class] is social rather than ‘ethnic’” (1993: 158). Ethnic and religious leaders, politicians, and military officials comprise a small, powerful, and increasingly integrated cohort.

“Afro-pessimism” abounds among both scholars and African citizens, and the corruption and criminalization of the state are themes prominent in both scholarly

and popular discourse. De Sardan (1999) posits a “corruption complex”, which he argues shares common features across African states: although corruption is broadly stigmatized, it is also routinized and faces few sanctions. According to De Sardan, corruption is a “trap” insofar as, “everyone is sincerely in favour of respecting the public domain and wants the bureaucracy to be at the service of the citizens, but everyone participates by means of everyday actions in the reproduction of the system they denounce” (263).⁵⁰

James Ferguson emphasizes that the virtual collapse of social services (including health care) in many African countries post-structural adjustment is the result of African marginalization in the global neo-liberal economy. Independence-era ambitions for true democracy and national sovereignty have ceded to administration by foreign donors, international institutions, non-governmental organizations, and relief agencies (2006). Furthermore, donor governments and international organizations have been unable or unwilling to impose any serious conditionality in regard to economic equity or political affairs (Bayart et al. 1999: 23). As African states increasingly neglect the provision of services and the maintenance of public order, moreover, they lose their monopolies on legitimate violence, leaving space for vigilantism (Momoh 2003) and religious extremism (O’Brien 1996; Ya’u 2003).

The plundering of vast oil wealth by government officials and persistent regional, class, ethnic, and religious divisions have made Nigeria an archetypal case

⁵⁰ Daniel Jordan Smith (2007) makes an equivalent argument about corruption in Nigeria.

of these systemic crises seen across Africa. Gavin Williams' assertion that the historical baseline for any analysis of the Nigerian state must be the imposition of colonial rule because colonialism is the "central determinant of Nigerian society" (1976: 3) is arguably as true today as it was in the 1970s. When Nigeria gained independence from Britain in 1960, groundnuts, cotton, palm oil, cocoa, and rubber dominated its export economy, and the three semi-autonomous regions of the country tightly circumscribed the power of the federal state. But this "delicate federalism exploded into civil war in 1966 and it was into this fragmented political economy, presided over by a military government, that the oil monies of the 1970s were inserted" (Watts 1994: 421). Oil revenues flowed directly to the state, which both centralized and expanded federal power under a period of phenomenal economic growth. This in turn led to intense competition for control of the federal government along regional and class lines, and "produced unthinkable corruption and administrative chaos." (Watts 1994: 422)

Because the Nigerian economy has come to rely overpoweringly on petroleum export, access to and position in the state have been the determining criteria of elite formation, a fact which leads Graf (1988) to call the Nigerian elite "in large measure parasitical" (230). National development outside the oil sector is precluded to the extent that the ruling class has an overwhelming self-interest in maintaining the export-trade orientation of the economy. Moreover, "the one possibility for the state class to escape from this cycle of delegitimation—namely, to deliver material progress via economic development"—is inhibited by the fact of Nigeria's developmentally dependent position vis-à-vis the world economy" (Graf

1988: 232). Nigeria is a prime example of a country suffering the "resource curse": the abundance of crude oil has the collapse of other economic sectors, in corrupt governance, and in economic and social volatility (Auty 1993).

Kristin Peterson (2012) extends the scholarship on Africa's marginalization in the neo-liberal world order to critique foreign intervention in Nigeria's AIDS epidemic. Her work is especially interesting in light of the United States' dual role as primary purchaser of Nigeria's oil and primary funder of Nigeria's AIDS response. Peterson argues that states, corporations, policy organizations and AIDS activists make "implicit agreements" with each other to address "the gaps" in HIV prevention and treatment, rather than addressing comprehensive health care. Under this logic, "the "gaps" in healthcare systems are transformed into the system itself, for which humanitarian and government organizations deploy millions of dollars dedicated to new infrastructure while health systems are left to wither with neglect (230-31). She further asserts that as a result of the International Monetary Fund's structural adjustment program, trade-related intellectual property laws, and AIDS treatment policies, the institutions of Nigerian pharmacy and drug manufacturing have become exemplars of "emptied-out spaces" into which profit-seeking global pharmaceutical companies move (229).

Peterson sheds considerable light on the political economy of AIDS intervention in Nigeria. Her evaluation clarifies how the oil trade, the withering of Nigerian health systems and the pharmaceutical industries, and the American-led provision of AIDS programming are interconnected. However, there are three weaknesses in her analysis that I will address.

First, Peterson proceeds from the assumption that "the U.S. government [seeks] to legally wipe out generic drug access" in Nigeria in order to expand the market of U.S. pharmaceutical companies (153). This is not however what is happening in Nigeria, at least not with regard to antiretroviral drugs. To the contrary, the PEPFAR program overwhelmingly relies on cheaper, generic drugs manufactured by Indian pharmaceutical companies and elsewhere. In 2003, when PEPFAR was initiated, no generic ARVs had yet been approved by the U.S. Food and Drug Administration (FDA), and the high cost of brand-name ARVs (which have generally been between 10 and 40 times higher than that of corresponding generic drugs) severely limited the number of patients who could receive ART through PEPFAR. Recognizing this limitation, in 2007 the FDA developed an expedited review and inspection process for generic ARVs, and by the end of that year more than ninety percent of ARVs in eleven of the PEPFAR focus countries were generics (Venkatesh et al 2012: 1430). While FDA approval of generic ARVs was indeed initially slow, the overwhelming reliance on generic ARVs today is consistent with the program's mandate "to fund the purchase of the lowest cost ARVs [antiretrovirals] from any source, regardless of origin, whether copies, generic or branded, as long as these drugs are proven safe, effective and of high quality and their purchase is consistent with international law" (cited in Venkatesh et al 2012: 1431). By 2010 virtually all ARVs purchased by PEPFAR were generic equivalents that had received tentative approval by the FDA (Holmes et al 2010).⁵¹

⁵¹ A personal irony is that patent protections honored in the U.S. prevent me from accessing much less expensive versions of the antiretroviral drugs I take daily,

Second, while Peterson is right to raise the alarm about government-run "health systems [being] left to wither with neglect" (231), it is uncertain to what extent, or even whether, PEPFAR exacerbated this already extant neglect. To the contrary, John Idoko, Director General of the National Agency for the Control of AIDS in Nigeria and formerly clinician at the Jos University Teaching Hospital, asserts that in addition to increasing ARV access in Nigeria at least 10-fold, PEPFAR has also improved laboratory services; integrated AIDS services with the treatment of malaria, tuberculosis, hepatitis B; and "led to other improvements for the health of all Nigerians, including implementation of safe blood transfusions, safe injection use, improved water and sanitation conditions, and better maternal health and family planning." (2012: 1425-26) In addition to considerable reductions of AIDS-related morbidity and mortality, the PEPFAR program has appears to have had a trickle-down effect of improving Nigerian health services more broadly.⁵²

Third, while Peterson's analysis laudably focuses on the macro political economic context of the PEPFAR program, she says very little about the effects of the program on the lives of HIV positive Nigerians, their families, and the clinicians who care for them. Her analysis again stands in stark contrast to Idoko's recent account, the subtitle of which ("A Transformative Decade of Hope") is good

whereas as an American HIV patient enrolled in the PEPFAR program in Nigeria I was not only provided my ART at the expense of the U.S. government but was also given generics.

⁵² The extent to which PEPFAR has improved or hindered other health services is part of a larger, ongoing debate about the impact of vertical health programs on other healthcare activities. For instance, Closser and colleagues (2012) are analyzing the effects of the Global Polio Eradication Initiative on primary health care and routine immunization in Nigeria and elsewhere.

indication of his appraisal of PEPFAR in Nigeria, which he calls a "miracle"(2012: 1424). Assuming that neither the Nigerian government nor any other entity had stepped in to expand ART in Nigeria, many of the HIV-positive people among whom I socialized and conducted fieldwork would have been dead. A full account of AIDS in Nigeria today must address the indisputable benefits of ART expansion in the lives of HIV-positive people, and for Nigeria more broadly.

Despite these concerns, I agree with Peterson's central argument: AIDS treatment in Nigeria recapitulates American political-economic hegemony and needs to be understood in the context of petroleum extraction and capital accumulation. Colonial era processes of administration and resource extraction that were central to the formation of the Nigerian state are loudly echoed in the client-patron dynamic of Nigerian-U.S. relations today. In a crude although not inaccurate sense, PEPFAR rewards the Nigerian government for maintaining a relatively steady flow of petroleum, upon which the United States relies. This is not *entirely* accurate because the PEPFAR program is not a 'reward' in the sense of a gift freely given. Rather, the program extends the patron-client dynamic that structures Nigeria's relationship with the United States in the global economy. By accepting the PEPFAR program--that is, by shifting its AIDS programming overwhelmingly to American dictates, management, and funding--the Nigerian government fulfills a portion of its healthcare responsibilities and retains a modicum of legitimacy in the eyes of global health institutions and foreign governments.

Is the PEPFAR program an instance of much-needed foreign aid to address a high-mortality epidemic? Is it a facet of imperial control from a powerful foreign

government? Ultimately it is both. I felt pride in PEPFAR on many occasions as I watched doctors and nurses care for patients in a newly built and reasonably well-equipped facility; and as I watched patients leaving the clinic with live-saving ART. I felt pride during interviews when HIV-positive people described the transformative effects ART has had on their lives and expressed their gratitude, knowing that my country's government had made it possible. But exiting the relatively calm of the hospital campus and reemerging onto the choked, pot-holed, trash-strewn streets of Kano, I could not help but contemplate the United States' role in the systemic neglect and disorder that constitute daily life for most Nigerians.

The Islamification of ART

In recent years drugs distributed for free by Western governments and international organizations have been met with suspicion and rejection by some Northern Nigerian Muslims. As discussed in the previous chapter, some HIV-positive people and practitioners working in Islamic traditions continue to express misgivings about ART. Some have questioned the interests and profit motives of Western drug companies and governments in distributing ART for free, echoing mistrust due to previous Western-initiated medical interventions in the region. Others express misgiving about the toxicity and side effects of ART as a chemically manufactured therapy, as compared to naturopathic and scripturally-based therapies. The overarching response to ART of the HIV-positive people I met who were taking the drugs was gratitude. However, some patients quietly voiced disappointment that ART is a therapy that treats but does not cure.

There has been, however, no large-scale opposition to the provision of ART in Northern Nigeria as there has been with certain other Western-funded biomedical interventions. To the contrary; biomedical practitioners and patients have warmly welcomed the increased availability of the drugs. In just a few years following their increased availability in 2004, ART became the orthodox therapy for treating HIV. How and why has ART become so widely accepted, especially when other drugs distributed for free by Western countries and organizations have faced protest and rejection?

Perceived need is one of two important factors explaining the quick uptake of ART. The polio eradication initiative, by comparison, continues to be met with suspicion (and more recently with homicidal violence⁵³) in large part because polio has not been seen by most Northern Nigerians as a health priority (Renne 2010). AIDS is perceived as a pressing health problem throughout Nigeria, and rightly so. In 2011, Nigeria had 62 reported incident cases of wild poliovirus (WHO 2012b: 110)—but an estimated 310,322 new HIV infections (Federal Republic of Nigeria 2012: 23). Treatment of a widespread health problem like AIDS is more highly valued than the prevention of a much less common affliction like polio.

The second factor explaining the quick uptake of ART is the perceived efficacy of the drugs. Improvements for many HIV-positive people on ART have been

⁵³ On 8 February 2013, nine female polio campaign vaccinators were shot and killed at two health clinics in metropolitan Kano by unknown men believed to be affiliated with Islamist group Boko Haram. It is suspected that this attack was modeled after the killing of female Pakistani health workers in retaliation against the United States' use of an immunization campaign to confirm the location of Osama bin Laden's compound in Abbottabad (McNeil 2013).

dramatic. Although the drugs are not the much-desired cure for HIV, people living with the disease have seen enormous health benefits from them. Many HIV-positive people I interviewed narrated astonishing rebounds from near death when they began ART, recalling the "Lazarus effect" experienced by HIV-positive people in wealthier countries when HAART was introduced in the mid-1990s.

Perceived need and efficacy are two crucial reasons for the therapeutic migration to ART. But something else underlies it, what I call the Islamification of ART: National Muslim organizations, Muslim biomedical practitioners, and patients' groups have 1) framed ART as the Islamically acceptable and even required treatment for HIV/AIDS, and 2) sought to harmonize the clinical requirements of ART with obedience to Islamic tenets. This ongoing process of Islamification is occurring on several levels simultaneously: on the level of health policy, of scriptural exegesis, of doctor-patient communication, and among support groups of HIV-positive Muslims.

Recall that in its 2009 *National Islamic Policy on HIV/AIDS*, the Nigerian Supreme Council for Islamic Affairs asserts:

Muslims [...] are committed to ensuring that persons infected or affected by HIV/AIDS including orphans and vulnerable children receive appropriate treatment, care and support in line with the National Guidelines for treatment of HIV and AIDS in adults and adolescents as well as the National Guidelines for pediatric HIV and AIDS treatment and care. To achieve this, access to quality healthcare and referral systems shall be encouraged with focus on ART, palliative care and establishment of support groups" (NSCIA 2009: 15).

By emphasizing ART-based care, the Council expressly endorses biomedical treatment guidelines while making no mention of prophetic or naturopathic

therapies as alternative or complementary treatments. Clinical staff and support group leaders insist to patients that ART is a manifestation of Allah's mercy, implying that rejecting ART (in favor of seeking a cure with prophetic treatments) is tantamount to rejecting this mercy.

HIV-positive Muslims seek to balance their social and faith responsibilities with the need for efficacious treatment. One issue where harmonizing adherence to religious obligations and adherence to clinical treatment guidelines has been most apparent is fasting (*azumi*). As one of the five pillars of Islam, abstaining from eating, drinking, smoking, and sex between sun-up and sundown during the holy month of Ramadan is an obligation that all Muslims who are able to do so must fulfill beginning at the age of puberty. People who are ill and traveling are exempt from *azumi*. However, because the spiritual rewards believed to accrue through fasting are great, ill and traveling individuals may choose to perform the days of fasting they've missed during Ramadan at a later time.

While it is foremost understood as a matter personal responsibility and reward, *azumi* is also an intensely social practice. Ramadan is a time of heightened solidarity with fellow Muslims. This solidarity is felt in the shared suffering experienced during the daily fast as people struggle to make it through the day's responsibilities and the heat without food or water. It is also felt in the collective relief of sharing specially prepared meals each day after sunset, and in the intensity of performing the day's prayers together with other fasters.

For HIV-positive Muslims, *azumi* can be fraught with indeterminacies and complications. Despite the allowances made for skipping or postponing the fast in

the case of illness, many HIV-positive people do not feel ill, nor do they appear ill to others. For those who are HIV-positive and well, there is often a strong desire to participate in *azumi*. Since many HIV-positive people have no physically perceptible manifestations of illness, the failure to fast may invite questions and suspicions from those who do know that the person is HIV-positive. Not fasting is socially notable and may invite questions. While each Muslim adult is responsible for herself in upholding the tenets of the faith, the rest of the community is felt to have an interest in supporting others in sustaining *azumi*.

Consuming ART during *azumi* is further complicated by the fact that some ARVs must be taken with food, while others should be taken on an empty stomach. *Azumi* is generally encouraged by clinic staff, since most patients are perceived as healthy enough to do so. Drug adherence officers in the clinic encourage patients on twice-daily dosing regimens--normally taken at twelve hour intervals--to take their morning doses at 4:55am, just before the first prayer of the day (*salla asuba*). Then, depending on one's particular drug regimen, the patient is encouraged to take one's evening dose immediately upon breaking the fast *if* they ought to take their medications with food. Those patients taking an ART regimen that includes the drug efavirenz are told to wait and take their second daily dose at 9pm, two hours after breaking the fast, because of the heightened side effects commonly experienced when taking efavirenz with food.⁵⁴

⁵⁴ From a clinical perspective, Habib and colleagues (2009) argue that this four-hour discrepancy in dosing time (i.e., taking drugs at 5am and 9pm during Ramadan rather than at regular 12-hour intervals) poses no real risk of diminished drug efficacy for the patient. They further assert that, "in order to succeed, provision and

While patients and clinicians are both concerned with making ART compatible with *azumi* and adapt treatment regimes to adhere to this religious obligation, clinicians make a distinction for patients on first-line versus second-line therapies. First-line therapies are drug regimens with high efficacy and low side-effect profiles that, as their name implies, are the first choice for patients whose viral strain has no known resistance to these drugs. Second-line therapies are those a patient will be started on when the first-line regimen ceases to effectively reduce viral load. Patients who are on second-line medications are those who have already "failed" first-line drugs--either because they have developed a resistance to them or because they were infected with a strain of the virus that is not sensitive to first-line medications.

Clinicians sanction those on first-line drugs to perform *azumi* insofar as they are otherwise understood to be healthy. To the contrary, patients on second-line therapy are strongly discouraged from *azumi* because clinicians perceive the risks of failing second-line therapy as too great. This highlights a certain pragmatic balancing between the needs for religious adherence and the needs for therapeutic adherence--and the divide between how some patients and clinicians prioritize religious versus therapeutic adherence. Most patients strongly want to participate in *azumi*. Clinicians take a more clinically cautious approach. But convincing some patients on second-line drugs not to perform *azumi* is a big challenge for clinical staff.

expansion of ART should adapt to local and religious cultural practices like Ramadan fasting and maintain fundamental principles of ART such as adherence."
(42)

A middle-aged man on a second-line regimen comes into the adherence office for his clinical visit during Ramadan and admits when asked by Sani, the adherence officer, that he's been doing *azumi*. "You must stop doing *azumi*," Sani tells him, sternly. "It won't work. These [second-line] drugs cost 2000 U.S. dollars a month. We don't have the salvage drugs [i.e. "third-line" therapy, for those who have "failed" two previous drug regimes] here [in Nigeria]. *Wallahi, Allah*, stop doing *azumi*. This second-line is the end, there's nothing else."

As this instance indicates, patients may prioritize *azumi* obligations over clinicians' pleadings that they prioritize therapeutic adherence. In the event that a patient on second-line drugs insists upon fasting, doctors and adherence officers may quietly tell patients to take all four of their daily Kaletra pills (a common second-line combination therapy) all at once with the evening meal, rather than taking two pills in the morning and two in the evening per standard dosing guidelines. Clinicians make this recommendation, grudgingly, because they adjudge that it is more important to take Kaletra with food than to take it at twelve-hour intervals. This highlights a certain clinical pragmatism that accepts patients' (and most clinicians') deeply felt need to participate in *azumi*. In this sense, the Islamification of ART entails making ART compatible with one's religious obligations.

Another way that ART becomes regulated by observant Muslims is in the realm of dosing and prayer. The five daily prayers are crucial time markers in Muslim societies, ordering the day with a temporal structure. Clinicians, adherence counselors, support group leaders and patients all use the five daily prayers as

reference markers for consuming ART. Taking ARVs becomes, for HIV-positive Muslims, an extension of *salla*. Sani, the adherence officer, tells patients, "When you hear the call for Maghrib [the fourth prayer of the day], take your medicine." Using prayer as a reminder for drug adherence is thus another instance of the Islamification of ART.

Conclusion

HIV-positive people and the clinicians who treat them have shown overwhelming enthusiasm for ART in Northern Nigeria following implementation of PEPFAR. Certain scholars have critiqued PEPFAR for its neoliberal economic underpinnings (Peterson 2012; Sastry and Dutta 2013). Others have critiqued the program's Christian conservative underpinnings, arguing that abstinence-until-marriage provisions and the de-emphasis on condoms impinge upon best epidemiological practice for controlling the epidemic (El-Sadr and Hoos 2008; Santelli et al. 2013). Furthermore, the emphasis on abstinence until marriage as a prevention strategy is only partially relevant in the sociocultural context of polygynous marriage, to be discussed in the next chapter.

Without denying these issues, certain PEPFAR directives actually overlap with ideals of moral comportment among Northern Nigerian Muslims. By focusing on prevention policies, certain critics have deemphasized treatment—the much more crucial component of the program in the lives of HIV-positive people. I have therefore argued for analyses that focus on PEPFAR in the context of global political

economy, the flows of capital and resources involved in the program, *and* patients' lived experiences of ART.

In the next chapter, I turn to another dimension of the AIDS epidemic in Islamic society: how HIV transmission unfolds in the context of gendered family life, and how Muslims living with HIV strive to reconstruct social bonds and fulfill religious obligations to care.

Chapter 4:

HIV, Polygyny and Ethics of Care Among Muslim Men

Tuzuru ya fi gwabro barna (An old bachelor is more harmful than a divorced man)

-Hausa proverb

Introduction

Saturday 2 August 2008: Dauda and Fahad, the chairman and vice-chairman of Taimaka HIV Support Group, are in Dauda's adherence office at the clinic preparing for the group's monthly meeting when Kabiru and I come in. We greet each other, and Dauda, Fahad, and Kabiru begin going over the meeting's agenda, which Dauda has handwritten. Marriage is the big item on the agenda today. "Some [men] see that women have become cheap" ["*Wasu sun ga mata, sun yi arha*"], Dauda exclaims; Fahad and Kabiru nod and click, assenting. I take him to mean that some of the men in the group regard the women in the group as easy to get, but the curious ambiguity of the phrase catches my ear. I write it down in my notebook.

The four of us I enter the main waiting area of the HIV clinic where the meeting is about to begin. Most of the members have arrived--and as usual, women outnumber men by nearly three to one. (This is easy to see because women and men sit in two separate sections.) The main refrain of the meeting is admonishing members not to just come to the group looking for a quick marriage, but rather to take time and get to know each other well before agreeing to marry. The *malam* who leads the opening prayer follows with a passionate oratory, addressed seemingly to

the men's section, about proper Islamic marriage rules still applying to HIV-positive people. "Women are desperate, and men are taking advantage of it," he declares.

Next, Dauda addresses the members with a cautionary tale about a positive man who beat his positive wife and gave her a black eye. He continues by explaining that there is a problem of men going from support group to support group, marrying a woman for three months, then divorcing her and going to find a wife in another support group. Because of this, all support groups in Kano have tightened their policies to prevent men from bouncing around from group to group.

After several male members have weighed in on the theme of marriage and responsibility, Dauda turns to address the women's section: "Women, you haven't said anything." In earshot of all the men sitting around us and with an indignant snort, the man sitting to my left says, "Well, what are they going to say? They're the ones in the wrong!" ["*T,o me za su ce? Ba su da gaskiya!*"] I understand him to mean that he feels women are infecting and taking advantage of men.

Another man enters the conversation, saying that he's been positive for over 15 years, before the first HIV support group in Kano formed, and that he agrees with the other man's estimation that it's a problem of women's behavior. Only one woman talks briefly in the course of the entire two-hour meeting, and nearly all the discussion from the group's nearly all-male leadership seems directed primarily to the male members. Several men in the group express concerns about high rates of divorce and marriage. Another *malam* says, "In the Muslim religion, if you want to marry a woman, you have to follow the right path. If you don't, you are cheating

yourself.” Dauda implores members that the support group is a place to seek knowledge, not only to look for marriage partners.

After the rather heated tone of the meeting, things lighten up at the end when each member is given a Styrofoam container with jollof rice and a few cubes of goat meat, a bottled soda pop, and 200 naira [about US \$1.25] to cover transportation costs to and from the meeting. Finishing our food and chatting with a few members on our way, Kabiru and I exit the clinic and hop on his motorcycle to ride home. As we're pulling away we see a man from the group walking past three women from the group. The man must have said something to them as he passed, because in unison the women offer up a high-pitched trilled laugh. Kabiru turns his head to me and says, “In Taimaka, a man who never had more than one wife when he was negative can take three wives now that he is positive.”

The two proceeding chapters considered HIV treatment in Northern Nigeria and analyzed the shift to biomedical approaches that have followed the massive, donor-funded expansion of antiretroviral therapy. I argued that this ongoing shift has entailed a reconceptualization of ART as the Islamically sanctioned treatment for HIV, even as *malamai* [Islamic scholars] working in the traditions of prophetic medicine have contested this new orthodoxy and struggled to remain therapeutically relevant. My emphasis thus far, then, has been on how religious doctrine, healing practices, and transnational political economy intersect to shape the therapeutic economy of AIDS in Northern Nigeria.

This chapter considers the AIDS epidemic from the vantages of gender, kinship, and sexual networks in the context of Islamic family life. Focusing on the experiences of HIV-positive Muslim men, I examine how HIV transmission and care unfold in the context of Northern Nigeria's "sexual value system", the rules and norms that divide sexuality deemed 'good' and 'blessed' from sexuality deemed 'bad' and 'damned' in a given society (Rubin 1984). The main questions I pose are: What is the Hausa Muslim notion of ideal masculinity, and how does it influence relationships between men and women? How do social-sexual dynamics between men and women affect HIV transmission and care? What effects does HIV infection have on marital opportunities and obligations? How are marital norms among Northern Nigerian Muslims protective against HIV transmission, and how do other norms inadvertently promote transmission?

To answer these questions I emphasize the centrality of marriage and demonstrate how HIV infection affects the marital trajectories and aspirations of positive men and women. In this chapter, I focus on how Muslim men's opportunities and sense of obligation to marry polygynously—a key component of a hegemonic masculinity—actually increase as a result of being HIV-positive. This finding reveals that for some people, and given certain conditions of structural gender privilege, HIV infection has unexpectedly beneficial effects. This chapter thus departs from the preponderance of accounts of the social effects of HIV/AIDS, which overwhelmingly emphasize negative outcomes of HIV infection.

I analyze the social conditions undergirding the seeming paradox about the partially beneficial effects of HIV infection for men: Polygyny is the cultural and

religious ideal for Muslim Hausa men, indexing both socio-economic success and religious piety. Moreover, social anxieties about the threat that unmarried women pose to the social order are pervasive, and marriage is considered a crucial component of respectable adulthood for both men and women. In a society where HIV disproportionately affects women and constrains their marital choices, positive men have increased access to the "surplus" of positive women seeking husbands, revealing a gendered dichotomy in the social effects of HIV. Women's marital opportunities are constrained by infection and their bridewealth drops⁵⁵ (Rhine 2009), whereas men become more highly sought after due to their relative scarcity in the community of positive people.

Drawing on semi-structured interviews and participant observation in a HIV support group, I demonstrate how HIV-positive Muslim men understand their duty to marry—and to marry multiple wives—as a privilege, but also a masculine religious duty to care for widowed and divorced HIV-positive women and their children. I also draw on data from my survey of 174 HIV-positive men recruited from the HIV clinic where I conducted research to hypothesize about the association between HIV serostatus and polygynous marriage for men. I show that in this era of improved treatment and quality of life, being HIV positive and healthy intensifies

⁵⁵ Among Hausa Muslims, bridewealth payments from the groom and his family to the bride before the wedding ceremony include cash; housewares and furniture [*kayan daki*]; and personal items for the bride including jewelry, cloth, and perfumes [*kayan amarya*]. The value of the bridewealth payment depends on the wealth of the couple's families, whether the marriage is a woman's first (previously unmarried women command higher bridewealth, other factors notwithstanding), and other factors determining the relative desirability of the woman as a wife (including her health status).

both men's opportunities and their religious obligations to provide for multiple wives and children, allowing them to advance their masculine social status.

Kirki and hegemonic masculinity

Raewyn Connell's (1995) postulation that multiple forms of masculinity exist in every society has been influential to the burgeoning interdisciplinary field of men's studies. These multiple masculinities are ranked in a hierarchical relationship, Connell posits, with a hegemonic masculinity organizing the dominance of some men over other men and the reproduction of patriarchal power vis-à-vis women. In recent years, scholarship on masculinity has expanded to analyze the detrimental influence of hegemonic masculinities on men's risk for a wide range of negative health outcomes, and on men's willingness to seek help for health problems (Courtenay 2000; Galdas 2009).

Hegemonic masculinity for Muslim men in Northern Nigeria is defined foremost in terms of Islamic piety and socio-economic status. The ideal man demonstrates his adherence to the tenets of Islam by treating others with respect, patience, and charity. He is financially successful and uses his success to provide for a large family with several wives and many children, for the clients of his benevolent patronage, and for the good of the larger Muslim community. As in many societies, compulsory heterosexuality is a key feature of hegemonic masculinity (Morrell and Swart 2005: 107).

Kirki is the central value by which Hausa people evaluate an individual's character and behavior. The term most closely approximates to the English concepts

of 'goodness', 'kindness', and 'virtuousness', without being easily reducible any one of these. To be considered *mutumin kirki* [a 'good person'] is the highest commendation that someone can be paid and is rarely expressed sarcastically or as a platitude. Those adjudged as *mutumin kirki* demonstrate a constellation of positively valued traits, including *tosai* (mercy; compassion); *mutunci*, (friendliness; magnanimity); *dubayya*, (respect); and *daraja* (social rank; status).

Individuals are evaluated in terms of *kirki* regardless of their socio-economic status. But since generosity is one important measure of it, the wealthy have more opportunity to prove themselves as *mutumin kirki* (Barkow 1974). That class status (*daraja*) is one standard by which *kirki* is understood is a logical extension of Hausa society's longstanding hierarchical class structure. The *kirki* of *sarauta* (royalty) and *attajirai* (wealthy businessmen) is of greater importance than that of *talakawa* (the poor; peasants) because, due to their high social position, *sarauta* and *attajirai* have greater capacity to contribute to the good of society.

Kirki is only applied in valuations of human and spiritual beings (*jinn*); non-human animals and inanimate objects are not evaluated with reference to *kirki*. *Kirki*, moreover, is centrally understood in terms of Islamic comportment. Non-Muslims are evaluated as having (or lacking) *kirki*.⁵⁶ But for Hausa-speaking Muslims, the term is conceptually linked with adherence to Islamic moral standards. Allah, then, is the manifestation of *kirki* in its most perfect form.

⁵⁶ Salamone and Salamone (1993) claim, "that Hausa believe [*kirki*] is distinctive to themselves and would not be evident in other groups "(361). While I agree that the concept is central to Hausa self-conception, based on my experiences living in rural and urban Niger and Nigeria I disagree with the further assertion that Hausa people do not conceive of or evaluate non-Hausa as possessing (or lacking) *kirki*.

Both men and women are evaluated in terms of *kirki*, although the distinct social roles of men and women mean that the concept is applied somewhat differentially based on gender. Given the importance of marriage in Hausa society, and by virtue of the fact that a woman's status is largely tied to that of her husband, the evaluation of women's *kirki* is primarily in terms of her performance as *mata mai kirki* (a 'virtuous wife'). A woman's respectability (*mutunci*) derives from her comportment within married life, particularly as she bears and raises children (Schildkrout 1982, Coles and Mack 1991, Callaway and Creevey 1994, Renne 2004). As I discuss further in what follows, an adult woman of childbearing age who stays unmarried or remains unmarried for too long after a divorce or after being widowed risks being branded with the epithet *karuwa* (very roughly equivalent to 'prostitute'), a designation that precludes her from the status of *mata mai kirki*.

Marriage is the central institution around which all other social and kin institutions revolve in Muslim societies (Fluehr-Lobban 2004: 98), Hausa society inclusive. As Murray Last explains, "an adolescent male becomes an adult when he takes a wife; he is responsible for another person. A woman becomes an adult, not when she marries, but when she has her first child, when she too is responsible for another person." (2004: 726) Men's marital status is a matter of less cultural anxiety than that of women, yet marriage is a crucial predicate of respectable adulthood for both men and women.

Near the bottom rung of Hausa masculine status is the *tuzuru*, the middle-aged or elderly man who has never married. The never-married man evokes something between pity and contempt; indeed the very word *tuzuru* often elicits a

snicker. This attitude to the social ill of a man's non-marriage is encapsulated in a Hausa proverb: *Tuzuru ya fi gwabro 'barna* (An old bachelor is more harmful than a divorced man). The degraded masculinity of the *tuzuru* follows from his failure to participate in the sex/gender system that assures women's subordination to male authority (Rubin 1975) and his failure to father children.⁵⁷

Masculinity and the polygynous ideal

Practices, legal statutes, and social attitudes towards polygyny differ significantly among Muslims worldwide. Polygyny is fairly common in some Muslim-majority societies and rare or non-existent in others. The passage in the Qur'an that most directly addresses polygyny is Surah 4:3:

And if you fear that you cannot act equitably towards orphans, then marry such women as seem good to you, two and three and four (amongst the orphans, obviously); but if you fear that you will not do justice (between them), then (marry) only one or what your right hands possess; this is more proper, that you may not deviate from the right course.

Both advocates and detractors of polygyny cite this passage as justification for their respective positions. Detractors argue that because it is ultimately impossible to love and treat two (let alone three, or four) women precisely equally, Surah 4:3 should be interpreted as an interdiction against polygynous marriage. Advocates interpret the passage as permitting a man up to four wives at any time, on the conditions that he is financially able to provide for all of his wives and children and that he is disposed to loving and caring for them all equally.

⁵⁷ In the next chapter I consider the social and HIV vulnerabilities of *'yan daudu* ('feminine men') and other *masu harka* (men who have sex with men).

Islam is proffered as the ultimate justification for polygyny, but the practice predated the arrival of Islam in the region and is not reducible as an "Islamic practice". Neither, however, is polygynous marriage a stable and unchanging feature of "Hausa culture". Although social life in contemporary Northern Nigeria is the historical antecedent of the pre-colonial Hausa city-states, the region has also been dramatically altered by incorporation into the Nigerian polity. As in earlier historic eras, a man's ability to marry polygynously is strongly tied to his social-economic position.

Northern Nigeria is frequently referred to as a 'polygynous society', although this designation is imprecise. More accurately, Muslims in Northern Nigeria hold a polygynous *ideal*. Although a minority of men has multiple wives concurrently, polygyny is culturally and religiously valued for Hausa Muslim men. Being married to one wife is "enough" for a man to attain respectable adult status, however the number of wives a man is expected to have is related to his social position. Attitudes about the "appropriate" number of wives for a man are tied to the social position of individual men: wealthy men such as successful businessmen, politicians, and traditional rulers have greater social expectations to marry polygynously. It is virtually assumed, for instance, that a *sarki* (emir) will have four wives, but rare that a man of the *talakawa* (peasantry; poor) will.

While polygyny is socially idealized and legally permissible, there is no consensus among Northern Nigerian Muslims on the desirability of polygynous marriage. Many men have or aspire to marrying more than one wife, but certainly not all do. Most men, either because of personal preference or financial constraint,

are married to only one woman at a time. "One is enough" (*'Guda daya, ya isa'*) is a common refrain of both never married men and men who are married to one wife. Muslim men in Northern Nigeria take a 'live and let live' approach to polygyny: If a man wishes to do so and finds it within his means to marry two or more wives, his decision will be met with general social approval. If he does not, this decision will be *nearly* as socially accepted.

Women's attitudes towards polygyny are also not easily reducible. Conflicts between the *uwar gida* (first wife; literally, "mother of the house") and an *amarya* (a new bride) are the thing of literary and cinematic legend in Hausa society. Wealthier men in polygynous marriages may keep their respective wives and their children in separate houses, and possibly even in separate cities or countries in the case of men who travel regularly for business. Conversely, co-wives often develop loving, life-long friendships, sharing their social lives and domestic responsibilities in relative amicability. Co-wives may be age-mates or may be separated in age by several decades, particularly in the case of a much older man who has been married for decades to a wife or wives and then marries a much younger woman later in life.

In sum, I suggest that the conditions and attributes by which a man would be considered *mutumin kirki* (a good man) are the same conditions and attributes that would be used to adjudge his fitness as a polygynous husband: religious piety, financial prosperity, charitableness, and adherence to tenets of equity. In itself, being married polygynously is neither necessary nor sufficient as a marker of a man's attainment of hegemonic masculinity as measured through the valuation of his *kirki*. But the maintenance of and provision for a polygynous family is one

significant index of a Muslim man's attainment of ideal masculinity in Northern Nigeria.

Polygyny and HIV/AIDS: "benign" sexual concurrency?

Considerable social-epidemiological analysis of HIV/AIDS in African contexts has focused on concurrent sexual partnerships, whereby individuals have sexual relationships with more than one person over a given period of time. The preponderance of sexual concurrency at the population level, many have argued, is the primary reason among several other contributing factors for the very high incidence of HIV in the worst affected regions of sub-Saharan Africa (e.g. Halperin and Epstein 2004). AIDS prevention campaigns in Africa have generally stressed the encouragement of marital sexual monogamy and otherwise limiting one's number of sexual partners, over and above other prevention strategies.

Relative sexual privilege compared to women is among the most discernable masculine gender privileges in many societies. Men in Northern Nigeria have numerous opportunities for multiple sexual partnerships over the life course. Although forbidden by sharia and subject to strong social opprobrium, premarital sex and extramarital sex certainly occur clandestinely. Because men are permitted much greater freedom of movement, they have more opportunities to pursue non-marital sex than women do. Officially, both men and women face equivalent legal

action if extra-marital sex can be proven.⁵⁸ In actuality, however, the reputational and legal risks of sex outside of marriage are much greater for women.

Polygyny, sustained through high rates of divorce and remarriage, is the only socially and legally acceptable form of concurrent sexual partnerships in Northern Nigeria. While the relationship between the AIDS epidemic and patterns of sexual relationships in African societies has been well studied, polygyny as an institutionalized form of sexual concurrency has received much less research consideration. Only quite recently have researchers begun testing hypotheses about the protective or harmful effects of polygynous marriage on HIV prevalence. Moreover, questions about the effect of polygyny on HIV epidemics have generated rather opposing viewpoints.

In a meta-analysis of data from nineteen African Demographic and Health Surveys (DHS) and HIV/AIDS Indicator Surveys, Reniers and Watkins (2010) note that HIV prevalence is lower in countries where polygyny is common, and that within countries prevalence is lower in areas with higher levels of polygyny. HIV prevalence *decreases* by 0.5% for each one-percentage point increase in the prevalence of polygyny. This, they argue, is because (barring extra-marital sex) polygyny is a form of "*gender asymmetric* disassortative mixing" that "creates small

⁵⁸ Married and divorced men and women could, according to sharia law, be stoned to death for adultery. However the burden or proof for conviction—four independent adult male witnesses to the sexual act—is so stringent that this punishment has not been carried out in Northern Nigeria. Furthermore, the global uproar and eventual reversal of the 2002 stoning conviction of Amina Lawal in Katsina State for adultery (with her pregnancy while an unmarried woman proffered as proof of adultery) has made Northern Nigerian sharia courts subsequently unwilling to issue capital convictions.

isolates of concurrent partnerships in which the virus is trapped until one or more of the (infected) spouses start a new relationship" (303).

Reniers and Watkins further propose that a second, counterbalancing characteristic of polygynous marriages delays the spread of HIV, what they call a *coital dilution effect*: "Compared to a monogamous man, a polygynous husband divides his time between two or more wives, which inevitably leads to a reduction in the coital frequency with each wife [and] could reduce HIV incidence in serodiscordant couples within a polygynous union" (303-4). Nigeria would appear to be case in point for this line of analysis: polygyny is most common in the Muslim-majority north, and taken as a whole the region has the lowest HIV prevalence in Nigeria.

In a rejoinder to Reniers and Watkins, Epstein and Stanton (2010) cast doubt on the innocuousness of polygyny, citing several studies that have found that men and women in polygamous marriages tend to have *more* extramarital sex, HIV, and other sexually transmitted infection than those in monogamous marriages. Given this, they ask: how can polygyny be a risk factor for HIV at the *individual* level but not at the *community* level? Epstein and Stanton forward the hypothesis that cultural attitudes to women may explain this discrepancy:

Communities where formal polygyny is common, such as those in some West African countries, might be more conservative, and more similar to the Asian or Middle Eastern pattern in which women's roles tend to fall into one of two categories: faithful dependent wives or largely urban prostitutes. In such cases, the spread of HIV is largely confined to sex workers and their clients, and the epidemic in the general population is limited. However, compared with people in monogamous unions, polygamous people might still be individually more vulnerable to infection, especially if they are more likely to

be unfaithful, because they are put at risk not only by their own infidelity, but also by that of all the others in the marriage. (1791)

Polygyny clearly does not preclude men from having extramarital sex. In a sample of 1153 Nigerian men from the 2003 Nigeria DHS (73.6% of whom were from northern regions and 63.9% of whom were Muslim), Mitsunaga and colleagues found that men with three or more wives were *more* likely (19.3%) to report having had extramarital sex within the last year than men with one wife (12.9%) or two wives (5.3%).⁵⁹

Furthermore, as I will demonstrate in what follows, culturally specific factors relevant to the social organization of polygyny have significant implications for HIV transmission at the individual and community levels. In Northern Nigeria—where rates of divorce and remarriage are high, postmortem autopsy is unacceptable, and pre-marital HIV testing is rare—the potential for HIV transmission in polygynous marriages exists *even if* all spouses remain sexually exclusive within their current union. This suggests that the high frequency of divorce and remarriage in Muslim Hausa society constitute a culturally specific pattern of HIV transmission that belies assumptions about the protective effects of marital fidelity.

Muslim Hausa family dynamics and HIV transmission

⁵⁹ A possible skew to this data is social desirability bias: survey respondents may have answered untruthfully about engaging in extramarital sex at differential rates depending on their number of wives. For instance, men with more wives might perceive themselves as having greater prerogative to have concurrent sexual partnerships and thus be more likely to answer truthfully about extramarital sex.

The main assertion throughout this dissertation is that Islamic doctrines, institutions, and social practices are of crucial importance for how people understand and respond to HIV/AIDS in Northern Nigeria. Enactments of Islamic sexual morality, gender roles, and family life in Northern Nigeria have profound effects on progression of the epidemic. Northern Nigerian Muslims frequently assert that adherence to Islamic orthodoxy on sexuality and family life protects against HIV transmission.⁶⁰ In what follows, however, I argue that culturally specific enactments of Islamic tenets on sexuality, gender, and family are both protective of *and* implicated in HIV transmission.

HIV prevalence in predominantly Muslim societies is generally low, a fact which has been attributed to a range of possible factors including the universal circumcision of Muslim men, prohibitions against alcohol consumption, and restricted opportunities for socialization with the opposite sex (Gray 2004; Hasnain 2005). As discussed in the previous section, in Muslims societies where polygyny is common, gender asymmetric disassortative mixing (i.e. the fact that men are sanctioned to have multiple concurrent sexual partnerships in the context of polygynous marriage whereas women are strongly prohibited from sexual concurrency) may also hinder transmission at the population level (Reniers and Watkins 2010).

⁶⁰ In this, Northern Nigerian Muslims are similar to Nigerian Christians, who presume that adherence to Christian sexual orthodoxy protects against HIV transmission (cf. Smith 2003).

On the other hand, the form and frequency of *socially sanctioned* sexual partner changes in Hausa Muslim society constitute conditions *for* HIV transmission. Rates of divorce and remarriage in Muslim Hausa society are among the highest in the world (Solivetti 1994). Divorce is particularly common in the marriages of young couples, whose first marriages are often arranged by parents. Divorce is not considered socially desirable, but neither is it highly stigmatizing, and moreover it is relatively easy to obtain. As the proverb that begins this chapter indicates, having been married and then divorced is certainly considered more respectable than never having married.

Unmarried women as a social problem

Divorced and widowed women face pressures to remarry quickly because women's reputation and economic survival are closely tied to their marital status. Pragmatically, marriage offers women structures of economic and social support where there are few opportunities for most women to generate income outside of kinship networks (Rhine 2009).⁶¹ As Barbara Callaway contends, "there is no acceptable place for non-married women of childbearing age [...] Adult Hausa society is essentially a totally married society" (1987: 35). Religious doctrines and popular discourse stress the importance of marriage, and a divorced or widowed woman of reproductive age who fails to remarry within a year or two may soon face presumptions of promiscuity.

⁶¹ Schildkrout (1982) demonstrated how secluded women in Kano remain economically active through their children, who mediate between the woman-controlled domestic domain of the house and the male-dominated public domain.

Adult women in Hausa society thus find themselves divided into two basic groups. The first, *mata masu aure* [married women], are considered to have fulfilled their most important socio-religious responsibility when they marry and have children. (A wife's infertility is a frequent reason for a man to initiate divorce.) The second broad status position for adult women is *karuwai*. *Karuwanci*, which has variously been described as 'prostitution' and 'courtesanship', has been the central institution through which extramarital sex occurs in Hausaland. *Karuwai* ['courtesans', 'independent women', 'prostitutes'] generally reside together in *gidan mata* ['houses of women'] where they cook food, serve alcohol, entertain guests, and have sex with male clients/patrons (Pittin 1979; Pittin 1983). Since the formalization of sharia in 2000, however, *karuwai* have been increasingly harassed, arrested, and forced to abandon *karuwanci* altogether (Gaudio 2009).

While *karuwanci* was never a socially respectable role for women, it did at least provide one socially institutionalized opportunity for women's economic self-sufficiency outside of marriage. *Karuwanci* has not completely disappeared, but efforts by law enforcement and *hisbah* to enforce public morality (such as Kano State's *A Daidaita Sahu* campaign, discussed in Chapter 1) have effectively decimated the practice since 2000. As a result of this clampdown on *karuwanci*, divorced women and others who—out of personal choice or economic need—might have turned to *karuwanci* as a means of subsistence for themselves and their children in the short-term or long-term have become increasingly dependent on marriage for legitimacy and survival. Whether or not a woman is actually engaged in sex-for-money exchanges with multiple men, being marked a *karuwa* casts her as a

threat to the upright morality of men and to the entire Islamic social order. Some progressive and feminist Hausa have attempted to reframe unmarried adult women as *mata masu zaman kai* (roughly, 'self-sufficient women'). However, the *karuwa* designation with all its attending moral disapproval remains normative for women of childbearing age who remain unmarried or do not remarry.

Anxiety about the pernicious effects of unmarried women on society is perennial. I first encountered this sentiment at the beginning of my first trip to Kano in 2007. Knowing that I was traveling to Nigeria, an eminent older American scholar who had lived in Kano decades earlier asked me to take along gifts and well-wishes to his old friend, a Hausa man in his late 60s. Upon my arrival I contacted the scholar's friend who came to meet me at my hotel. As a just-arrived ethnographer I was keen to hear the perspectives of an older person and he was kind enough to talk with me at length. In the course of our conversation—and seemingly out of nowhere, from my perspective—the man grew rather serious as he told me, "Our main problem here is all these unmarried women. It's not good. I swear it's not good." His proclamation took me by surprise; from my cultural vantage as an American, there did not seem to be very many unmarried women at all. Yet this assertion about the social ill constituted by unmarried women proved to be one that I heard repeated many times and by different men in the course of my research.

HIV serodiscordance and divorce

Islamic scholars have concurred that HIV infection is grounds for divorce, and may be initiated by either by a husband or a wife if the other spouse is infected.

This makes the disease distinct from other life-threatening illness such as cancer or heart disease, which would not be grounds for seeking divorce (Al Islaah 2008). Neglecting one's spouse is considered sinful in Islam; as illness is often a time of great need, it is the responsibility of married people to attend to each other when one is sick (al-Jibaly 2000: 36-9). Islamic scholars have thus figured HIV/AIDS as a condition that effectively overrides the responsibility of one spouse to the other.

Since reproduction is of great social importance in many Islamic societies, and because an HIV-positive spouse would put his or her HIV-negative spouse at risk of infection through sexual intercourse, the serodiscordance of the couple threatens their ability to have children.⁶² Using donor sperm or a surrogate biological mother is not a religiously permitted solution to such a problem (Clarke 2006; Inhorn 2003). Sperm washing for *in vitro* fertilization, whereby individual sperms are separated from the seminal fluid (and from the HIV virus in the case of HIV-positive men), is one Islamically acceptable solution for serodiscordant couples seeking to conceive when the man is HIV-positive and the woman HIV-negative. However, the procedure is prohibitively expensive for all but the richest Nigerians and is uncommon in Nigerian fertility clinics, requiring the further cost of overseas travel.

⁶² When an HIV-positive mother is on ART during pregnancy, delivery and breastfeeding, the risk that her baby will become HIV-positive can be reduced to less than 5 percent (UNAIDS 2012a: 27). Nigeria, however, is one of eight countries with a generalized HIV epidemic (all eight of which are in sub-Saharan Africa) where less than 25% of HIV-positive pregnant women were receiving ART in 2011 (UNAIDS 2012b: 45).

HIV/AIDS Stigma

Stigma is a major concern for HIV-positive people in Northern Nigeria, as it is in much of the world. Stigma arises out of ill-informed fears about casual transmission of the virus, and moreover because being HIV-positive marks one with a suspect character and the assumption that one has violated Islamic codes of sexual morality. Several informants confided that they feared telling their families that they had HIV, even when they became sick and needed care, for fear of being ostracized and judged. The situation is often worse for women, who, in addition to facing presumptions of sexual immorality, bear additional anxieties about losing financial support for themselves and their children.

One common strategy by HIV-positive Northern Nigerians attempting to deflect the stigma of their serostatus is to overemphasize non-sexual routes of transmission, thus deemphasizing sexual transmission. HIV transmission from barbering, blood transfusions, the re-use of needles and razors, and mother-to-child make up a small percentage of all incidents of transmission. Yet these are often foregrounded in HIV-positive people's discussions of transmission, whereas sexual transmission was quickly glossed. The downplaying of the sexual transmission of HIV--indeed, avoidance of public discussions of sexuality more generally--likely contributes to the spread of HIV.

Post-mortem autopsy

Islamic prohibition against post-mortem autopsy also plays a role in the AIDS epidemic in Northern Nigeria. Post-mortem autopsy is un-Islamic because it is

considered a desecration of the body, nor is it a part of traditional Hausa mortuary culture (Last 2004: 723). Burials are performed typically within a few hours of death, or early the following day if death occurs at night. Family and acquaintances may know the cause of death; or may hypothesize about it--particularly in cases where sorcery is suspected. However the cultural expectation is that death be responded to stoically and without much discussion. In death, as in life, Allah's will is supreme. To question *why* someone died risks questioning this supreme authority rather than fully accepting it.

In cases where a married person dies of AIDS, his widow (or widows) may be unaware of the cause of his death. Even if the dying man himself knew that he had AIDS, he may not have disclosed his HIV status to his wife. If the widow feels healthy but is unaware of whether or not she is herself HIV-positive, from the perspective of future marriage prospects she may not perceive much personal interest in testing. This is because if she *does* test positive *and* chooses to disclose her status to potential marriage partners, her chances for remarrying plummet.

If she tests positive and keeps this information from a future husband, she must live with the moral weight of potentially infecting him without his knowledge. For many in this precarious situation, simply not testing may seem the best of several unfavorable options. Even in cases where a widow already knows she is HIV-positive, she may choose to keep this information from potential future husbands, knowing that being public about her status would be a serious obstacle to her remarrying.

In these suppositional cases, extrapolated from situations I saw or heard about in interviews, the HIV clinic, and support group meetings, the person who dies of AIDS is a man and it is his female widow (or widows) who must navigate the uncertainties of HIV status and remarriage. It is also of course the case that a woman dies of AIDS without her husband necessarily being aware of her status, without being aware of whether he is himself infected, and facing prospects for remarriage. In the next section, I elucidate why the gendered dynamics of marriage and HIV are of such importance for Northern Nigerian Muslims, and why HIV-positive men and women face different social outcomes from infection.

"Women are cheap": HIV infection and men's marital opportunities and obligations

Throughout Africa women experience a heavier burden of HIV/AIDS than men, a fact attributable both to women's greater biologic vulnerability and their lesser social and economic clout than men. When married couples learn that they are HIV serodiscordant, HIV-negative women are considerably more likely to stay with a husband who is HIV-positive than HIV-negative men are to stay with a wife who tests HIV-positive (e.g. Porter et al 2004 on Rakai, Uganda). This fact reflects greater dependence of women on men for financial security and social legitimacy. It also gives women considerable incentive *not* to disclose their status to current or potential husbands if they learn they are HIV-positive.⁶³

⁶³ In their analysis of nationally representative data for 13 sub-Saharan African countries, De Walque and Kline (2012) found that divorced, separated and widowed individuals who have remarried are more likely than those who are single or

Because the marital home is considered to be a Muslim woman's proper place in Northern Nigeria, her wellbeing and that of her children are closely tied to her husband's provision.⁶⁴ In this context, being HIV-positive *and* divorced or widowed can prove socially and economically devastating for a woman. As Katie Rhine's (2009) research with HIV-positive women in Kano indicates, these demographics are suggestive of the particular pressures to marry that women without husbands face. If their status becomes known, divorced and widowed HIV-positive women find that their future marital opportunities become seriously constrained and their bride wealth drops.

Most studies of the social effects of HIV/AIDS focus on the socially harmful impacts of infection, and understandably so. Also worthy of investigation are the collateral privileges that accrue to certain people, in certain contexts, as a result of being HIV-positive. HIV-positive men face considerable social, economic, and health challenges as a result of HIV, including dissolution of family ties, unemployment, morbidity and mortality. Yet HIV infection also has certain unexpectedly beneficial effects on the social status of Muslim men in Northern Nigeria. My initial puzzlement over the precise meaning of Dauda's assertion before the support group meeting that positive men perceive positive women as cheap [*arha*] yielded to greater clarity

married for the first time to be HIV-positive in 12 of the countries, especially if they are female. (Nigeria was not included in the analysis.)

⁶⁴ In a society as large and socio-economically diverse as Northern Nigeria, there are great variations in women's mobility and employment patterns. While some women live in seclusion and rarely leave the house, others work outside the home and travel with relative freedom. My point, then, is that in general Muslim Hausa have a gender binary conception of the public/private spheres, with the house [*gida*] understood as women's domain and *waje* [outside] and *cikin gari* [in the town] understood as men's spheres.

as I came to understand that the primary motivation for attending support groups for most members was finding future marriage partners.

Men's opportunities to marry multiple wives--and thus to attain an idealized masculine status--actually improve as a result of being HIV-positive. This is because eligible positive men become highly sought-after due to their relative scarcity *vis-à-vis* positive women; they have access to the "surplus" of positive women seeking husbands. If women become "cheap" as a result of HIV infection, then men--in the context of the marriage market--become more valuable by extension. For such men, improved prospects for polygyny accrue in a context of already considerable male gender privilege.

Furthermore, HIV-positive men experience their polygynous marital prospects not only as an opportunity, but also as a religious obligation to care for widowed and divorced HIV-positive women and their children. This sense of obligation is predicated on a gendered ethic of care that naturalizes men's dominance and women's economic and reputational dependence upon husbands. The concept 'ethics of care' has grown out of feminist moral philosophy and the effort to resituate morality in relational terms, rather than basing morality on abstracted ethical principles (Held 2007). I am therefore adapting this concept to focus on men's ethical obligations as caretakers, a topic still relatively underexplored.

Among my HIV-positive male respondents, most expressed interest in marrying, or in marrying again. One 40-year old HIV-positive man who had one wife

said the following when I asked him whether he'd ever considered marrying more than one wife:

I still have only one wife, but now I'm asking God the father to ready me for a second marriage. I have this aspiration in my heart. Or isn't that so. And why? Because if I had the means, I swear to God, I would marry four; I'd take three more wives in the future. We [HIV-positive men] need to keep on marrying women with this problem. Because if we don't, who's going to marry them? [...] You see at the (support group) meetings that there are more women than men. If every man married four wives [...] you would see that the problems of [HIV-positive] women would reduce. The issue [for men] is that you *want* to get married, but you don't necessarily have the means to do so.

The HIV-positive Muslim men I interviewed understood marrying single HIV-positive women and providing for their children as the fulfillment of a religious obligation. In HIV support groups, where women far outnumber men and where the "support" most sought after is the re-constitution of families through marriage, men face acute pressures to marry. I was privy to the discussions men had during the meetings, many of which revolved around the women sitting across the room. Was so-and-so married? What was her background? In this context, men exerted pressures on each other to initiate conversation (*zance*) with unmarried women in the group, with a goal of expediting new marriages:

4 December 2010: I walk into the Taimaka meeting just as it's about to begin, and notice that the gender balance today is particularly skewed: women outnumber men almost four to one. I see Shehu sitting on the men's side with an empty seat to his right and walk over to sit by him, greeting and shaking hands with the other men sitting nearby as I pass. Shehu is one only a few male members who's actually younger than me, and also one of the only other never-married men in the group. Shaking hands and touching our chests by our hearts in the customary way, we

rattle through a few standard greetings: how did you sleep, did you arrive in health, how's home? Then with a slightly mischievous smile he asks, "How's your wife?" I smile back and say, "You know I don't a wife." He cocks his head and winks at me, still smiling. "Well, you need to get one. Today we're going to give you one." The meeting begins with the opening prayer, and then the read-through of the day's agenda. A few minutes later, Shehu puts his hand on my knee and asks more quietly, "So what type of women do you want? A mature one or a small girl?" I think for a moment and respond noncommittally, "Not too old, not too young". The two men sitting to my right are also talking. "Don't you see that tall, light one over there?" the one man says to the other. "I'm looking at her, and she's looking back at me." The vice-chairman of the group is at the front of the hall discussing elements of 'positive living': Keep your home clean, eat good food, sleep under a mosquito net, avoid stress. Still smiling, Shehu takes his eyes off the women's side for a moment and says, "I swear to God, I'm going to get a girlfriend today," tapping his finger in the center of my chest for emphasis. "And you too. You're going to get a girlfriend today, you hear?" I smile back at him and click my throat in guarded agreement.

In my survey of 174 HIV positive men randomly recruited from the HIV clinic where I conducted fieldwork, 133 were Muslim. I had an incomplete response from one of these 133 individuals on how many wives he had, leaving a sample of 132. Of these 132 respondents, 51 were currently unmarried; leaving a sample of 81 currently married HIV-positive Muslim men. Of these 81, 55.5 % (n=45) were presently married to one wife. 25 had two wives, 9 had had three wives, and 2 had

four wives. Thus of the 81 married HIV-positive Muslim men surveyed, 45.5% (n=36) were currently polygynously married.

In order to hypothesize about the effects of being HIV positive on monogamous versus polygynous marital status I will compare this finding to data on men's number of wives from the 2008 Nigerian Demographic Health Survey (DHS). 455 currently married men age 15-49 were surveyed in Kano State. Of these men, 70.4% had one wife, and 28.5% had two or more wives. (Data was missing for 1.1% of respondents). (NDHS 2008: 362).

In sum, the married HIV positive Muslim men in my survey were *17% more likely to be married polygynously* than were married men from Kano State surveyed for the DHS. This finding appears to indicate a positive association between being HIV positive and being married polygynously for Muslim men.⁶⁵ I cannot definitively assert based on this data that becoming HIV positive *causes* men to marry multiple wives, although my qualitative data lends support to this proposition. It may also be the case, as others have suggested, that being polygynously married increases a man's likelihood to become infected with HIV. I suspect that the relationship between HIV risk and polygynous marriage is bidirectional: as a group, polygynous men are more likely to become infected with HIV than monogamously married men;

⁶⁵ Caveats must be stated, however: 1) I controlled for religious affiliation, whereas the DHS does not present disaggregated data on marriage for married Muslim men versus married male adherents of Christianity (and other religions). 2) My survey respondents were overwhelmingly urban residents, whereas respondents to the DHS were both urban and rural. Data on number of wives in the DHS was not disaggregated by urban versus rural level at the state level, but of all 7,018 married Nigerian men age 15-49 surveyed rural residents were more than twice as likely (19.5%) to be married polygynously than urban residents (9.0%).

HIV-positive men are also more likely to marry multiple wives for the reasons explained above.

The dissolution and reconfiguration of kinship

The relationship between an HIV-positive person and her family, like all kin relationships, extends into the wider realm of social life. An HIV diagnosis often makes even more salient the connection of the family to other social institutions. As Veena Das and Lori Leonard assert in a study of HIV-positive adolescent girls in the United States, “the knotting together of sex and death, seen through the lens of HIV infection, showed how kinship was made at the intersection of state, clinic, and family” (2007: 211). Religion, too, is a social institution and set of practices through which kinship is undone and remade in the context of HIV infection. In this section I consider HIV/AIDS as a force of both kin cutting and kin binding, and focus on HIV support groups as key institutional loci for the reconstruction of kinship for HIV-positive people.

Because of the stigma surrounding HIV/AIDS and because the disease is so often fatal, infection often results in rejection by one's family, divorce from a spouse, widowhood, and orphaning. These changes affect both one's family of orientation (the family one is born into) and family of procreation (the family one forms through marriage). Many people affected by HIV/AIDS experience the dissolution of marital ties through the death of a spouse or through divorce.

The financial burdens of AIDS on the household level can be great, especially in poor countries. Illness may have serious impacts on the family's resources and

income. Caring for the sick person requires medicines, treatment, trips to healthcare providers, and a quality diet. When the person dies, funeral costs are a further drain on resources. If the sick person is an adult, their illness and eventual death deprives the household of labor. If multiple family members are sick—as is often the case with AIDS—the burden is multiplied (Whiteside 2002:320).

If both parents die and the household dissolves, their dependents –usually children, but sometimes also the elderly—must either fend for themselves or be taken in by other households. When extended families step in to provide care of dependents, in most instances fewer resources will be available to their own household members (Whiteside 2002: 321). Adoption within the extended family, especially in poor countries and for poor families, means getting by with more people but with fewer resources less.

On the other hand, AIDS is also a force of kin binding: it results in new marriages, child fostering, friendships, "imagined" kinship among those who share HIV-positive status, and other enactments of care that are suggestive of kinship. Turning now to some of the constructive aspects of HIV/AIDS for family life in Northern Nigeria, my foci will be on both literal assemblages of families through re-marriage, and on more metaphoric assertions of kinship. By the latter, I refer to the phenomenon whereby HIV-positive people come to perceive of themselves as part of an extended family based on their shared experiences of disease and stigma.

HIV support groups

There are around a dozen support groups in metropolitan Kano for people living with HIV/AIDS.⁶⁶ The groups attract as many as 100 members each to monthly meetings from a broad segment of Kano society—although as in the HIV clinic and for reasons related to the avoidance of stigma, people of high socio-economic status appear to be underrepresented in the groups. A few HIV support groups have existed in Kano for over a decade, but many have been more short-lived; it is therefore difficult to give a precise count of the number of HIV support groups. However, there has been a marked trend towards more HIV support groups across Northern Nigeria and across Nigeria as a whole (Rhine 2009: 374). Taimaka Support Group, where I was a member and conducted participant-observation between 2007 and 2010, is among the more stable and better-established groups in Kano.

Support groups have broad missions to improve the lives of their members through education about living with HIV/AIDS, alleviating stigma, addressing the social and economic challenges of being HIV-positive, and linking members to clinical care and social services. In addition to the lectures and discussions that comprise the monthly meetings, some group members engage in other activities, ranging from workshops on income generating activities for widowed women to visiting group members who are sick in the hospital.

Support groups serve as key sites for the reconfiguration of kin relations for those affected by the disease. In-group care is especially important since many

⁶⁶ There exist numerous earlier Hausa examples of “biosocial” groups centered on physical disability such as the *k’ungiyar guragu* (“associations for the lame”), associations for the blind, and for those with leprosy (Rhine 2009: 396n6).

group members have faced rejection and death from their "real" families. One kin-related aspect of the support group is the metaphoric assertion of group members as family members. Frequently I heard utterances such as, "we all have the same mother and father" (*uwarmu dai, ubanmu dai*), and references to the meeting space as the "house." These assertions of metaphoric kinship speak to the commonalities of experience shared by people with a stigmatized identity. Furthermore, such kinship metaphors serve as injunctions to provide care and support to other group members, to treat them as though they were one's own:

6 November 2010: Dauda, the chairman of Taimaka Support Group, makes an announcement near the end of the meeting: a female member of the group has just given birth to a baby born without a tongue. "Ok, so what are we going to do? Are we going to wait for the government to help her?" he asks rhetorically. "We are her family. So let's help her." Members begin coming up to the front table to give money. The vice-chairman says the name of each person who comes forward to contribute, and announces how much she or he has given.

Endogamy, specifically cousin marriage, is considered culturally preferable in Northern Nigeria as it is in many Muslim-majority communities. Since group members metaphorically construct the support group as a large family, there is therefore a certain cultural logic to members seeking out marriage partners from within the group. By constructing the support group as a family and the meeting space as a house, the inter-marriage of group members becomes a socially recognizable and socially sanctioned enactment of endogamy. Boundaries between

"imagined" and "real" kinship, and between biological and social relatedness, become blurred in HIV support groups.

Public mixed-gender spaces are rare in Kano, and even more so in the era of *sharia*, due to cultural and religious injunctions against unrelated people of the opposite sex socializing. At Taimaka meetings nearly 100 people, both men and women, cram into a medium-sized, un-air-conditioned office. Some sat in plastic chairs lining the room, but most sat packed tightly together on the bare floor. The one concession to gender segregation is that men sit on one side of the room, nearer the entrance door.⁶⁷ Women, who make up at least two thirds of those present for each meeting, sit apart from the men.

Because men and women's seating was divided, men spoke overwhelmingly to men, and women to women, during the meetings. That said, the meetings provide the space for inter-gender interaction that was exceptionally permissive in relation to the wider social norm. It was at the end of meetings that men and women milled about the entrance of the office, talking and joking. Men were structurally advantaged in these interactions by virtue of the fact that many of the women at the meetings were looking to marry, so men had a wider selection of potential partners. Marriage was certainly actively encouraged, and for most members it was the most or one of the most important aspects of support group membership. Moreover, given the considerable stigma attached to HIV infection, support groups and HIV

⁶⁷ By 2009, the meetings had moved from the support group's office to the larger space afforded by the HIV clinic, but by late 2010 the meetings were in the process of moving back to the office. In both spaces, men and women sat in separate groups.

clinics are the only places where most HIV-positive people are open about their status and encounter other people whom they know are positive.

The group's mission statement is "to prevent the spread of HIV/AIDS and provide psychosocial support to PLWHA, widows and children orphaned by HIV/AIDS." As such, the mission of the group makes no *explicit* reference to facilitating matchmaking. Consider, however, the implicit kin expectation of "providing support to widows and children orphaned by HIV/AIDS" in a society where women are largely beholden to men for their economic survival. After all, what better way for men to provide support for widows and their children orphaned by AIDS than to marry them?

Like family members, support group members monitor sexual behaviors and attempt to promote a particular set of values surrounding ethical sexual behavior. These efforts map onto larger social assumptions about gendered dispositions and religiously permissible comportment. Women in the support group were admonished to behave honorably and not to rush into relationships. Men were cautioned against taking advantage of women's desperation. Both men and women were strongly encouraged to seek other HIV-positive people for marriage partners rather than risk infecting others.

Support group activities focusing on income generating skills for women (such as making soap and body oil to sell) provide them with new opportunities to financially care for themselves and their children since employment outside the home for women remains the exception rather than the rule. Some men I interviewed suggested that the small income generation activities that NGOs and

international aid organizations organized for HIV-positive women were well intentioned but missed the mark. They instead proposed a trickle-down approach, whereby HIV-positive *men* would be targeted for income generation initiatives, so that in turn they could improve the well-being of their HIV-positive wives. To paraphrase one man, if you help a woman, you've only helped her. But if you help a man, you've enabled him to marry again and you've therefore helped all his wives.

Gender differentials, masculine advantage, and marriage brokering in the HIV clinic

During my fieldwork I consistently observed two to three times as many women as men in HIV clinics and support group meetings. This reflects higher HIV prevalence among women, but also women's greater likelihood to be tested and know their status as a result of routine HIV testing during antenatal care. Men as a group have no regular equivalent interaction with biomedicine, and are unlikely to voluntarily test for HIV unless they suspect for some reason that they are positive.

Among my male interview respondents, nearly all recounted testing for HIV because they had become ill or because a wife tested positive. Only a small minority said they had discovered they were positive because they decided to test independently of any notable illness or a partner's positive test. Moreover, in my survey of 174 HIV-positive men randomly recruited from the clinic, only 23.5% (n=41) had had at least one negative HIV test previous to testing positive.

But men's absence from HIV-related spaces is due not only to women's increased biological vulnerability and gendered differentials in testing related to antenatal care. Many men of high socio-economic status leverage this status and

their masculine gender privilege to access care, including ART, outside public clinics. This allows them to manage the stigma and potential reputational threats posed by being seen at the HIV clinic. Other men, regardless of socio-economic status, circumvent the clinic by sending their wives to collect drugs for them. Gendered socio-economic capital, and gender privilege more generally, are thus cashed in on by men to buy their way out of the formal arrangements of the clinic. This allows some men to avoid the shame and stigma of appearing in the semi-public of the clinic as an HIV-positive person:

Thursday 29 July 2010: I am observing Dr. Fahad, a resident doctor, as he sees patients in one of the clinic rooms. Hajiya Ladi, the head nurse, is also in the room. As they consult with patients, they get on the subject of differences between male and female patients. Dr. Fahad says, "The men don't want to submit themselves, but the women can be tamed" into coming to the clinic. He explains that the doctors used to be strict about male patients coming themselves to the clinic, but that they are now more relaxed about seeing male patients outside of clinic hours. Because of stigma, some men send their wives to collect their drugs for them. "You can't force someone to come to the clinic", Dr. Fahad says. "Some big men on ARVs, we don't even know them in the clinic here," adds Hajiya Ladi. Some high-status men make special arrangements to collect their drugs after clinic hours or to meet the doctors elsewhere. "It's stigma, but they also don't want to queue up," says Dr. Fahad. He explains that he also sees "big men" outside the clinic and "finds a way" to bring them their drugs. "For some patients," he explains, "we go the extra mile." For big men, especially political office holders, who don't want to come to the clinic, he

arranges to see them at a private clinic where he also works at night. All of their patient care is done off-site: consultation, picking up drugs, and blood work. Dr. Fahad says that he draws their blood and then brings it to the clinic himself for lab tests. When I ask him how many male patients he sees outside of the clinic, he estimates around fifteen.⁶⁸

Doctors, nurses, and other staff at the HIV clinic care for the physical health of their patients. In addition to enacting these expected medical forms of care, I have seen doctors take not insubstantial sums of money from their own wallets and give them to destitute patients in the exam room. The clinic, then, is not only a place where clinicians execute 'rational' scientific practice, but also where Islamic ethics of care become enacted. One extra-medical way that some clinic staff enact care is by surreptitiously mediating marriages among patients:

Monday 19 July 2010: I'm observing Nurse Kareem as he sees patients in the morning. Kareem is the first staff member patients will see before they make the route through the various staff offices on the way to eventually collecting their drugs. A male patient around 40 years old, well dressed, tells Kareem during his consultation to not forget about the fact that he wants to marry a fellow patient. He gives the specifications of what he's looking for in a wife: he wants a woman who's tall, has a fair complexion, and who has no more than one or two children if she is a

⁶⁸ Such extra-clinical arrangements with male patients of high socio-economic status constitute a financial boon for doctors.

divorcee. He wants her to be living in Kano with her parents, and wants her to be ethnically Hausa. She should be also be "a bit intelligent" ["*'yar ilimi kadan*"], he adds.

About thirty minutes later, having seen two women in the clinic that he feels fit his qualifications, the man rushes back in to tell Kareem to inquire for him about whether the women are married. Kareem says that during their respective consultations he will ask if they're married. If they are not married, he will send the woman to the adherence office, where another man on the staff will ask her several questions about her life and advise her to marry. He'll tell her, 'You're young, pretty, looking good, why not marry?' If she says, 'No one wants to marry me because I'm sick', he'll respond, 'don't worry, even among our patients there are those who want to marry other patients. I can introduce you to someone right now.'

It's a set-up. The male patient has already seen her and expressed interest, but the woman does not know this. Kareem explains that the adherence officer will tell her next: 'you already know each other's status. If you meet and like each other, you can date.' If the woman agrees, the adherence officer will call the male patient, and he will introduce the woman to him directly at that time. Or, he'll take her phone number and give it to the male patient. Later, they can make an arrangement to meet. If they meet and like each other, they can become boyfriend and girlfriend, and potentially get married. This particular man already has one wife but wants to marry a second wife.

I ask Kareem how many times he's done this sort of matchmaking. "Many times", he tells me, smiling. But he does not want the authorities at the clinic or

hospital or to know that this is what they are doing. I ask him to estimate how many marriages he's arranged. Thinking for a moment, he responds, "Wow...a lot!" Sometimes it's the male patients who initiate it and other times it's the women, he says.

"So why do you get involved in this sort of thing?" I ask him. Kareem says the first reason is that the staff wants to reduce spread of the virus, which they do by encouraging intermarrying among positive people. Secondly, Islamically, they want to help women get married, since people will often not want to marry an HIV-positive woman. Otherwise, he says, the woman might leave Kano, go to Kaduna, and not tell a man that she's HIV-positive so that she can get married. Her options would be limited by the fact of her being positive. She would either have to become a *karuwa* or leave Kano to travel where no one knows her to marry an unsuspecting man. And, he adds, some important people [*"manyan mutane"*] are not able to go to support group meetings to look for marriage partners.

Conclusion

Nigeria has experienced a massive, if still uneven, expansion of biomedical treatment options for HIV/AIDS. This has already begun to improve quality of life and longevity for positive people who have access to ART. For these people, what was once an almost invariably fatal infection becomes a highly manageable chronic condition. This shift has profound effects on the life trajectories of people living with HIV, most significantly in the realms of marriage and parenthood.

By re-marrying after being divorced or widowed, HIV-positive people stake a claim to a continued social existence and social acceptance that transcends their stigmatization as people with HIV/AIDS. I've argued that HIV-positive Muslim men in Northern Nigeria experience their changed prospects for marrying multiple wives as both an opportunity and as religious obligation to care for widowed and divorced HIV-positive women and their children. Dissimilar to findings from most other African settings that, "hegemonic notions of masculinity that frame men as self-reliant family providers subordinate HIV-positive men as unmanly and inadequate" (Wyrod 2011: 453), my research suggests nearly an opposite result for HIV-positive Muslim men in Northern Nigeria. Without denying the serious health risks and social dislocations that such men continue to face, I have argued that healthy, HIV-positive Muslim men are poised for improved polygynous marital prospects and concomitant improvement in their masculine status.

One implication of these findings is that HIV prevention strategies urging faithfulness to one partner defy the Muslim Hausa cultural logic that defines the economic and sexual provision for multiple wives as a component of male piety and ideal masculinity. Such prevention messages are based on the premise that monogamy is protective of the spread of the virus for both men and women. What prevention messages of this kind do not address is that multiple concurrent partnerships, in the form of polygynous marital unions, are desired by positive people for the stability and social status effects that such unions confer to both HIV-positive men and women. I will address this issue in greater depth in the conclusion

chapter, where I suggest culturally acceptable interventions that may help reduce HIV transmission and improve quality of life for those already living with the virus.

While data from my survey suggests a positive association between being HIV positive and being married polygynously for Muslim men, further epidemiological research is needed to make stronger inferences about this association. If it can be demonstrated more conclusively that an association exists between HIV status and the number of wives a man has, it will be important to know whether there is a causal relationship to this association. Knowing to what extent being in a polygynous marriage increases a man's risk of being HIV-positive, to what extent being HIV-positive increase a man's likelihood of marrying more than one wife, may have useful implications for AIDS interventions.

Chapter 5:

The Mode of Transmission That Dare Not Speak Its Name: Islam and the Public Secret of Male Homosexuality

Introduction

I never suspected that El Haji Salisu has sex with men. We meet on a Saturday afternoon in 2008 during my second visit to Kano for field research. My friend Kabiru picks me up on his motorcycle and we head to the third floor office of Taimaka Support Group, where I will conduct my first semi-structured interviews with men who are HIV-positive. It rained hard last night and the streets are still flooded, but Kabiru weaves a masterfully circuitous route around the massive rain-filled holes that pock Kano's streets. Eventually we make it to Zaria Road, the busy southern thoroughfare into the city, where the office is located. There is no support group meeting today, and I'm curious to see what happens when there are not 70 people improbably crammed inside.

When Kabiru and I arrive there are a few men in the office, chatting and watching a TV on a plastic table in the corner. As usual, the electricity is not working; a generator loudly sputtering smoke on the balcony powers the TV and ceiling fan. The men are watching English Premiership football, sitting in plastic chairs covered by the logo of a mobile phone service company. A couple of the men are wearing jeans and long sleeve shirts despite the humid heat, while others are wearing *dogon riga*, the local version of tailored cotton kaftans that men wear across the West African Sahel.

Salisu is one of the men I meet this afternoon. The first thing I notice about him is his bright-eyed laugh that reveals a flash of teeth. He has a *hak'orin Maka*, or gold-plated "Mecca tooth", covering one of his top incisors. More than merely fashionable, this signifies a level of social status: These gleaming gold teeth are one of the most obvious markers of having performed the pilgrimage and spending time in Saudi Arabia, which all observant Muslims aspire to do. After watching some football and chatting about Nigerian politics for a while, Kabiru and I explain my intention to do interviews, and ask if anyone wants to hear more. Salisu is the first to say that he does.

We go into an inner room so that we can conduct the interview in private; there's a wobbly ceiling fan, a dusty computer on a desk, and a few sewing machines donated by an American aid organization. Salisu tells me he is 33-years old and has only known he is HIV positive for seven months. He'd been living and working in Saudi Arabia for several years, but when he took an HIV test to renew his Saudi residence permit and found out he was positive, he knew that his visa would not be extended. As a foreign national, he would also be denied treatment for HIV in Saudi Arabia.

Salisu flew home to Nigeria not knowing what would happen next. Hoping to return to his well-paying job serving a member of the Saudi royal family but knowing that this would not be possible as long as he was HIV positive, he began seeking out treatments from several different people across Nigeria who claimed that they could cure HIV. Despite paying the equivalent of several thousands of dollars for various herbal and prayer-based treatments, Salisu's condition worsened

and he fell seriously ill. When he became emaciated and weak his mother brought him to a government hospital, where he was started immediately on antiretroviral drugs.

His recovery was dramatic. Practically dead just months before but now back to robust health, Salisu told me how fortunate he felt to be receiving free ART and for the doctors who managed his care. He spoke about the financial insecurities he continued to face in Nigeria, and hinted at the complexities of his family life. I appreciated his willingness to divulge so much personal and emotionally trying information, even though we had just met. We continued to see each other at support group meetings over the next few years whenever I was back in Kano, and occasionally called and text-messaged to greet each other from overseas.

As we became better acquainted, I came to think of Salisu as something of a ladies' man. At the end of Taimaka Support Group's monthly meetings, when members briefly socialize in mixed-sex groups—a rarity among Muslims in Kano, for whom opposite sex socialization with non-family is generally proscribed—he often flirted with one or more women, teasing and laughing and flashing his golden smile. Salisu is a husband several times over. He's married to one wife who lives in Kano, and another who lives several hours away in the Abuja. He's also looking to marry a third wife, telling me that he believes doing so will improve his fortune. (How incurring the expenses of a third marriage would improve his already tenuous financial situation was never clear to me, but he seemed convinced that it would be advantageous.) He's divorced from another woman who still lives in Saudi Arabia, and was widowed by his first wife, who died of AIDS. Sharing a box of wine one

evening at Salisu's favorite outdoor drinking spot in Kano's crowded and predominantly Christian Sabon Gari neighborhood, he tells me that he also has ongoing sexual relationships with several other women, including a long-term girlfriend he has no intention of marrying because his mother dislikes her.

Two years pass before Salisu and I reveal to each other, almost by accident, that we are both involved in *harka*. The standard meaning of the Hausa word *harka* (plural: *harkoki*) is 'matters' or 'affairs'; secondarily it denotes 'movement', 'activity', and 'business dealings'. (*Ina harkoki?* ['How's business?'], is a typical Hausa greeting among men.) As a tertiary definition, *harka* connotes the sex trade and other activities considered immoral. Among Hausa-speaking men who have sex with other men, *harka* has a related in-group meaning, of which many Hausa speakers are unaware: for such men, *harka* means homosexual sex⁶⁹. More expansively for *masu harka* ('men who have sex with other men' in the in-group lexicon), *harka* is the intricate and carefully concealed culture that surrounds sex among men.

Sexual behaviors considered immoral are addressed publically in Northern Nigeria only in the context of condemnation⁷⁰. Extending analyses from previous chapters of how gendered expectations of morally righteous comportment and Islamic norms of sexual discourse structure the epidemic, this chapter is about *masu*

⁶⁹ For the remainder of the chapter I use *harka* with this meaning in mind.

⁷⁰ This is true, to an extent, of all societies. But because Islamic teachings—which are considered incontrovertible by northern Nigerian Muslims—play such a crucial role in shaping moral norms, public discussions of sexuality are generally focused on what is *halal* (permissible) and *haram* (forbidden). Moral positions are generally framed in deontological terms, as opposed to consequentialist ones.

harka and their position in Northern Nigeria's HIV epidemic. I consider male-male sexuality and HIV transmission from the perspectives of *masu harka* themselves, from the perspectives of the broader Muslim community, and from the perspectives of those outside of northern Nigeria who hope to address the epidemic among 'men who have sex with other men' ('MSM'). This multi-perspectival approach reveals that understanding of male-male sexuality, its moral status, pleasures, and risks differ. My aim is to demonstrate the consequences of these different understandings for the AIDS epidemic.

Public acknowledgement of the male-to-male sexual transmission of HIV is rare in Northern Nigeria, and health initiatives addressing this mode of transmission have been virtually non-existent. This silence and inaction is a consequence of cultural, religious, and legal injunctions against homosexuality. The longstanding assumption in much public health discourse that male homosexuality plays an insignificant role in Africa's AIDS epidemics has further compounded the problem. My research reveals that as a result of these silences, *masu harka* significantly underestimate their likelihood of contracting HIV from sex with other men.

I conclude the chapter by thinking through the broader social and epidemiological implications of these silences surrounding homosexuality. Living in a society where marriage is a crucial predicate of respectable adulthood, *masu harka* nearly always marry women and have children, while keeping their same-sex sexual relationships hidden. I argue that this *de facto* bisexuality, in conjunction with low condom use and high HIV prevalence among *masu harka*, has underappreciated consequences. Integrated into larger sexual networks, such men contribute

disproportionately if unwittingly to northern Nigeria's AIDS epidemic. This underscores the need for HIV initiatives that address *masu harka*, while recognizing the social volatility of such efforts.

Representations as social facts: Category, identity, and sexuality

Anthropologists have argued with increasing vigor since the so-called reflexive turn of the 1980s that who is represented in ethnographic texts, by whom, and how, are matters of epistemological and political consequence. (Clifford and Marcus' *Writing Culture*, while neither the first nor the last work to question the production of ethnographic authority and its consequences, is the pivotal volume in this regard.) Writing about social dimensions of an epidemic as deadly, painful, and costly as AIDS, I am keenly aware that my definitional and interpretive choices have consequences. What, to paraphrase David Valentine, is my complicity as a social scientist in producing the objects of my investigation, and what are the politics of this process? (2007: 19)

In this chapter I write about '*masu harka*', privileging (and also exposing to outside purview) an in-group term; and translating it roughly as 'men who have sex with men'. Aside from a general anthropological preference for using emic terms in ethnography, why do this? Why refer to *masu harka*, instead of 'homosexuals', 'bisexuals', or 'gay'? Why not refer to them as 'MSM', the *de rigueur* category in global public health discourse? Why not use a more mainstream Hausa term such as '*yan ludu*' ('sodomites'), or '*yan daudu*', a term that central to Gaudio's 2009 monograph on feminine men in Kano? More broadly, what is at stake—

epistemologically, politically, epidemiologically, morally--in the terms researchers have used to represent people's non-normative sexualities?

Foucault (1978: 101) dated the epistemic shift in Western societies from understanding 'sodomy' as a highly punishable if widely tolerated act to the emergence of 'homosexuality' as "a psychological, psychiatric, medical category" and "a certain [pathological] quality of sexual sensibility" (1978: 43), to 1870, around the time that European imperialism was reaching its apex. This thesis, that modern 'homosexuality' (and, by extension, 'heterosexuality') as a distinct personhood was talked into existence in the late 19th century by psychiatry, religion, and state policing of sexual behavior, has been analytically foundational to much subsequent work on sexuality. Recognizing that only recently and in some sectors of Western societies have some people been 'homosexuals', even though people have had same-sex desires and sexual experiences in many different historical times and places (Halperin 1990), historians, anthropologists, sociologists and others have actively deconstructed sexual identities, desires, and conducts over the past three decades, bringing to light the socio-historical and political contexts for the assignation of sexual meanings (Katy 2002:115). In the anthropological canon, Ortner and Whitehead's anti-essentialist position that the meanings of gender and sexuality cannot be detached from their cultural contexts (1981) followed logically from the discipline's cultural relativism and has remained axiomatic.

The identity category 'gay' did not become prominent in Western (and especially American) discourse until the late 1950s and early 1960s. In a schema that gained considerable currency, Adam (1986) distinguished "egalitarian/'gay'

relations” from age-structured, gender-defined, and profession-defined homosexualities (recognizing however that these typologies sometimes co-exist in the same society). The term ‘gay’ has increasingly marked what Herdt and Boxer (1992: 4) have called “a full spectrum of social life: not only same-sex desires but gay selves, gay neighborhoods, and gay social practices that are distinctive of our affluent, postindustrial society.” The seeming fixity and stability which characterizes Western gay personhood, it has been argued, is in large part the result of gay civil rights strategies in the West which have emphasized sexual identity (as a pseudo-ethnic identity) over sexual desire or conduct (Katyal 2002).

Herdt and Boxer's proposition that gayness as an identity, a geography, and set of social practices is “*distinctive of our affluent, postindustrial society*”, has come up for scrutiny in other corners. Hoad (2000), for instance, has rebutted that this line of reasoning has the tendency to reproduce mono-evolutionary narratives long out of favor. There is little doubt that ‘gayness’ as an identity and set of social practices emerged from particular socio-economic conditions. And yet, as anthropological research has made abundantly clear, self-consciously ‘gay’ identities and movements have flourished around the world, even in places afflicted by pervasive poverty (Drucker 2000). The past decade has seen substantial scholarly attention to the so-called “globalization of gayness”—how Western-styled gay identities and cultural formations have moved (and to a lesser extent, been resisted) across national and cultural settings. This attention has followed on from more general theorizing about impacts of global processes on local cultural formations (e.g., Appadurai 1996; Hannerz 1992; Urban 2001).

The expansion and globalization of entertainment and news media have propelled the notion of gayness around the world with increasing speed. Asked to date the start of the gay movement in Soweto, for instance, some young black men there named the appearance of a gay character on the American program *Dynasty* on South African television (McLean and Ngcobo 1995: 180). This, in turn, has created even more demand for gay-themed media on the part of those who see their lives reflected in it. Knowing that I was coming back to Nigeria from the United States, a young colleague living in Abuja who already identified as gay and worked with a "LGBTIQ"⁷¹ organization asked me to bring him DVDs of *Noah's Arc*, the first television series about the lives of gay black men and set in Los Angeles.

Of course, it is not only sexual minorities that encounter these identity concepts. I can recall an evening in 2002 when, as a U.S. Peace Corps volunteer, I was eating dinner with friends at an open-air restaurant in Maradi, the second most populous city in Niger. The restaurant had a small black-and-white television playing while the almost exclusively male patrons ate their dinners and drank soda or beer. On this particular evening, an episode of the gay-themed American sitcom *Will and Grace* was being broadcast, dubbed into French.

For me it was a moment of great cultural dissonance. I had heard little public mention of homosexuality in Niger, yet here was a program depicting the lives and relationships of gay American men, garnering nonchalant chuckles from a viewing audience of urban Nigeriens. My first sense was that what was being depicted was

⁷¹ Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer (or Questioning). I remember this acronym gliding casually past his lips the first time he said it in my presence.

culturally untranslatable; that a publicly declared sexuality based on exclusive homosexuality was inconceivable in the local context. So in Hausa I asked my friends, who were local married men in their mid-thirties, “Do you know what this TV show is about? These men don’t have sex with women, only with other men.” “Well of course,” my friends replied unfazed, “that’s what gay means!”

Scholars have also considered how non-Westerners living in diaspora in the West facilitate transnational flows of gay culture, sometimes influencing the adoption of Western-styled gay identities back home—such as the role Latin American migrants in the United States have on the Westernization of queer sexual identity in Latin America (Drucker 2000), and that of Asians living in North America, Australia, and Britain on spreading consciousness of gay life back to Asia (Altman 2000). Others have focused on shorter-term tourism and international business, with “holidaymaking” affording the (non-Western) traveler an emotional distance from home that has the potential of to affect sexual behaviors and identities (Cox 2002). However, encountering specifically 'gay' sensibilities often creates a sense of “complex loyalties”, whereby gay identities are balanced with ethnic, racial, and national identities that may seem incompatible (Cant 1997: 14). The extent to which 'gay' has been conceptually adopted by sexual minorities and by society-at-large, or constructed as culturally "other", has varied considerably across societies. Recent ethnographies in settings as diverse as Bolivia (Wright 2005), South Africa (Donham 1998), Japan (Suganuma 2007), and the Philippines (Johnson 1998) have lent support to the proposition that differently structured sexual typologies often co-exist in the same society.

Wealthy northern Nigerians live, travel, and conduct business in Europe and North America, although in considerably smaller numbers than do southern Nigerians. For northerners, Islam and other longstanding trade and cultural connections make Middle Eastern cities (particularly Saudi Arabia, followed by Dubai, and Egypt) much more common destinations. To the extent that homosexuality is "othered" in northern Nigerian society, *Larabawa* ('Arabs') are much more commonly instigated as its progenitors than are *Turawa* ('Europeans/Whites'). A now considerable body of scholarship has examined the terms of same-sex relationships among Europeans and "others" from the time of European colonialism (e.g. Bleys 1995; Aldrich 2003; Massad 2007) to the present; much less discussed has been the influence of Islamic and Middle Eastern same-sex typologies outside the Middle East. *Masu harka* acquaintances who had spent time in the Middle East seemed to enjoy disabusing me of my half-surprise that same-sex pick-ups were so brazen in those countries. As a young man in his mid-twenties responded during a formal focus group discussion I held with *masu harka* while a consultant with the non-governmental organization the Population Council, "Men do harka in Mecca more than any other place. I have a cassette videotaped in Jidda where such things happened. Sometimes, you will be approached by them [Saudi men] while walking or on your way home. Another quickly added, "Whenever *me'koki* travel to Mecca, everybody knows what they're going there to do." Another married friend who travelled occasionally on business to Cairo recounted experiences of Egyptian men who boldly picked him up on train platforms, in

markets, and out on the street.⁷²

"We could not come across any Nigerian with such sexuality"

Across Africa, the Middle East, and elsewhere, political leaders have denied the existence of 'gays', arguing that such people do not exist in their countries and are instead emblematic of a morally depraved West. In what is today Nigeria, sodomy laws have made homosexuality an offence since the time of British colonization. Chapter 21, Articles 214 and 217 of the Nigerian penal code make homosexuality punishable by imprisonment for up to 14 years throughout the country. (In the context of Shari`a in Northern Nigeria, homosexuality is technically punishable by death, about which I will say more in the next section.) While Nigeria already has among the world's most stridently anti-homosexual laws, there have been increasingly forceful national and state-level efforts to legislate against gay relationships and organizations since the mid-2000s. This new batch of anti-gay legislation has often echoed transnational debates over same-sex marriage. In November 2011, the Nigerian Senate passed a bill criminalizing two people of the same sex living together "as husband and wife or for other purposes of same sexual relationship". The bill further calls for punishing anyone who "witnesses, abet[s] and aids" such a union with up to 10 years imprisonment, and outlaws advocacy for

⁷² Gaudio recalls similar conversations with *harka* friends: "Alhaji Zinari regaled me with stories about 'Saudiyya' that painted a picture of Saudi social life far different from what I'd imagined while reading the *New York Times*. I was especially intrigued by his descriptions of the sexual excesses of Arab men, whom he characterized as *jarababbu* [horny, oversexed]..." "If they see a 'dan daudu in the street, they'll get an erection and follow you all the way home." Zinari then underscored his powers of ethnographic observation by adding, "Especially Egyptians." (2009:138)

LGBT rights. (Approval of the bill is still pending in the House of Representatives.) Similar legislation has been introduced in several African countries, most notably in Uganda where anti-gay conservative Christian organizations from the United States were instrumental in Uganda's (recently reintroduced) anti-gay legislation that would, among other things, make homosexuality punishable by death (Cheney 2012).

Also in 2009—and rather ironically, as it was the same year that the new anti-gay legislation was being debated by the National Assembly—the Nigerian Minister of Foreign Affairs told the United Nations Universal Periodic Review on Human Rights that there was no gay, lesbian, bisexual and trans community in Nigeria: "We went out of our way to look for the gay, lesbian and transgender group, but we could not come across any Nigerian with such sexuality."⁷³ In 2011, Nigeria joined a large minority of mostly African and predominantly Islamic countries that voted against the United Nations' first successfully adopted declaration to condemn discrimination against gay men, lesbians, bisexuals, and transgender people. Western governments, on the other hand, have recently become more vocal in their support of 'gay' and 'LGBT' people around the world. In a December 2011 speech before the United Nations Human Rights Council in Geneva, and following a memorandum in which President Barack Obama wrote that he was "deeply

⁷³ Alliance Rights, Nigeria's first LGBT organization, formed in 1999. Several other groups have since organized. Moreover in a brave action that made the front page of Daily Trust, the most widely read English language newspaper in much of Nigeria (DATE), gay activists delivered a petition and speech to the National Assembly during debates over the 2009 anti-gay legislation. The Minister's claim is therefore implausible.

concerned by the violence and discrimination targeting *L.G.B.T.* persons around the world", U.S. Secretary of State Hillary Clinton declared to the world the intention to use the tools of American diplomacy to promote gay rights internationally: "Some have suggested that *gay* rights and human rights are separate and distinct, but in fact they are one and the same" [emphasis added].

Countries advocating for and against human rights for 'gays' have reached an impasse, one predicated on different cultural perspectives concerning the moral status of homosexuality. Advocates argue that consensual sex among adults of the same gender is morally neutral and should be protected as a universal human right. Opponents assert that homosexual behavior in any form is morally impermissible, predicating the position on religious doctrine.

A further terminological inaccuracy underlies this disagreement. By arguing for 'gay' and 'LGBT' rights, advocates elide the socio-historically contingent nature of sexual personhood and identification. Although based (from my perspective) on noble intentions to protect a socially vulnerable minority, this approach is ethnocentric to the extent that the vast majority of people in the world who have sex with others of the same sex do not identify as lesbian, gay, bisexual, or transgender. Ultimately, I do not recommend another etic term that would be better than 'gay', 'LGBT', or any other. My point is to recognize the ethnocentrism inherent to the situation, and to advocate whenever possible linguistic and cultural specificity when talking about communities in particular times and places—which makes using emic terms such as *masu harka* most accurate.

Are masu harka gay? And what is at stake in identifying them this way if a

vast majority of them do not self-identify as such? In extensive ethnographic research Boellstorff has explored "where cultural translation appears to meet its incommensurable limit: *gay* and Muslims in Indonesia." (2005: 575) He chooses to keep the word *gay*, when used in its Indonesian context, italicized, "because *gay* is a concept that partially translates to the English concept "gay," without being reducible to it" (575). In his recent monograph on '*yan daudu*'⁷⁴ ("feminine men") in northern Nigeria, Rudi Gaudio addresses this question:

The answer is not so straightforward. In the earliest days of my research, when all I know about '*yan daudu*' was what other people had written or said about them, I imagined I might, as a gay man, be able to become involved in their largely hidden social world. I was intrigued the first few times I saw '*yan daudu*' strolling and dancing at nightclubs and outdoor parties, and could not help but compare these images to gay life at home. Although subsequent events forced me to reconsider, but not reject outright, the naive idea that '*yan daudu*' were men with whom I could communicate on the basis of a shared sexuality, my interactions with them introduced me to a thriving social world of men who acknowledged and acted upon their sexual attraction to other men. These men comprise what could arguably be called a Hausa homosexual community, though their social life differs in important ways from gay life in the West. (2009: 9)

I concur with Gaudio that that, similarities in sexual behavior, sociality, and cultural self-identification aside, considerable differences exist between what it means in to be gay in Western countries and what it means to be a *mai harka*. The most formidable difference, to quote Gaudi again, is that "unlike most Western men

⁷⁴ During the time of my research in the late 2000s, *me'ka* [an in-group term without independent meaning but which roughly translates as 'queens'; plural, *me'koki*] was more commonly used among *masu harka* when referring to feminine men. My sense was that '*yan daudu*' increasingly carried a pejorative connotation with which few wished to be identified. '*Yan daudu/me'koki*' are thus the subset of feminine men within the larger category of *masu harka*, "a 'secret' code term" (Gaudio 2009: 9) that encompasses both '*yan daudu/me'koki*' and more conventionally masculine men who have sex with other men (known variously in the in-group lexicon as 'civilians' [*fararen-hula*], '*yan aras*, or simply as 'men' [*maza*]).

who describe themselves as gay, *masu harka* do not see homosexuality as incompatible with heterosexual marriage or parenthood, or vice versa. At some point in their lives most *masu harka*, including a majority of '*yan daudu*, marry women and have biological children" (2009: 10). In African societies where kinship ties and social pressure to marry remain strong, the public insistence on gay identity exclusive of heterosexual marriage is figured as a serious threat to the family (Aarmo 1999). Thus, "the African lesbian or gay man is figured outside the clan, the tribe, the race, the nation-state" (Pincheon 2002: 47). More importantly for Muslim Nigerians, a public gay identity—that is, an identity that forecloses upon marrying someone of the opposite sex—figures oneself outside the faith community.

As I argued in Chapter 4, and as Gaudio (2009), Cooper (1997), and others expounded, marriage for Hausa people is seen foremost as a religious and social obligation, a critical stage in the attainment of social adulthood. Some individuals, particularly men, have more say than others over who their partners will be and when they will marry—particularly in the case of marrying second, third, or fourth wife. But whether or not to marry is not understood as a choice. Again, Gaudio (2009: 10) observes:

My own refusal to marry based on my lack of sexual desire for women typically did not follow the cultural logic of my homo acquaintances [in northern Nigeria] who did not see a necessary connection between marriage and heterosexual desire. 'Bisexuality' is thus expected of all *masu harka*, whether or not they actually desire or enjoy sex with women.

I recall being in my apartment in Kano with a *harka* friend in his late twenties. Looking at some digital photos on my laptop computer, he came upon a photograph of two friends of mine, a gay American couple in their 50s and 60s,

respectively. In the photo, one of the two was kissing the other on the cheek with a loving look on his face. "Do they do *harka*?" my friend asked me with what sounded like surprise. "Yes, they're married to each other," I responded. "There should be a retirement age!" he exclaimed, expressing that same-sex relationships should be no substitute for married heterosexual life.

Are *masu harka* bisexual? This harkens to a larger debate about the extent to which human sexual desire is an innate, super-social feature of individuals, or shaped by social learning and constraint. Gaudio chooses not to use the term bisexual for married *masu harka*, arguing that bisexuality refers to "an individual's capacity to be sexually attracted to both women and men, and to pursue that attraction socially and physically; this implies a degree of choice regarding sex and kinship which is not widely recognized in Hausa society" (2009:10). He thus implies that *a priori* sexual attraction to both men and women, in the absence of social pressure, should be the criterion by which bisexuality is measured.

Insofar as virtually all *masu harka* have sex with both men and women over the life course, I believe that judicious employment of the term 'bisexual' is warranted. This is because the behavioral bisexuality of *masu harka* in the aggregate is highly relevant to the social epidemiology of HIV, over and above the thornier issue of a given individual's innate sexual attractions. (The term 'behaviorally bisexual' has become common in public health discourse to emphasize sexual behavior over desire or identity, a theme to which I turn more directly in the next section on 'MSM'.) Moreover, I am doubtful about the possibility or even utility of neatly disambiguating sexual desires from other desires—for instance, the desire to

have children, love and affection for one's spouse, even the desire to meet gendered social expectations. An aim of this chapter is to elaborate the specific context of men's bisexuality, showing how the confluence of sexual pleasure, emotional attachment, and socio-religious norms structure *masu harka's* position in the AIDS epidemic.

'MSM' and the "the general population": Bridging the conceptual divide

Responses to AIDS in low-income countries can never be understood as entirely independent of the influence of models and interpretations in the high-income countries from which much AIDS-related research, funding, media, and scholarly literature has emanated since the beginning of the epidemic. This has been especially true in the case of sexual minorities (Padilla et al. 2007), of whom local public representations and discussion may be lacking. The sexual identity terms used by international health and human rights organizations have thus constituted a way of “making gays” (Wright 2005), even if the extent to which this has occurred across and within countries has been uneven. Homosexually and bisexually behaving men who maintain hetero-normative identities and self-conceptions, or who self-identify with some other category, have often been missed by HIV initiatives that target “gay” men (Padilla 2007; Padilla et al. 2007; Wright 2005).

Recognizing this, epidemiologists coined the term 'men who have sex with men' around 1988 (more commonly seen today in its acronymic form 'MSM') in an attempt to disaggregate sexual risk behavior from sexual identity. In the subsequent two decades, global public health programs have overwhelmingly adopted this

terminology. Like 'homosexual' in the context of the 19th century, 'MSM' was a scientific and bureaucratic coinage that appeared in response to the need for surveillance and social control (Boellstorff 2011: 291). The term is presumed to cast a wider and more accurate net, correcting the Western ethnocentric assumption that all men who have sex with other men necessarily identify as gay. In Nigeria, to the limited extent that male-male sexual transmission of HIV is addressed, 'MSM' has indeed become the predominant term used in public health AIDS-speak. As a focal vocabulary term 'MSM' has the benefit of being unknown by most Nigerians, allowing NGOs to surreptitiously work for a popularly reviled group without mentioning 'gays' or 'homosexuals'.

Since at least the mid 2000s, however 'MSM' has come under scrutiny from both public health practitioners and anthropologists. In an article about the terms 'MSM' (and the less commonly used 'WSW', 'women who have sex with women') in public health discourse, Young and Meyer (2005) argue that these purportedly neutral terms are problematic for: obscuring the social dimensions of sexuality; undermining self-labeling of "lesbian, gay, and bisexual people"⁷⁵; ignoring epidemiological relevant variations in sexual behaviors aside from one's partner's gender; and implying a lack of community, networks and relationships in which same-gender sexual pairings mean more than merely sexual behavior. 'MSM' reifies

⁷⁵ That the authors of this paper choose culture-bound terms like "lesbian, gay, and bisexual people" to talk about the obfuscation of the social dimensions of sexuality is a testament to the imperfect terminological options at hand. I generally prefer the term 'sexual minorities' for the global context, although this too is imperfect.

both 'men' and 'sex' as prediscursive, conflating sex with anal-penile intercourse and maleness with biology (Boelstorff 2011:294).

I agree that 'MSM' is problematic for all these reasons. But there is a paradox at play with the term 'MSM' in Nigeria, and elsewhere: Even as the term obscures social dimensions of sexuality, undermines self-labeling, ignores variation in sexual behavior, and implies lack of community, it is simultaneously *becoming* an enculturated identity term. As Boellstorff (2011) explains, MSM has "metamorphosized into an identity, the very thing it was coined to avoid" [...] "The epidemiological category has become a subject position. The etic has become emic" (298). Working as a consultant with the international non-governmental organization Population Council in Nigeria on research about 'male sex work' (itself a problematic concept), I frequently encountered the term "the MSM community". My Nigerian colleagues (and particularly those who were not themselves 'MSM') seemed to have certain assumptions in mind about who constituted this community: young, urban, unmarried men with a distinguishable affect. Older, married, and non-gay-identified men—precisely the individuals the 'MSM' category was originally created to include—were much less likely to be recognized as belonging to "the MSM community".

Throughout this dissertation I've endeavored to read epidemiological texts as social artifacts. Precisely because they are intended as objective statements of biosocial reality, I contend that epidemiological data can be interpreted as expressing implicit moral assumptions. That is, the way facts and categories are delineated in epidemiological texts, particularly as they relate to morally charged

epidemics like AIDS, reveals much about the social imposition of moral order.⁷⁶

Consider, for instance, the following passage from the "Epidemiology" section of the Federal Government of Nigeria's 2009 *National Policy on HIV/AIDS*:

The result of mode of transmission analysis in Nigeria, carried out by the National Agency for the Control of AIDS (NACA) in 2008, showed that about 62 percent of new infection occur among persons perceived as practicing "low risk sex" in the general population including married sexual partners. The rest of the new infections (38 percent) are attributable to injecting drug users (IDU), female sex workers (FSWs), MSM and their partners who constitute about 3.5 percent of the adult population." (NACA 2009: 2)

In this passage, knowledge of and representational authority over Nigeria's epidemic is vested in the federal government's AIDS agency. Next, "low risk sex" is conceptually equated with "the general population" and "married sexual partners"—an assumption which, especially for married women in high prevalence areas, is not justified (e.g. contributors to Hirsch et al. 2009, including Smith's chapter on married Ibo in southeastern Nigeria). Then, three implicitly high-risk groups are named, assigned acronyms⁷⁷, and constructed as separate from the (married, hence heterosexual, and implicitly moral) general population.

⁷⁶ I draw here on Foucault's (1980) conceptualization of the mutually constitutive nature of knowledge and power, Gramsci's (1992) work on hegemonic discourse as a generally unnoted means of exerting social control, and Bourdieu's (1977) insight that "symbolic violence" structures the cognition of individuals by imposing legitimacy on social order.

⁷⁷ As this instance evinces, acronyms are much more likely to be used when referring to "problematic" and stigmatized social groups (e.g. MSM, FSW, IDU). In the AIDS-speak current in Nigeria today, MSM have become one of the "MARPs" ('most at risk populations'). Rendering a group as an acronym is one way of signaling it as pathological.

The fallacy to which I draw attention is that which constructs 'MSM' as necessarily discrete from "the general population including married sexual partners". To the contrary, most men who have sex with other men in Nigeria are themselves (or will eventually become, if current social norms hold constant) "married sexual partners." In Hausa society, both recognizably feminine men (*'yan daudu/me'koki*), and many more men who publically present as stereotypically masculine, have sex with other men *and* are highly integrated—socially and epidemiologically—into the general population.

Few *masu harka* in Northern Nigeria know the English term 'MSM', let alone self-identify with it. And as I have explained, the term itself has become indigenized in Nigeria (as elsewhere) such that those who *do* use it typically do so with a cultural identity in mind that does not include a very large proportion *masu harka*. I nevertheless loosely translate *masu harka* as 'men who have sex with men' because it expresses what the in-group understands the term to mean. (Gaudio's translation, 'people who do the deed', is more useful for matching the linguistic covertness and ambiguity of the term when heard by those outside the *harka* network.) *Masu harka* are a culturally specific subset of MSM, but the cultural specificities of *masu harka* mean that they are not analytically reducible to 'MSM'. At this point, "it is neither possible nor desirable to put the MSM genie back into the bottle of epidemiological categorization" (Boellstorff 2011: 306). However, ethnographic specificity about different groups of MSM in their social contexts is both possible and desirable for revealing the experiences that broad epidemiological categories like MSM merely suggest.

The blind and the sighted

I begin to learn about my friend Salisu's involvement in *harka* one Saturday evening in 2010. A few friends, all *masu harka*, are over at my small apartment across from the Kano Zoo drinking tea, eating biscuits, and chatting. Salisu calls unexpectedly to tell me that he's in my neighborhood and has stopped over to visit. Nervous about any of my friends inadvertently blowing the cover, I warn them that Salisu is *makaho*, or 'blind'—the *harka* slang for 'a heterosexual'. After his brief visit inside my apartment, where he meets my friends, I walk Salisu back down to the street to see him off. Seemingly out of nowhere he surprises me by telling me the story of his friend, a businessman who is having problems with his younger boyfriend. We say goodbye and I go back upstairs rather taken aback by this conversation: I'd never had any acquaintances in Nigeria whom I didn't explicitly know to be involved in *harka* mention homosexuality so casually in conversation, and certainly not in such a morally neutral way.

When the two of us meet for lunch the next day, Salisu makes a few more subtle allusions to homosexuality, using words from the "harka dialect" (Gaudio 2009) that have double meanings generally known only to *masu harka*. When I pick up on these hints and return in kind, Salisu becomes even more obvious and asks if I can connect him with anyone sexually. I play coy, telling him I don't know if we're interested in the same type of people. "So what type do you like?" he asks me in Hausa, winking and using the masculine form for the phrase 'what type'. With the

secret seemingly out of the bag, Salisu and I admit to each other that we both like men.

He tells me he has many boyfriends and tends to go for men in their mid-twenties, about ten years younger than his own age. I ask how he normally meets other men involved in *harka*. "Ah, there are plenty!" he exclaims, as if my question is rather naive. "There are at least one million in Nigeria. And anybody who sees me...you know, I am handsome. If I say I like it, they will not reject me. And if they don't agree, I will use my money", he tells me with a sly laugh. "But normally", he continues more seriously in a blend of Hausa and English, "*harka here is considered a sort of abomination*. If you find somebody who knows you are in the act, people will hate you. It's not like America, where a person can show that 'I am gay'. *Here, if you show it, it's going to be a big problem.*"

As Salisu alluded, the idea of liberating oneself by "coming out" to family and acquaintances has been a cornerstone of gay movements in Western countries such as the United States since the late 1960s. Dissimilarly, attitudes and legal sanctions against homosexuality in Northern Nigeria are such that intentionally and publically revealing one's own homosexual activities is unimaginable. Aware of the serious social and legal sanctions, *masu harka* insist upon a sharp distinction between *masu ido* (literally, 'those with eyes/those who see', metaphorically, 'those who are aware of *harka*') and *makaho* (literally, 'the blind', metaphorically, 'straight'). Throughout Nigeria, homosexuality falls outside of what Rubin (1984) has called the "charmed circle" of socially sanctioned sexuality. For the Muslim *ummah*, this circle is

conceptually understood in terms of the *halal/haram* [acceptable/forbidden] binary; practically all Islamic exegeses concur that homosexual behavior is *haram*⁷⁸.

In addition to the sections of the Nigerian penal code that make homosexuality punishable by imprisonment for up to 14 years throughout the country, sodomy has been technically punishable by death in Nigeria's 12 predominantly Muslim northern states since the formalization of Islamic Shari`a laws beginning in 2000. "Technically", because the stringent burden of proof required for meting out a capital punishment would require four adult male witnesses to independently testify to having witnessed the sexual act. In addition to this heavy burden of proof, it seems that since the international outcry over the (eventually overturned) 2002 stoning conviction of northern Muslim woman Amina Lawal for adultery, Northern Nigerian governments have demonstrated little will in carrying out judicial killings, and Muslim leaders have rarely called for them. To my knowledge, no capital punishments have been meted out for homosexuality since Shari`a went into effect.

Nevertheless, rhetoric about rooting out sexual vices by the politicians and religious authorities that rose to prominence with the adoption of Shari`a has made the need for caution on the part of *masu harka* great. *Kunya*, the far-reaching Hausa cultural value of 'shame' and 'modesty', is expected in all sexual matters; even public

⁷⁸ A few progressive Muslim scholars, most forcefully Kugle (2003), have argued that "the Qur'an does not address homosexuality or homosexuals explicitly *and* the Prophet Muhammad did not act to punish people as homosexuals or for acts associated with them in his lifetime" (219). Kugle argues instead that historical evidence suggests the *hadith* addressing homosexuality "were fabricated long after the Prophet Muhammad had died and were retrospectively projected back onto him" (221).

displays of affection by married couples are socially unacceptable. Thus while the demands for sexual discretion is not new, the Shari`a era has been a time of renewed and intensified enforcement of sexual propriety. This policing has been institutionalized with the formation of *hisbah* moral vigilante groups. Moreover, strong norms against any public displays of sexuality result in the tacit self-policing of behaviors.

Regardless of one's respective social position, the possibility that the secret of one's homosexual behavior might be exposed is a source of generalized anxiety for many *masu harka*. The dissolution of relational ties with family, neighbors, friends, and colleagues is seen as the inevitable result of such an exposure. An unmarried man in his mid-twenties expressed in an interview⁷⁹ what he thought would happen if the word got out that he was having sex with men:

My family would feel depressed if they knew. They would stop treating me the way they do now. They might even disown me. They would say I would spoil the family's image, or spoil other people's children. People in the area would warn their children to stop talking to you or going on errands for you, and things like that. All this would happen because of what you are accused of. I really don't want to be exposed. It would honestly be devastating.

A married man in his early thirties told me that he initially aspired to stop doing *harka* upon getting married, and expressed exasperation at the persistence of his sexual desires for other men. But because such same-sex extramarital relationships would constitute a serious threat to his marriage, he was at great pains to keep his extramarital homosexual encounters hidden from his wife:

⁷⁹ This excerpt and the one that follows are taken from interviews I conducted with a research assistant under the auspices of Population Council.

If my wife knew, she would not like it at all. I would say it's not a good thing when it comes to Muslims. I'm not sure about Christians, whether it's okay or not in their religion. But if it's a Muslim, I would say it was a bad thing. And if a person's wife found out, she would probably leave and ask for a divorce. So a person should be very careful. If you have a family, he should never let them find out what he does, because that would be really bad.

Male sociality and the public secret of homosexuality

Despite the steep social and legal consequences that *masu harka* fear if their same-sex sexual behaviors were to be revealed to people outside the *harka* network, Muslim Hausa society is ironically reputed, both in scholarly literature and popular Nigerian sentiment, as a bastion of homosexuality. Popular southern and Christian sentiment in Nigeria has long maintained that among Nigerians it is northern Muslims—and particularly men of the Muslim ruling class—who show the strongest predilection for homosexuality.

The theme appears in Nigerian popular literature as early as Woye Soyinka's 1965 novel *The Interpreters*: When a southern Nigerian acquaintance insists upon the absence of homosexuality in Nigeria, the gay American character Joe Golder retorts, "Do you think I know nothing of your Emirs and their little boys?" (199). A more recent literary illustration can be found in Jude Dibia's 2005 novel *Walking With Shadows*. While the lead character Adrian, a southern Christian, is painfully struggling to reconcile his closeted homosexuality with his married heterosexual family life, it is northern Muslim businessman Yahaya who demonstrates a nonchalant ease with his preference for men, and tries to initiate a sexual relationship with Adrian when they meet. "I like men and I'm married. It's just the way things are. What about you?" Yahaya tells Adrian matter-of-factly.

I became acquainted with a wide social network of *masu harka* that included men of all ages and spanning socio-economic status. I knew young men who barely eked out a living selling bags of water to motorists on the hot and polluted streets of Kano, and others who sold sex to other men. I knew university students, army officers, men who sold cloth at the market, men who prepared tea and omelets at roadside stands, and men who repaired automobile engines. I was introduced to wealthy businessmen, traditional rulers, and former high-ranking government officials who lived in palatial houses staffed by a small army of domestic servants. Once, when I expressed surprise at just how extensive *harka* seemed to be, a middle-aged friend quipped, "If you know one guy who does *harka*, you know a thousand."

There are two reasons, in my analysis, that male homosexuality appears to some observers to be tolerated in Northern Nigeria. The first reason is that Islamic norms of gender segregation and women's curtailment from the public sphere have constrained opposite-sex socialization among unrelated adults, concurrently promoting homo-sociality. This social separation of unrelated men and women exerts considerable constraint on both men's and women's sexual opportunity structures with opposite-sex partners. Whereas women are often restricted to the domestic sphere, men are allowed substantial freedom to move around and pursue social relationships with other men. This, unintentionally, allows considerable leeway for discreet homosexual relationships. Extensive social-sexual networks of *masu harka* have persisted and—according to older *masu harka* who shared with their longer-term perspectives—are ironically flourishing under Shari`a. The

supposed tolerance of male homosexuality must be understood in relation to the intolerance of contact between unmarried men and women.

An event early in my fieldwork illustrates the seriousness with which gender segregation is typically enforced. Before moving into my apartment in Kano, my landlord stressed above all that I not have any women visitors. After just a few days in the apartment, I left for the weekend to attend a conference in another city, leaving a Christian college student I was acquainted with behind to help with some repairs. Knowing that he had a girlfriend, I informed him of my landlord's strict rule and asked him not to invite his girlfriend over. Upon my return to Kano, my landlord handed me the rent money I had paid a few days earlier and told me I would have to move out. When I asked why, he said that he had seen a young woman coming into my apartment, and explained that it would tarnish his family's reputation in the neighborhood if unknown women were seen entering and exiting the building. After an hour of pleading for a second chance my landlord finally relented, on the condition that I sign an oath that no more women would be over. I later found out that another unmarried male tenant had been forced to move out just a week prior because a woman was seen entering his apartment. Suffice it to say that visits by male friends were never questioned.

The second reason that homosexuality may seem relatively tolerated in Northern Nigeria is that homosexuality remains less prominent in public discourse than it has recently become in several other parts of Africa. For instance, numerous rights-demanding LGBT political organizations have formed in Southern Nigerian cities and in the federal capital since 1999. This, in turn, has propelled an

increasingly homophobic response on the part of the popular media, lawmakers, and religious figures who consider gays a threat to the moral order. By contrast, sexual minorities in the north have thus far made no public demands for rights. Homosexuality has remained what Taussig (1999) calls a "public secret": that which is generally known, but cannot easily be articulated. *Masu harka* understand that so-called tolerance of homosexuality is predicated on the fact that it remains unspoken and poses no threat to the institution of heterosexual marriage.

The limits of 'heterosexual African AIDS'

The assumption that AIDS in Africa is spread through heterosexual sex has driven approaches to addressing the pandemic on the continent. Epidemiologists, politicians, and religious leaders—African and foreign—have generally rejected the notion that male homosexual transmission plays any serious role in Africa's epidemics, often premising this on the assertion that homosexuality is un-African.⁸⁰ Until very recently, the Nigerian government's AIDS programs have been notable for their nearly complete lack of initiatives addressing MSM.

Bureaucratic justifications for neglecting MSM in AIDS programs have vacillated contradictorily between denying that sexual transmission among men even happens and vilifying MSM for intentionally spreading the virus. Pressed in a 2004 interview about homosexual transmission, then Chairman of Nigeria's National Action Committee on HIV/AIDS (NACA) Professor Babatunde Osotimehin

⁸⁰ Epprecht (2008) provides a historically informed refutation of this claim. See also contributors to Murray and Roscoe (1998).

responded, "The point I want to make very clearly is that the major cause of infection in Nigeria is by heterosexual transmission. I don't think we should detract from that because if we detract from that, we may have problems with the prevention of HIV/AIDS" (Abdullahi 2004). The following year, NACA's project manager asserted in an interview that, "Homosexuals are only interested in spreading HIV/AIDS. They are a serious threat to human existence anywhere in the world" (Akanji 2005).

The academic literature on AIDS in Nigeria has largely followed suit in its reticence on MSM. For instance, the extensive section on HIV/AIDS in Nigeria in *The International Encyclopedia of Sexuality* makes no mention whatever of homosexuality, instead claiming that "95 percent of all infections are by heterosexual intercourse, 4 percent are through blood transfusions, and one percent are through mother-to-child transmission" (Esiet 2001). In a hefty 2006 volume edited by Adeyi and colleagues that is otherwise the most comprehensive publication to date on AIDS in Nigeria, scant attention is paid to homosexual transmission. In the epidemiology chapter, Nasidi and Harrys state only that, "Homosexual intercourse does not appear to contribute significantly to the HIV epidemic in Nigeria" (21), without offering any further explanation or evidence to support this assertion.

In their chapter on reaching vulnerable and high-risk groups, Onwuliri and Jolayemi make the volume's only other remarks on homosexual transmission. In a section on prisoners, they mention "the not-uncommon practice of unprotected intercourse, both consensual and forced, between male inmates", noting that "policy

does not allow condom distribution to inmates" (316). MSM are then addressed in their own short section as follows:

Homosexuality is not prominent in Nigeria, possibly because male-to-male sex is highly stigmatized; in some cultures it is either a taboo or legally prohibited. Same-sex contacts are becoming increasingly practiced, however, and those who engage in them are becoming more open about it. HIV transmission results from high-risk factors such as unprotected sex, STIs, and non-condom use during anal sex with a non-regular partner. The use of alcohol and illicit drug use continues to be prevalent among some men who have sex with men (MSM) and is linked to risk for HIV and other STIs. The stigma associated with homosexuality makes reaching MSM difficult. It is therefore important that efforts be made to break all barriers so they can be offered AIDS education, preventative services, and HIV care. (316-317)

The convergence of three facts should cast doubt on the supposed irrelevance of male-male sexuality in Nigeria's AIDS epidemic. First is the bio-behavioral fact that unprotected receptive anal sex carries 18 times the HIV risk associated with unprotected vaginal sex (Baggaley et al 2010). Second is the historical fact that in much of the rest of the world, and since the beginning of the global pandemic, the virus has disproportionately affected MSM. Third, there is increasingly ample ethnographic and anecdotal evidence suggesting that male homosexuality exists across Nigeria. The insistence that male-male sexual transmission of HIV is of little concern on the continent that suffers two-thirds the world's total HIV/AIDS burden makes the most sense when we consider the stigma and criminal persecution that MSM face in many African countries, the lack of political will that most African governments have shown in putting limited resources towards a generally reviled group, and the complicity of foreign AIDS donors who have thus far done little research or intervention on African MSM.

Mounting evidence has shed doubt on the received wisdom that Africa's AIDS epidemics are exclusively (or nearly exclusively) heterosexual. A systematic review of data from 38 low- and middle-income countries, including several African countries, found that MSM were 19 times more likely on average to have HIV than the general population (Baral et al 2007). While virtually no HIV prevalence studies among African MSM were conducted before the mid-2000s, recent studies from sites spanning more than a dozen African countries have found prevalence among MSM to greatly exceed general population prevalence, frequently by factors of ten or more (Smith et al. 2009).

In Nigeria, the best (and practically the only) data on HIV prevalence among MSM come from the Federal Ministry of Health's Integrated Biological and Behavioural Surveillance Survey, conducted first in 2007 and repeated in 2010. Whereas national adult HIV prevalence in Nigeria is estimated at 4.1%, the 2010 survey found that prevalence among 1545 MSM in the six study cities was 17.2%, the second highest prevalence of any group after female sex workers. Furthermore, MSM were the only group of the seven studied to show increased prevalence from the 2007 study. Among all the HIV-positive people in the study, MSM were the population least likely to know that they were positive: only 36.9% did. Admittedly, much remains unknown about HIV among MSM in Nigeria. However, these high prevalence estimates, the institutional inaction that has thus far characterized the national response, and the fact that MSM in Nigeria are behaviorally bisexual over the life course are causes for concern.

The moral politics of avoidance

Having asserted that the price, as it were, for the toleration of homosexuality in contemporary Northern Nigeria is that it stays out of sight, unannounced, and that *masu harka* uphold the social expectations of heterosexual marriage and discretion, I turn now to what this has meant for the male-to-male sexual transmission of HIV and attempts to prevent it. My argument is that the enforcement of the norms of public silence surrounding homosexuality have thus far foreclosed upon the possibility of addressing male-male sexual transmission of HIV through institutional channels.

Dr. Ashiru Rajab is the Deputy Director of the Kano State Ministry of Health's AIDS Control Programme. A life-long resident of Kano's old city and a medical doctor tasked with overseeing his state's response to the AIDS epidemic, he has made efforts to address MSM in HIV/AIDS research and programs in the state, even as he is aware that the religious and political climate seriously constrain his ability to carry out programs based on what he believes is best epidemiological practice.

When he isn't traveling for conferences in Nigeria or internationally, Dr. Rajab's small but mercifully air conditioned office on the third floor of Kano's Ministry of Health is constantly busy with a stream of visitors and phone calls; CNN is always playing on the wall-mounted TV. An African bureaucratic "big man", the doctor nevertheless seemed more focused on the duties of his job than in cultivating others' deference. During our second recorded interview, we talked at length about the importance of MSM in Kano's epidemic. Here, Dr. Rajab explains the controversy that arose during the first Integrated Bio-Behavioural Surveillance Survey (IBBSS)

in 2007, the first time that anyone attempted to estimate HIV prevalence among MSM and other "high-risk groups":

We had to kind of downplay the information going into the community that this survey is happening or is going to happen. Uh, we usually keep quiet, remain low, conduct our survey, and then that is it--unlike other surveys that we are free to broadcast. And even if I can remember, after the dissemination meeting of the last IBBSS survey in 2007 there was quite a controversy in Kano. Unfortunately one of the media houses that attended the dissemination meeting went ahead and wrote something that was not really what happened, uh, that 'An NGO came into Kano and they claimed that they have seen homosexuals, they have tested them [for HIV], that Kano has so-so much number of homosexuals which is a lie, and the survey was not sanctioned, blah blah blah.' You know? So that information is of course on the national daily⁸¹. It got to the CDC, the GHAIN project, and the Federal Ministry of Health. What I learned later is that it went as high as to the presidency, and the governor of Kano was, uh, asked to clear the information, whether the state had actually rejected the results [of the survey]. Because if the state says that they have disowned the result it means they cannot go public; it's null and void. There was concern, serious concern. So immediately the information got to the [state] government house; the S.S. was informed. And as soon as the S.S. was informed they came to the [State] Ministry [of Health], and they were sent to see me. So it was a big battle. And, uh, they [Daily Trust] were quoting my name that I said I didn't know when the survey was conducted, blah blah blah. So my own thinking was that this was somebody made out of...he's so patriotic, maybe an indigene of Kano that doesn't want the name of the state to be spoiled, who on his own decided to change the news. [...] So I suppose the person that wrote that article wanted to...maybe to him he was doing a service to Kano, so to say.

The IBBSS included several other groups that might be seen as tarnishing the state's reputation, including female prostitutes and injection drug users. I asked Dr. Rajab clarify whether it was the issue of homosexuality that had provoked the denial:

It's basically the homosexual component of it. Because they were saying, 'How can you say you come to Kano and you find them [homosexuals]? Where did you find them?' Because they know you can go and find prostitutes all over the place. But where did you find them [homosexuals]?

⁸¹ Daily Trust, Nigeria's national newspaper with the greatest circulation.

Yeah, they don't believe, they don't want to believe. So I actually had to clear the story, that it wasn't true that we rejected [the survey results]. [...] [JT: *so the concern then was that someone from outside of Kano...*] Exactly. [...] *...was somehow tarnishing the reputation of the state by saying, 'There are homosexuals in Kano, they have this problem with HIV...'*] Exactly, exactly. So that's the way I read the situation. That's just to show you that this kind of high-risk survey, we are not free. Yeah, we are constrained because people are still not accepting the situation.

Dr. Rajab explained how he perceives mainstream attitudes on homosexuality hindering his work of addressing the epidemic among *masu harka*:

That is my challenge now: stigma generally against these certain populations, and still for now we don't have the means of tackling it. That is the most challenging aspect of it. How can you tell an imam to preach that an MSM is a normal person, just that he has deviated--just like somebody that goes and takes alcohol? It's deviation. It's really difficult. It's a crucial question, yeah. A real challenge, a real challenge.

The Nigerian Supreme Council for Islamic Affairs' AIDS Programme for the Muslim Umma has been similarly unable to address homosexual transmission of HIV among Muslim men. In an interview with the Programme Manager, he narrated what happened during the development of the Council's *National Islamic Policy on HIV/AIDS* in 2009, when a Western staff researcher with the United Nations Development Programme providing technical assistance for the new policy raised the question of male-male sexual transmission:

She [the UNDP staffer] brought about the issue; they [the Nigerian Muslim scholars writing the policy] shouted her down. They said it's not an issue. So who am I? So you see, big problem. And the researcher, she showed me her research that it's more prevalent in the north, men having sex with men. And we know it, but we are just like the ostrich⁸². So it's a big challenge. It's not something I can address at my level. A whole lot of big people have to come to say 'you can address it.' Because when she [the UNDP staffer] talked to me about it as the programme manager, I was like, 'Good, it's something I can do'. But when I spoke to my director, my director spoke and said, 'Don't talk

⁸² I.e., burying their heads in the sand and thus ignoring the problem.

about it'. So it's a big challenge--and you know it, having stayed in the north. But it's something I hope some day [chuckles], *some* day, yeah, because if you want to address it, not here. I would have to go somewhere else.

A program manager with the Global HIV/AIDS Initiative Nigeria (GHAIN), one of the main national agencies working on HIV/AIDS in Kano State, had a similar response when I asked about prevention initiatives for MSM: "No known homosexual has ever come to identify himself in this office." When I asked why he thought this was, he responded, "Kano is a state practicing Shari`a. If anyone admitted to any of those things, he would be a pariah. It hasn't been addressed. These are social taboos in the north. It would be difficult for anyone to come out and identify himself as a prostitute or a gay person."

Risk awareness and the unspeakable

In countries where it has long been recognized that MSM bear a disproportionate burden of HIV/AIDS and safer sex campaigns have existed for such men, most know at least basic facts about transmission and risk reduction. Many *masu harka*, however, are unaware that as a group they carry a much heavier burden of HIV, or even that anal sex poses any risk of infection. When I steered interviews and informal conversations with *masu harka* towards HIV/AIDS, most told me that they believed female sexual partners posed a much greater risk of infection, while sex with men was a lesser concern. Others expressed the belief that sex with other men posed *no* risk of HIV infection. This misperception is understandable to the extent extremely few messages about male-to-male sexual

transmission of HIV are in circulation in northern Nigeria. A married 27-year old father of two who did *harka* told me:

People who only sleep with women are more at risk of getting infected than those who sleep with men. This is my point of view. That is the way I see it. People who sleep with women only are more infected; they come in contact with diseases like gonorrhoea more often, because it's easier to catch them from women. [...] For instance, if two men have sex and the one on top is negative, if he screws the positive person he won't get infected, as long as there is no blood in there. He is safe as long as he does not come in contact with any blood.

Harka is not conceptually identical with anal sex (the colloquial Hausa term for which is *yin baya*, to 'do behind'.) Many other forms of sex between men carry drastically less risk, or no risk, of HIV infection and fall under the rubric of *harka*, including mutual masturbation, oral sex, and interfemoral (thigh) sex⁸³. For some men, whether one is the insertive or receptive partner for anal sex, as well as the level of familiarity one has with one's partner, is a deciding factor for whether or not a condom will be used, as this man in his early twenties expressed:

My friend that introduced me to *harka*, when we are having sex together we don't use condoms. But when it is other people, we use condoms when we are going bottom. But if we are just to play top, we don't use condoms.

Another married man in his 30s explained that he did not often use condoms when having sex with men because he was worried about how doing so might reflect on his reputation:

Sometimes I feel too embarrassed to buy condoms or lubricants, because I am not the type of person who should be buying condoms--that's what they [the people selling the condoms] will think. I look too respectable, and I'm a

⁸³ In *harka* dialect, the anus is commonly called *birni* (literally, 'city'), whereas interfemoral sex is called *kauye* (literally, 'the area outside the city'). *Kauye* is a common sexual practice among *masu harka*, and from an HIV transmission perspective is safe sex.

married man, so I shouldn't need condoms in the first place. The majority of people who use condoms commit adultery or have sex before marriage.

One young man whom I knew occasionally had sex with other men for money reflected on his perceptions of the norms surrounding safer sex among *masu harka*:

In Kano they don't wear condoms at all—except for big people who ask pimps to bring them boys from different cities like Abuja. When they have sex with them [i.e. boys from cities like Abuja] they wear condoms because they don't trust them. But usually they don't wear condoms. They only wear them when they're having sex with women. [JT: Why don't they use condoms?] Some people think it hurts when they use condoms, and some people don't enjoy using condoms. [...] Some say you have to use one because they're scared of getting infected, but most have anal sex and have it just like that [unprotected].

In semi-formal interviews and informal conversations, *masu harka* expressed ambivalence about condoms. Because they are so connected in the popular imaginary with *zina* [adultery, and any sex between non-married partners], condoms are likely to be avoided to deflect perception of immorality. Moreover condom-compatible lubricants are not easily found in Northern Nigeria, making condoms much more difficult to use properly for anal sex. Lastly, condoms were seen to be disruptive of sexual pleasure, and indicative of a lack of trust in one's sexual partners.

Conclusion: The morality of intervention

In this chapter I have explored the tensions in Northern Nigeria between adherence to Islamic doctrine concerning virtuous sexuality on the one hand, and adherence to secular (but perhaps no less moralistic) public health doctrine on the other. A few global health NGOs and southern Nigerian LGBT organizations,

operating under the paradigm of ‘health as a universal human right’, have begun deliberating about how to reach MSM in Northern Nigeria with sexual health information, preventative technologies like condoms, and social support—without attracting the ire of Muslim political and religious leaders. Moreover, major international AIDS funders including the President and Secretary of State of the United States, the Prime Minister of the United Kingdom, and the Human Rights Commission of the United Nations, have begun making forceful statements on behalf of gay, lesbian, bisexual, and transgender individuals globally.

Thus far, however, very little progress has been made. This dearth of MSM-specific public health initiatives in Northern Nigeria should be understood as a consequence of the powerfully enforced norms of sexual propriety at play in a society where the demands of modesty supersede claims of human rights for individuals engaged in sexual behaviours considered religiously abhorrent. Homosexuality is considered sinful in Northern Nigeria, as it is in most African and Islamic societies. This deeply held moral position, which aligns with the dominant of hetero-patriarchal family structure, has thus far foreclosed upon addressing the epidemic among *masu harka*. Moreover, national statutes, state Shari`a laws, and harassment by police and Islamic vigilante groups have repressed the plausibility of such men safely coming forward to claim protection or insist upon culturally and behaviorally relevant prevention programs. In the concluding chapter, I propose culturally appropriate interventions that can lower the burden of the AIDS epidemic in Northern Nigeria, including among *masu harka*.

Chapter 6:

Ethics of Intervention

“If the emir of Kano is not safe then who is?”

Nigeria has been plagued by turmoil since its independence from British rule in 1960. Longstanding religious, linguistic, and social differences among the nearly 300 ethnic groups brought together by the colonial regime have little resolved in subsequent decades. Taking the reigns from a resource extracting colonial state and over the country's vast oil riches, the politicians who have run the country in the ensuing years have engaged in corruption of monumental scale. This has drastically deepened economic inequality, exacerbating extant divisions. Today, perhaps more than at any time since the gruesome 1967-70 civil war when the southeastern region attempted to secede as the Republic of Biafra, the country seems on the precipice of disunion.

Northern Nigeria in particular has experienced increasingly violent upheaval in recent years. On 18 April 2011, Acting President Goodluck Jonathan, who had assumed the presidency in February 2010 upon the death of President Umaru Musa Yar'adua (a northerner with broad Northern support) was elected to office over the North's favorite candidate, General Muhammadu Buhari. Upon the announcement of Jonathan's victory, Kano and other northern cities erupted in protest. Much of the ensuing animosity became directed against southerners. A Christian friend in Kano whose son's baptism I'd attended a few months earlier called to say that he'd been

forced from his home by a mob of young men; my research assistant Malam Usman told me he was harboring a Christian neighbor at his home as rioting raged.

On 1 January 2012, President Jonathan announced that the federal government would cut the nationwide fuel subsidy on government-controlled petrol across the country—one of the few benefits average Nigerians enjoy from their country's oil wealth. This provoked a week of massive, animated, and sometimes-violent protests across the country. Dusk to dawn military curfews were imposed in several northern cities. Bowing to pressure, the Jonathan administration partially reversed the fuel subsidy cut (Labous 2012). However, the already entrenched antipathy on the part of many northerners against the federal government—and, increasingly, against southern Nigerians—deepened in the wake of the protests.

On 20 January 2012, a series of coordinated suicide bomb attacks claimed by militant Islamist group Boko Haram killed at least 180 people in metropolitan Kano. The main targets of the attacks were police stations. Two days later, President Jonathan traveled to Kano. Wearing traditional Hausa dress, he issued a statement from the palace of the Emir of Kano that, “the federal government will not rest until the perpetrators are brought to book. We will not rest until these terrorists are wiped out” (Oboh 2012). A few months later, on 29 April 2012, at least 16 people were killed and others seriously wounded following bombing and gun attacks on Christian worshipers at Bayero University Kano (Lobel 2012).

On 19 January 2013, an attack occurred that shocked even the violence-weary residents of Kano. Approximately eight unmasked young men opened fire on the convoy of El-Haji Ado Bayero, the Emir of Kano, who has been on the throne for

since 1963. The emir survived the attack, but three of his bodyguards were killed shielding him from the gunfire. For many, the attack was unthinkable; the emir is widely revered, and is considered the second most important Muslim leader in the country after the Sultan of Sokoto. As one Kano resident was reported as saying, "If the emir of Kano is not safe then who is?" Others seemed to condone the violence on grounds of the emir's association with the government elite. "The masses have found out that the emirs and chiefs are now stooges of the political class and this must stop", proclaimed Usman Faruk, the first military governor of the former North-Western State (Ross 2013).

The violence has continued unabated this year. On 8 February, nine female polio eradication workers were gunned down outside two local health offices in Kano as they prepared to distribute door-to-door oral polio vaccinations (Smith 2013).⁸⁴ On 10 March, Ansaru, alleged to be a splinter group of Boko Haram, killed seven foreign construction workers from European and Middle Eastern countries whom they had kidnapped in February (Nossiter 2013). On 19 March, 22 people were killed and at least 65 were injured when a suicide car bomb inside Kano's predominantly Christian Sabon Gari neighborhood exploded inside a station where busses bound for southern Nigerian cities load and depart (Falade et al. 2013).

This summary highlights only a portion of the violent attacks that have plagued Northern Nigeria in the past few years—and which the overwhelming majority of Nigerians throughout the country reject. Governments and newspapers

⁸⁴ That polio workers were targeted is not surprising, given some Northern Nigerians' rejection of the Polio Eradication Initiative as a Western plot to harm Muslims (see Renne 2009).

around the world have attributed these attacks and many others like them to Boko Haram, the jihadist militant organization founded in 2001 by the young Mohammed Yusuf to further Shari`a, oppose Westernization, and reject the authority of the secular government. (Yusuf was killed in the custody of Nigerian security forces in 2009, allegedly while trying to escape detention).

Despite the centrality of Boko Haram in most analyses of the recent violent attacks, political historian Jean Herskovits maintains that, “there is no proof that a well-organized, ideologically coherent terrorist group called Boko Haram even exists today. Evidence suggests instead that, while the original core of the group remains active, criminal gangs have adopted the name Boko Haram to claim responsibility for attacks when it suits them.” (2012) From this perspective, Boko Haram has become a lightning rod for different groups responding to *and* fueling instability in Nigeria—and a scapegoat for a government unwilling to address the conditions underlying this instability.

Herskovits further asserts that, “the root cause of violence and anger in both the north and south of Nigeria is endemic poverty and hopelessness.” Economic deprivation is surely relevant to the rise and violent turn of Boko Haram. However, the movement must also be understood “in the broader context of Islamic movements that espouses unorthodox beliefs and unconventional religious practices that are often linked to ethnic and religious violence in Nigeria” (Anonymous 2012: 120). The evolving Boko Haram phenomenon defies simplistic explanations and requires “a holistic conception of the divergent religious and intellectual orientations as well as the political, economic, and historical factors”

that explain the group's emergence and increasingly violent trajectory (Anonymous 2012: 119).

Conflict and AIDS

What effects with the growing unrest in Northern Nigeria have on the AIDS epidemic? Any answer to this question will necessarily be speculative. But given that violence in the region appears to be escalating in frequency, severity, and geographic scope—and that the conflicts underlying the violence show no sign of resolution—such speculation is warranted.

The impact of conflict on HIV incidence is largely unknown, although notably, sub-Saharan African countries have the highest incidence of both HIV/AIDS and internal conflicts in the world. The United Nations' 2001 *Declaration of Commitment on HIV/AIDS* states that, "populations destabilized by armed conflict...are at increased risk of exposure to HIV infections", and calls on "all United Nations agencies, regional and international organizations, as well as non-governmental organizations involved with the provision and delivery of international assistance to countries and regions affected by conflicts" (United Nations General Assembly 2001: 36-7). Some scholars has asserted that populations affected by conflict do not necessarily have increased HIV prevalence compared to other populations (Mills et al. 2006); others have contended that it is "highly probable" that conflicts increase HIV and STI incidence (Hankins et al. 2002: 2250).

On the one hand, HIV risk in conflict areas may decrease as a result of decreased casual sex, disruption of sexual networks, increased isolation, and deaths

among high-risk groups. On the other hand, HIV risk may increase as a result of increased military-civilian interaction, increased transactional sex, decreased availability of health services, increased malnutrition, increased sexual predation and violence, and the fragmentation of families (Milles et al. 2006: 714). Given available data, it may not be possible to conclude that civil unrest *necessarily* results in increased HIV incidence; not all conflicts are alike, and no two societies are the same. What seems less ambiguous is that that population displacement, insecurity, dilapidated infrastructure, and the incapacitation of existing services and prevention programs pose serious challenges to efforts to prevent and treat HIV/AIDS (Mills et al. 2006; Hankins et al. 2002; Ellman et al. 2005).

Conflict can pose a challenge to preventing and treating HIV/AIDS in unexpected ways. Because men on motorcycles carried out the attack against the Emir of Kano (and several other recent attacks), the governor of Kano State summarily banned motorcycle taxis (*achaba*). This move disenfranchised the nearly half million economically marginal young men, many of whom are young migrants, who make a living driving *achaba* (Salihi 2013).⁸⁵ Moreover, the ban shut down the main mode of motorized transportation for the majority of people in the city, particularly men.⁸⁶ As a result, Kano's already stressed and chaotic transportation

⁸⁵ This claim of half a million *achaba* drivers in metropolitan Kano seems an overestimate, but they may easily number in the hundreds of thousands.

⁸⁶ Women are never drivers of motorcycle taxis, and virtually never drive private motorcycles. They were banned by the Kano State House of Assembly from using them as passengers in 2004 on grounds that they brought about un-Islamic gender contact. Subsequent protests by *achaba* drivers loosened the outright ban. However, Women generally move around the city in mini-bus taxis or car taxis, three-wheeled motorized carts known locally as *A Daidiata Sahu* (named after the Shari`a

system has become even less efficient and more expensive. This will almost certainly affect the ability of patients to attend clinical appointments and collect their medications, since there are only a few clinics supplying ART in the vast city. It may also reduce people's likelihood to get tested for HIV.

As described in Chapter 3, AIDS treatment and prevention throughout Nigeria are largely beholden to foreign—particularly American—funding and administration. The recent kidnapping and killing of foreign workers has worsened perceptions of safety for foreigners in the region. If violent conflict in the north continues to escalate, the United States PEPFAR program and the Global Fund may become unwilling, or unable, to maintain the supply chain of antiretroviral drugs into the region. If this happens, the considerable progress made on ART treatment access over the last decade would be compromised.

Speculation about the effects of continued violent conflict notwithstanding, the effects of growing Muslim-Christian tension could already be seen among the HIV-positive people I worked among in Kano. Between 2007 when I first joined Taimaka Support Group and 2010 when I completed my fieldwork, the group shifted from an intentionally inter-religious group of Muslims and Christians to a group that was almost exclusively Muslim. This shift presaged the anti-Christian violence that erupted in 2011 surrounding the presidential election and which has resurged more strongly in violent attacks on churches, Christian owned businesses, and in Christian neighborhoods. The fact of this Islamic-Christian bifurcation in HIV support groups

commission that instituted them for women's travel), or in private cars (Adamu 2008).

demonstrates that biosocial solidarities based on HIV status can become eclipsed by religious affiliation in times of ethno-religious tension.

Anthropology and intervention

At a conference organized by the Religion and AIDS in Africa Research Network that I attended in Lusaka, Zambia in 2009, anthropologist Eileen Moyer (who has studied the disease in Tanzania and China) said while serving as the discussant on a panel that, “AIDS is good to think with”. Her phrase stuck with me. The pandemic connects many aspects of human life, and anthropological research has made important contributions to analyses of these complex interconnections. While global in scale, the pandemic is comprised of a network of local epidemics, with their own epidemiological and social peculiarities. It is in the specificity of local epidemics that AIDS lays bare the influence of culture and social organization on the trajectory of the pandemic. Anthropological research usefully complicates assumptions about universality, demonstrating the importance of socio-cultural difference in interactions between different human populations and the virus.

With its emphasis on long-term field research into cultural meaning and action, ethnography can make important contributions to the analysis of social problems; the AIDS pandemic is surely a social problem. AIDS certainly *is* good to think with. Like most everyone affected by the epidemic in some way, I am also disposed to seeing AIDS as something good to act on. It would be difficult to study something as deleterious to human well being as AIDS and not feel spurred to put one’s research towards reducing the disease’s harms.

Anthropology has a long history of applied and intervention-oriented research. Still, anthropologists have sometimes been uneasy with the notion of intervention. (In this, anthropology is different from my other field of graduate study, public health, for which intervention is axiomatic.) In part, this unease has to do with anthropologists' deep commitments to cultural relativism. If human's beliefs and activities should be understood in their own cultural terms rather than from some external standard, then efforts to bring about change could constitute the imposition of external value in certain contexts.

Relatedly, anthropologists have been troubled by the discipline's historic role as what Kathleen Gough called "a child of Western imperialism" (1968: 12). As Gough explained, "applied anthropology came into being as a kind of social work and community development effort for non-white peoples, whose future was seen in terms of gradual education, and the amelioration of conditions many of which had actually been imposed by their Western conquerors in the first place." (1968: 13) Moreover, efforts to bring about the "development" of non-white peoples have seemed problematically predicated on discredited, ethnocentric assumptions that all societies progressed in a unilinear manner through the same stages between "primitive" and "civilized", with Western civilization at the apex (e.g. Tylor 1871; Morgan 1877)

Applied research has also been viewed as less intellectually rigorous than theoretically oriented scholarship. Applied anthropologists have generally worked outside of academic institutions: for governments, development and social service agencies, advocacy groups, and businesses. Academically situated anthropologists

could be seen as doing the more intellectually challenging, first-order theoretical work; from this perspective, applied anthropologists do the second-order work of applying these theories to social problems. This higher valuation of theoretical over applied research mirrors the discrepant valuation of theory over application in other disciplines: physics, or psychology, for instance.

I hope that the findings of this dissertation will contribute to several areas of longstanding theoretical concern to sociocultural and medical anthropologists. I have explained how patients negotiate different healing systems in an era of expanded therapeutic options. I have advanced the critical medical anthropology of infectious disease and global health by demonstrating the interaction of micro- and macro-level forces on the AIDS epidemic, providing insight into how policies and treatments originating in the West are received in a very different cultural context. And I have contributed to scholarship on gender and sexuality with an account of how Muslim men and women are affected by the AIDS epidemic. I have also woven epidemiological data throughout the dissertation, and hope that my ethnographic conclusions will find application in public health efforts to reduce the destructive effects of AIDS.

Anthropological research has been, and still is, put to the service of bringing about changes that those affected by these changes do not agree with.⁸⁷ More

⁸⁷ For instance, anthropologists and other social scientists have worked with U.S. Army and Marine units in combat zones in Iraq and Afghanistan to conduct semi-structured and open-ended interviews, polling and surveys, text analysis, and participant-observation with local populations to gain strategic footholds in military operations. This project, the Human Terrain System, has been disapproved of by the

ethically ambiguously, intervention-driven research may be considered beneficial by some groups in a society but harmful by others groups.⁸⁸ In Chapter 5, for instance, I argued that interventions to address male-male sexual transmission of HIV challenge strongly held preferences in Northern Nigeria to avoid public discussion of behaviors considered religiously forbidden. If we take cultural relativism seriously, such tensions find no easy resolution.

In most respects, however, reducing the burden of AIDS is a moral priority for Northern Nigerians, as it is for people around the world. Anthropologists can and should conduct research with the intention of improving human wellbeing. Moreover, change-oriented research can be compatible with the principle of cultural relativism to the extent that local beliefs, intentions, and commitments remain at the forefront of the research agenda. I concur with Stuart Kirsch's position that "anthropologists can amplify indigenous forms of political expression, bringing the resources of the discipline and the moral weight of the academy to bear on injustice" (Kirsch 2006: 187). In arguing for the significance of anthropology in confronting disease and suffering, I echo Paul Farmer's affirmation that "inequalities of access and outcome [that] characterize our world [...] could be the focus of our collective action as engaged members of the healing and teaching professions, broadly

American Anthropological Association as a violation of the AAA Code of Ethics (American Anthropological Association Executive Board 2007).

⁸⁸ Efforts to eliminate female circumcision in Sudan and other parts of Africa are one example of how interventions are perceived quite contrarily by different groups, both within and outside a society (Gruenbaum 2001).

conceived. We have before us an awesome responsibility—to prevent social inequalities from being embodied as adverse health outcomes” (1999: 282).

To this end, I conclude the dissertation by outlining several culturally appropriate interventions that would lessen the burden of the AIDS epidemic in Northern Nigeria.

Treatment

HIV treatment is HIV prevention. Because ART is so effective at disrupting viral replication, HIV-positive people on ART have drastically lower viral loads than those who are not on treatment. A recent randomized clinical trial involving 1763 serodiscordant couples from nine countries has demonstrated that ART reduces the sexual transmission of HIV in HIV-serodiscordant couples by more than 96% (Cohen et al. 2011). The significance of this finding can hardly be overstated.

Increasing the number of HIV-positive people on treatment must be the top priority in the effort to control the spread of the epidemic and improve the lives of those living with HIV/AIDS. Recall however that in Nigeria only 26% of those who ought to be on ART according to WHO clinical guidelines actually are. Furthermore, the U.S. government has signaled that funding for PEPFAR has likely flat-lined, and that the Nigerian government will be expected to take much greater financial responsibility for HIV/AIDS treatment. Given the relative expense of ART and furthermore the Nigerian government’s poor track record of funding and administering healthcare, this is very worrisome.

The last ten years have been characterized by massive scale-up of ART in poor- and middle-income countries, Nigeria inclusive, and most of this scale-up has been the result of PEPFAR and the Global Fund. It is not clear whether this trend towards greater availability will continue however, or whether even current levels of treatment will be maintained. The Obama administration has already indicated the intention to shift global health aid to health concerns considered more cost effective to treat, such as those arising from water-borne contaminants, child and maternal health initiatives, and nutrition programs (Denny and Emanuel 2008).

From a utilitarian perspective of saving the most lives with finite resources, this shift makes sense. However, the AIDS burden is heaviest among young adults who are the socio-economic backbone of society and care for children and the elderly. The failure to adequately provide ART-based care for those infected—and for those who stand to become infected when HIV-positive people remain highly infectious due to lack of treatment—has broader implications on societies that must also be taken into account in health policy decisions.

The cost of ART has lowered dramatically as generic versions of the drugs have become widely available in poor and middle-income countries exempted from the strictures of drug company patents, and they continue to become less expensive. HIV prevention initiatives that emphasize abstinence, marital fidelity, and condoms have in some contexts been effective at reducing transmission—Uganda being the most frequently cited case. However, the effectiveness of the ‘ABC’ strategy is context dependent. In Northern Nigeria, condoms carry the heavy stigma of immorality, and marital fidelity is only partly protective given high rates of divorce

and polygyny. Increasing access to ART, while relatively costly, is the best strategy for both containing the epidemic and improving the lives of those living with the disease.

Universal pre-marital HIV testing

The AIDS epidemic has prompted debate among Muslim leaders over the necessity and permissibility of pre-marital HIV testing. These debates have weighed scriptural precedent, the moral demands of protecting against harm, prerogatives to marry, and suspicions of state intrusion into what is considered a religious and family matter. This debate evinces one way in which Northern Nigerian Muslims have grappled over the proper Islamic response to the epidemic. It further demonstrates how kinship in the era of AIDS is made and unmade at the intersection of affinal desire, religious doctrine and obligation, health status, and medical technology.

Malamai and other Muslim leaders in favor of mandatory pre-marital HIV testing argue that it is scripturally justified as a component of the courtship period religiously expected of a couple prior to marriage. The pragmatic need to protect the Muslim community in a time of epidemic is also forwarded as justification for mandating pre-marital testing. Without explicitly stating that it should be mandatory, The Nigerian Supreme Council for Islamic Affairs' *National Islamic Policy on HIV/AIDS* advocates for pre-marital counseling and testing as a prevention strategy for both first marriages and remarriages (2009: 13).

Conversely, many *malamai* insist that there is no religious precedent for mandating pre-marital HIV testing and that requiring it would constitute an unnecessary barrier to marriage—a key religious obligation. Moreover, because most Muslim marriages in Northern Nigeria take place without state formalization (i.e., a government-issued marriage license), requiring premarital testing would be seen by some as an intrusion of the (corrupt and illegitimate) Nigerian state into Muslim family life. In recent research that surveyed 128 Muslim clerics in Sokoto State, none responded that they would demand premarital HIV testing as a prerequisite to marriage (Umar and Oche 2012). Premarital HIV testing remains uncommon among northern Muslims.

Conversely, all 30 Christian leaders surveyed in Sokoto State by Umar and Oche said that they *would* insist upon premarital HIV testing before performing a marriage. Most Christian churches in Nigeria today will not marry a couple unless they have been tested for HIV and are found to be sero-concordant (Durojaye and Balogun 2010). There is, therefore, a divergence in Christian and Muslim attitudes and practices regarding premarital HIV testing in Nigeria. While universal premarital HIV testing has been pushed globally as a prevention strategy, there is currently no national policy in Nigeria mandating it. Whereas premarital testing has become normalized among Christians due to the mandates of most churches, there has been no equivalent shift to mandatory premarital testing among Muslims.

As discussed in Chapter 4, rates of divorce and remarriage are high among Northern Nigerian Muslims. Women's reputation and economic survival are closely tied to their marital status; as such, divorced and widowed women are often keen to

remarry quickly. Furthermore, marriage and divorce are essentially family affairs: rarely do Muslims engage the Nigerian state for marriage or divorce proceedings.

Since postmortem autopsy is religiously unacceptable, a widowed person whose spouse has died may be unaware if AIDS was the cause of death. The widowed person would thus not necessarily know that she or he had been exposed to HIV. This may be especially true in the case of a woman whose co-wife in a polygynous marriage is ill with or dies from AIDS. When co-wives are not co-resident in the same household, or especially in the same town or city, knowledge about the illness of a co-wife may be particularly limited.

Moreover, there is a gendered differential in HIV testing. This arises for two major reasons. First, many women discover that they are HIV positive because they are routinely tested for the virus during antenatal care. Men have no equivalent context in which they are routinely tested for HIV.

Second, men may perceive particular disincentives to testing related to cultural expectations of masculinity. Anthony Simpson (2009) found that among Zambian men, reluctance to get tested is related to stigma (especially from their wives), the risk of being seen as perpetrators, the fear of being discredited, and perceptions of reduced virility. Robert Wyrod found five reasons that Ugandan men were reluctant to test for HIV: 1) men were too busy to attend HIV/AIDS seminars, 2) they saw health clinics as women's spaces⁸⁹, 3) they were afraid of discrimination from a current or potential employer, 4) they feared their sexual partners would

⁸⁹ In the *National Islamic Policy on HIV/AIDS*, The Nigerian Supreme Council for Islamic Affairs calls for the establishment of men's only HIV/AIDS clinics, presumably because clinics are seen as women's spaces.

leave them, and 5) men were conditioned to be independent and feared having to deal with the consequences of being HIV-positive alone (2011: 448).

Among the 174 men I surveyed, only 41 (23.5%) had ever been tested negative for HIV prior to testing positive. Moreover, my HIV-positive interview respondents overwhelmingly reported that they went to be tested because they had already fallen ill. Earlier and more frequent testing would have several benefits. For those who test positive, early knowledge of their status would in many cases mean an opportunity to begin treatment sooner and thus avoid life-threatening immune-compromise. For the sexual partners of those who test positive, knowledge of a partner's status could reduce transmission risk through sexual behavior change, to the decision to test oneself, and to begin treatment if necessary.

Durojaye and Balogun (2010) assert that a national policy mandating premarital HIV testing in Nigeria would be ill advised, basing this position on concerns about the violation of human rights and personal freedom that such a mandate would entail. While I share this concern, there is a much more important reason to oppose government-mandated premarital testing in the context of Northern Nigeria. Namely, Muslims there would likely oppose such a policy as an intrusion of the state into what is understood as an Islamic family affair.

In light of high rates of marriage and divorce, the prohibition on postmortem autopsy, and men's current low rates of testing, premarital HIV testing should be strongly encouraged by Muslim organizations and leaders in Nigeria. For premarital testing to become a norm, Nigerian Islamic organizations and prominent imams and emirs will have to make public declarations that pre-marital testing is a religious

obligation in the context of the AIDS epidemic, basing this on scriptural exegesis, thus normalizing (and moralizing) the practice. Umar and Oche's (2012) research in Sokoto found that 34 Muslim clerics surveyed responded that they could only insist on mandatory premarital HIV testing if they got an instruction from "the highest Islamic body" in the country. This suggests that many *malamai* are unaware that the Nigerian Supreme Council for Islamic Affairs already endorses the practice.

Insofar as Islamic scholars have widely concurred that HIV serodiscordance in itself is grounds for divorce, it plausibly follows that premarital testing—which would reduce the number of marriages ending in divorce, not to mention widowhood—should be encouraged. The expansion of premarital testing could allow for more effective marital HIV sero-sorting. As HIV positive people live longer and healthier lives in the wake of expanded ART, the stigma of living with the disease will continue to lessen. The greater the number of people who know their status, begin treatment, and engage with other positive people, the greater the likelihood that these individuals will marry and otherwise sexually partner with other people they know are positive.

Current HIV prevention initiatives in Africa typically emphasize abstinence and condom use. As such, they are frequently irrelevant to married couples and those wishing to remarry. To help reduce HIV transmission within couples, de Walque and Kline (2012) recommend that alternative approaches to prevention emphasize testing for remarrying couples. HIV testing is inexpensive, while the social and economic tolls of the AIDS epidemic are high. While I do not speak from a position of doctrinal authority, from my perspective the spirit and intended

outcomes of pre-marital testing are consistent with Muslim ethics of care and the promotion of stable marital unions.

Lastly, I advocate for an increase in the number of HIV testing locations in Northern Nigeria. Currently there are too few testing facilities, people interested in testing often have to travel long distances to reach a testing site, and wait times to test are frequently many hours long. Religious organizations might also partner with AIDS NGOs and government programs to offer testing outside of clinics, such as at mosques, markets, or sporting events where they will be more likely to reach men.

Marriage promotion

In many societies where HIV prevalence is high, marriage can pose a major risk for HIV infection, particularly for women (Hirsch et al. 2009). Conversely, marriage itself is a resource with which individuals can manage their exposure to HIV (Reniers 2008). For those who *are* HIV-positive, and particularly for women, seeking marriage can be a critical strategy for ameliorating the negative physiological, economic, and social consequences of infection (Rhine 2009).

Current efforts to aid HIV-positive people in Northern Nigeria focus on treatment. And rightfully so: without ART-based medical care, HIV/AIDS remains highly fatal. Expanding the availability of ART (which currently covers only 26% of HIV-positive Nigerians who need it), laboratory testing, and treatment for opportunistic infections must remain a priority.

Committees for home-based care affiliated with HIV treatment clinics also play an important role in providing HIV-positive people and their families with

psychosocial support; health-related technologies such as mosquito nets to prevent malaria and water filters and to prevent parasitic infections; and basic foodstuffs. With funding from NGOs, HIV support groups occasionally support members (particularly women and their children) with training and resources for small income generation activities, such as sewing and soap making. These efforts contribute to the well being of people living with HIV/AIDS and should be expanded.

As elaborated in Chapter 4, HIV disproportionately affects women compared to men in Northern Nigeria, as is the case across much of sub-Saharan Africa. The disproportionate burden experienced by women is a matter of higher HIV prevalence, and moreover of women's increased social and economic vulnerabilities resulting from infection. In a virtually totally married society where women are largely reliant on their husbands to meet their material needs and those of their children, divorced and widowed women living with HIV are keen to remarry quickly. However, insofar as they seek to marry a man who is also HIV-positive, women living with HIV are at a disadvantage in finding a husband from among the relatively smaller pool of HIV-positive men.

My research among HIV-positive men found that many aspire to marry HIV-positive women, but that the financial burden of providing for a wife and her (current and future) children is often a hindrance—particularly for men who are already married. In this context, international donors, state governments, AIDS NGOs, and religious organizations can contribute to the well being of HIV-positive people by actively supporting marriage. This can be accomplished in several ways.

First, local and state governments, AIDS NGOs, Muslim organizations, and HIV support groups should collaborate to establish voluntary registries of HIV-positive people seeking marriage partners. Currently, marriages among HIV-positive people are facilitated through HIV support groups, and surreptitiously at HIV clinics. These venues have indeed facilitated the intermarriage of many HIV-positive people. However, support groups policies that prevent members from changing groups have meant that members seeking marriage encounter a relatively small number of potential spouses. Moreover, patients attend their clinical appointments only a few times a year, which limits their interaction with other HIV-positive people. The establishment of voluntary registries of HIV-positive people seeking marriage will increase the likelihood that those living with the disease will be able to reconstitute affinal families, particularly for women.

Second, international funders, religious groups, and state and local governments, and organizations for HIV-positive people should provide financial support to encourage marriage. This support could come in several forms. Organizations could make the equivalent of bridewealth payments to marrying women in order to remove one financial obstacle to HIV-positive men seeking marriage. While it is important that women living with HIV be trained and financially supported in income-generating activities, it is also important that men are reached with these opportunities. In Muslim Hausa society, men are responsible for providing resources to their wives and children. Providing HIV-positive men with opportunities to increase their income will therefore benefit not only these men but will improve the lives of their wives and children.

Promisingly, northern states have already taken an interest in promoting marriage. In an effort to curb the perceived negative social consequences of unmarried women, the Kano State Hizba Board organized a mass marriage ceremony on 15 July 2012 for 250 divorcees, widows and young unmarried girls. The state government paid bridewealth to each woman including bedding, clothes, food, and 20,000 Naira (US\$130). HIV testing was conducted for all couples—most of whom were unacquainted before the wedding (Adow 2012).

Ahead of the third round of mass weddings organized by the Kano State Hisbah Board in April 2013, eight people who had applied to be married tested positive for HIV and were told that they were ineligible for the program until a partner who is also HIV-positive could be found (Garba 2013). While it is laudable that the Board conducted HIV testing, the effective exclusion of HIV-positive people from the initiative might inadvertently give the impression that needs of positive people are less of a priority, thus further stigmatizing them. The Hisbah Board could partner with HIV support groups and other Muslim organizations to periodically organize weddings specifically for Muslims living with HIV.

HIV prevention messaging

Public HIV/AIDS messages proliferate in urban Nigeria, blending into the visual and aural cacophony of daily life. Riding in a shared taxi, one might hear a radio spot in Nigerian Pidgin with a man encouraging his brother to get tested: "My

broda, AIDS no dey show for face, o! Abeg, make we go for test."⁹⁰ In Kano and other northern cities, street signs with the ubiquitous AIDS ribbon proclaiming that "AIDS Is Real" and the exhortation to "Live Responsibly" have become commonplace.

The HIV prevention model of 'ABC' (abstain, be faithful, use condoms) has been prioritized across Africa. The message of sexual abstinence outside of marriage is certainly attuned to Muslim requirements of sexual morality. However, condoms are strongly associated with sexual immorality in Northern Nigeria, to the extent that it's really an 'AB' prevention strategy that is affirmed in public discourse.

Moreover, what "being faithful" means in the Western context (broadly glossed) and Northern Nigerian Muslim context is quite different. In the Western—implicitly Christian—context, 'faithfulness' implies married sexual monogamy. Muslims are quite concerned with sexual morality and consider adultery a grave offence, but faithfulness in Northern Nigeria in no way presumes sexual monogamy. An implication of this is that dominant HIV prevention strategies that urge faithfulness to one partner defy the Muslim Hausa cultural logic that defines the economic and sexual provision for multiple wives as a component of male piety and ideal masculinity.

A poster I saw on the walls of several HIV clinics, testing centers, and NGO offices during my fieldwork is illustrative of the disconnect between HIV prevention messaging and the realities of sexual networks in Northern Nigeria. The top of the poster reads, "STOP HIV BE FAITHFUL"; at the bottom are the logos of USAID,

⁹⁰ 'My brother, you can't tell someone has AIDS by looking at them! Please, let's go get tested.'

PEPFAR, Society for Family Health, and Make We Talk, a Nigerian AIDS prevention campaign. The poster is a glossy and colored, with a cartoon drawing in each of the four quadrants. [APPENDIX 1]

In the first frame, a man wearing a green kaftan walks into a bedroom and finds a woman in hijab sitting on the lap of another man on a bed. Unpleasant surprise registers on all three of their faces. In the second frame, the man who was on the bed is running out the door. The man in green glares at him, hands on his hips, his back turned to the woman. The woman has her hand on the man in green's shoulder, seemingly to calm him.

In the third frame, the woman has dropped to her knees in front of the man in green, her hands raised in a pleading prayer as she looks up at him. He points at her, his face registering anguish. A dialogue pictograph comes from his mouth: we see the woman with hearts above her head and arrows pointing from her to four different men; from this scene depicting the woman's multiple sexual relationships, an arrow points to a picture of the woman alone and seemingly dejected.

In the fourth and final frame, the woman and man stand next to each other and gaze warmly into each other's eyes. He has put his arm around her. She holds up a single finger, as if making a promise or indicating the number one. In a pictograph coming from the woman, her four lovers have been covered by a large X, and an arrow points from this to the woman and the man in green embracing, hearts above their heads, and a red check mark. In a pictograph coming from his head, the identical picture of the two of them embracing with hearts and a check mark is repeated.

The woman's headscarf clearly signifies that she is a Muslim. That the men are also Muslim is less self-evident, but this is strongly implied by the fact that they wear Hausa-styled embroidered kaftans and matching hats. Moreover, it is not permitted in Islam for a Muslim woman to marry a non-Muslim man.

The message of the poster is that it is the woman's sexual licentiousness—and by extension, the sexual licentiousness of women as a group—that threatens the spread of HIV. 'Being faithful' in this context has a double, but interconnected, meaning. First, the woman is faithful (at least, she promises to reform herself to faithfulness) by rejecting her other sexual partners and becoming sexually monogamous with the man. This, by extension, demonstrates her faithfulness to the Islamic requirement that she has sex with only her husband. The meta-message is that women's faithfulness to Islam's demand of married sexual fidelity has the power to stop the spread of HIV.

Health promotion messages targeted at a general audience are often necessarily simplified. Even still, there is much in the just-so story portrayed in this poster that is culturally implausible. Assume that the woman is married to the man in green. Given the seriousness with which women's marital fidelity is guarded in Northern Nigeria, it is highly implausible that the man would forgive his wife for having sex with other men. Moreover, as his speech to her in the third frame makes clear, he was aware that she had other sexual partners even before walking in on her on the bed with the other man.

This poster conveys is a common refrain of HIV prevention: partner reduction, and more specifically sexual monogamy, will keep one safe from HIV

infection. Indeed, while sexual network size is far from the only predictor of HIV infection risk, smaller sexual networks have been correlated with lower infection rates in many instances (Thornton 2008). The cultural mismatch, and thus the ineffectiveness of the message, arises from the fact that Northern Nigerian Muslim men—not women—are more likely to have multiple sexual partners. Indeed, men are permitted in the context of marriage to have up to four sexual partners at a time.

The problem, as Reniers and Watkins point out, is that "public health policies that target concurrency in a generic fashion are likely to be as culturally insensitive as early missionary efforts to ban polygyny. In addition, [...] they may have counterproductive public health implications" (2010: 304-5). HIV prevention messages directed at Muslims in Northern Nigeria must be attentive to the fact that men's prerogatives for sexual concurrency are of greater concern in HIV transmission. Discouraging men from marital polygyny will be culturally inappropriate. Instead, messages should encourage men and women to test for HIV, encourage men in particular to remain sexually faithful to their spouses, and should aim to reduce HIV/AIDS stigma. Such messages will have better chances of reducing HIV transmission in Northern Nigeria than those that insist that "AIDS is real", vaguely exhort responsible living, and shift the onus of the epidemic onto women's sexual promiscuity.

Addressing the epidemic among MSM

The Integrated Bio-Behavioral Surveillance Survey, conducted in partnership by the federal government, state governments, international health and human

rights NGOs, Nigerian LGBT organizations, and "most at risk populations" in 2007 and 2010 demonstrated that successful epidemiological research can be carried out with men who have sex with men, injection drug users, and female sex workers. The next, as-yet untaken step with MSM will be to use these results to develop culturally sensitive interventions and further research priorities. However, any HIV intervention with *masu harka* in Northern Nigeria will have to proceed with extreme caution. Dominant socio-religious attitudes against homosexuality have a strongly deterrent effect on the implementation of prevention and treatment initiatives.

I advocate a multi-faceted approach in beginning to address the HIV epidemic among *masu harka*: First, a process of advocacy and coalition building will be crucial. Programs that do not have some institutional support within national and state government will surely fail. Programs perceived to be imposed or initiated from outside the region will also likely fail. There are well-placed advocates for initiatives addressing MSM—generally those who have solid epidemiological and cultural understanding of *masu harka*'s role in the local epidemic. Garnering their support will be indispensable.

Second, peer education should be a main strategy for getting *masu harka*, and subsets of this population such as men who engage in transactional sex, the health information they need. The benefits of peer education are at least twofold: first, given the secrecy and stigma surrounding same-sex sexuality in Nigeria, *masu harka* are in the best position to reach out to other *masu harka*—especially to older men who are unlikely to be “found” by government agencies and NGOs. Second, a peer

education model recognizes that with proper institutional support, *masu harka* can be empowered to effectively address the unmet needs that members of the group consider the most pressing. Just as cell phone technology is used by *masu harka* to discreetly arrange sexual and social connections, it should also be used as a tool to discreetly spread information about HIV and other STI prevention and services.

Masu harka should be involved in all aspects of planning, message development, and campaign roll-out for education campaigns to be effective—rather than used as “implementing partners” when programs have already been developed. A peer education model does not relieve the federal and state governments of their duty to protect the public health by shifting the programmatic onus to marginalized and under-resourced groups of MSM. Rather, it challenges the government and NGOs to forge meaningful alliances with MSM and recognizes that programmes that do not incorporate MSM in all levels of decision-making are unlikely to succeed in the long term.

Third, *masu harka* need access to HIV testing, preventative technologies, psychosocial support, and treatment. No such programs currently exist in Northern Nigeria, outside of Kaduna. *Masu harka* are unlikely to reveal their sexual behaviours to most medical practitioners due to stigma and likelihood of negative social consequences. It is also unlikely that, given prevailing attitudes towards homosexuality, most Nigerian medical practitioners would feel comfortable working with this population. I advocate for the establishment of a network of medical staff who have been trained in both the medical specificities and social sensitivities of working with *masu harka*. At this time, advocate the creation of *masu harka*-specific

clinics is infeasible for reasons of social stigma. Rather, clinicians should be both easily accessible and in an environment where MSM feel safe from being exposed as MSM.

Ideally, clinical services should follow a 'one-stop shopping' model, with testing and treatment for STIs and HIV, condoms and condom-compatible lubricants, referrals to other clinical services, and MSM-specific health information all readily available. The cost of services is another major factor. Many *masu harka* are unable to afford appropriate healthcare when they need it. Such services should therefore be provided free of cost to maximize uptake. As identity management is a key concern for many MSM, service providers must also be trained in the importance of maintaining strict patient confidentiality. While HIV interventions for MSM will be highly challenging in the current legal and socio-political climate, continued inattention to this high-prevalence population will have considerable epidemiological, economic, and social tolls in Northern Nigeria.

Appendix 1



Bibliography

Aarmo, Margarete

- 1999 How homosexuality became 'un-African': the case of Zimbabwe. In *Female Desires: Same-Sex Relations and Transgender Practices Across Cultures*. E. Blackwood and S. Wieringa, eds. New York: Columbia University Press.

Abdalla, Ismail H.

- 1997 *Islam, Medicine, and Practitioners in Northern Nigeria*. Lewiston, New York: Edwin Mellen Press.

Abdullahi, F.

- 2004 To Many, HIV/AIDS is Not Real. This Day [Nigeria]. 16 November.

Abdulraheem, I.S., A.R. Olapipo and M.O. Amodu

- 2012 Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities. *Journal of Public Health and Epidemiology* 4(1): 5-13.

Abu-Lughod, Lila

- 1988 Fieldwork of a dutiful daughter. In S. Altorki & C. Fawzi El-Solh (Eds.), *Arab Women in the Field: Studying Your Own Society*. Syracuse, NY: Syracuse University Press.

Adam, Barry

- 1986 Age, structure, and sexuality: reflections on the anthropological evidence of homosexual relations. In *Anthropology and Homosexual Behavior*. E. Blackwood, ed. Pp. 19-33. New York: Haworth Press.

Adamu, Fatima

- 2008 Gender, Hisba and the Enforcement of Morality in Northern Nigeria. *Africa* 78(1): 136-152.

Adamu, Mahdi

- 1978 *The Hausa Factor in West African History*. Zaria, Nigeria: Ahmadu Bello University Press.

Adeyi, O. et. al., eds.

- 2006 *AIDS in Nigeria: A Nation on the Threshold*. Cambridge: Harvard Center for Population and Development Studies.

Adow, Mohammed.

- 2012 Nigeria's Kano shakes off divorce capital tag. Aljazeera, 16 July.

<http://blogs.aljazeera.com/blog/africa/nigerias-kano-shakes-divorce-capital-tag> (accessed 19 March 2013).

Ahmed, L.

1992 *Women and Gender in Islam: Historical Roots of a Modern Debate*, New Haven: Yale University Press.

Ajakaiye, D. Olu and O.F. Odumosu

2002 *Socio-economic Burden of HIV/AIDS Epidemic in Nigeria*. Ibadan: NISER.

Akanji, M.

2005 Re: Abuja Homosexuals are Spreading HIV/AIDS. Electronic document, http://www.mask.org.za/SECTIONS/AfricaPerCountry/ABC/nigeria/nigeria_14.htm. Accessed 2 July 2005.

Akeroyd, AV

2004 Coercion, Constraints, and "Cultural Entrapments": A further look at gendered and occupational factors pertinent to the transmission of HIV in Africa. In *HIV & AIDS in Africa*, Kalipni, E. (ed), pp 89-103.

Aldrich, Robert F.

2003 *Colonialism and Homosexuality*. London: Routledge.

Ali, S.

1996 AIDS and Muslim communities: opening up. *AIDS STD Health Promot Exch* (2):13-6.

Al Islaah (anonymous author)

2008 Q & A on AIDS. EveryMuslim.net, accessed electronically, 16 April 2008: http://www.everymuslim.net/index.php?option=com_content&task=view&id=1194&Itemid=31

al-Jawziyya, Ibn Qayyim

1998 *Medicine of the Prophet* (translated by Penelope Johnstone). Cambridge, UK: Islamic Texts Society.

Al-Jibaly, Muhammad

2000 *The Fragile Vessels: Rights and Obligations Between the Spouses in Islam*. Arlington, Texas: Al-Kitaab & as-Sunnah Publishing.

Altman, Dennis

2000 The emergence of gay identities in Southeast Asia. In *Different Rainbows*. P. Drucker, ed. Pp. 137-156. London and Chicago: Gay Men's Press.

American Anthropological Association Executive Board

2007 Statement on the Human Terrain System Project. 31 October.
<http://www.aaanet.org/issues/policy-advocacy/statement-on-HTS.cfm>
(Accessed 5 April 2013).

Anonymous

2012 The Popular Discourses of Salafi Radicalism and Salafi Counter-radicalism in Nigeria: A Case Study of Boko Haram. *Journal of Religion in Africa* 42: 118-144.

Appadurai, Arjun

1996 Disjuncture and difference in the global cultural economy. In: *Modernity At Large: Cultural Dimensions of Globalization*. Minneapolis: University of Minnesota Press.

Auty, Richard M.

1993 *Sustaining Development in Mineral Economies: The Resource Curse Thesis*. London: Routledge.

Baggaley, Rebecca et al.

2010 HIV transmission risk through anal intercourse: Systematic review, meta-analysis and implications for HIV prevention. *International Journal of Epidemiology* 39(4): 1048-1063.

Baral, S., et al.

2007 Elevated risk for HIV infection among men who have sex with men in low- and middle income countries 2002-2006: A systematic review. *PLoS Med* 4 (12).

Barkindo, Bawuro

1993 Growing Islamism in Kano City since 1970: Causes, form and implication. In: Brenner, L. (ed.) *Muslim Identity and Social Change in Sub-Saharan Africa*. London: Hurst.

Barkow, Jerome

1974 On Hausa Character and Social Control. *Ethos* 2: 1-14.

Barnett, Tony and Alan Whiteside

2003 *AIDS in the Twenty-first Century: Disease and Globalization*. Basingstoke: Palgrave.

Bayart, Jean-François, Stephen Ellis, and Béatrice Hibou

1999 *The criminalization of the state in Africa*. Pp. xviii, 126 p. Oxford and Bloomington, Indiana: International African Institute in association with James Currey; Indiana University Press.

Beauchamp, Dan

- 2003 Public health as social justice. In *Health and social justice: politics, ideology, and inequity in the distribution of disease*. 1st edition. R. Hofrichter, ed. Pp. 267-284. San Francisco: Jossey-Bass.
- Becker, Gay
 1997 *Disrupted Lives: How People Create Meaning in a Chaotic World*. Berkeley: University of California Press.
- Becker, Felicitas
 2009 Competing explanations and treatment choices: Muslims, AIDS and ARVs in Tanzania. In: Becker, F. & Geissler, P.W. (eds.) *AIDS and Religious Practice in Africa*. Leiden: Brill.
- Bendavid, Eran, and Jayanta Bhattacharya
 2009 PEPFAR in Africa: An evaluation of outcomes. *Annals of Internal Medicine* 150(10): 688-695
- Biehl, Joao
 2007 *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton: Princeton University Press.
- Bierlich, Bernhard
 2007 *The problem of money: African agency and Western medicine in northern Ghana*. Pp. xix, 228 p. New York: Berghahn Books.
- Biersteker, Thomas J.
 1987 *Multinationals, the state, and control of the Nigerian economy*. Princeton, N.J.: Princeton University Press.
- Bleys, Rudi
 1995 *The Geography of Perversion: Male-to-Male Sexual Behavior Outside the West and the Ethnographic Imagination, 1750-1918*. New York: New York University Press.
- Blomkamp, Neill, dir.
 2009 *District 9*. 112 minutes. TriStar Pictures. Culver City, CA.
- Boellstorff, Tom
 2005 Between religion and desire: Being Muslim and gay in Indonesia. *American Anthropologist* 107(4): 575-585.
 2011 But do not identify as gay: A proleptic genealogy of the MSM category. *Cultural Anthropology* 26(2): 287-312.
- Bourdieu, Pierre
 1977 *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

- Brown, D.
2011 Obama proposes helping more people get access to AIDS drugs. Washington Post. Dec 1.
- Brown, E. R.
1976 Public Health in Imperialism: Early Rockefeller Programs at Home and Abroad. *American Journal of Public Health* 66(9):897-903.
- Brown, Peter J., and Marcia Claire Inhorn, eds.
1997 *The Anthropology of infectious disease: international health perspectives*. Amsterdam, Netherlands: Gordon and Breach; OPA (Overseas Publishers Association).
- Burson-Tolpin, Anne
1989 Fracturing the Language of Biomedicine: The Speech Play of U. S. Physicians. *Medical Anthropology Quarterly* 3(3):283-293.
- Campbell, Catherine
2003 *Letting them die: why HIV/AIDS intervention programmes fail*. Oxford: International African Institute in association with James Currey.
- Cant, Bob
1997 Introduction. In *Invented Identities?: Lesbians and Gays Talk About Migration*. B. Cant, ed. Pp. 1-17. London: Cassell.
- Carsten, Janet
2011 Substance and relationality: Blood in contexts. *Annual Review of Anthropology* 40: 19-35.
- Chabal, Patrick, and Jean-Pascal Daloz
1999 *Africa works : disorder as political instrument*. Pp. xxi, 170 p. [London]: International African Insitute in association with James Currey, Oxford, Indiana University Press, Bloomington.
- Cheney, Kristen
2012 Locating Neocolonialism, 'tradition', and human rights in Uganda's 'gay death penalty'. *African Studies Review* 55(2): 77-95.
- Clarke, Morgan
2006 Islam, kinship, and new reproductive technology. *Anthropology Today* 22 (5): 17-20.
- Clifford, James and George E. Marcus
1986 *Writing Culture: The Poetics and Politics of Ethnography*. Berkeley: University of California Press.

Closser, Svea, Anat Rosenthal, Thomas Parris, Kenneth Maes, Judith Justice, Kelly Cox, Matthew A Luck, R Matthew Landis, John Grove, Pauley Tedoff, Linda Venczel, Peter Nsubuga, Jennifer Kuzara, and Vanessa Neergheen
2012 Methods for evaluating the impact of vertical programs on health systems: protocol for a study on the impact of the global polio eradication initiative on strengthening routine immunization and primary health care. *BMC Public Health* (12): 728.

Cohen, Myron S, Ying Q. Chen, Marybeth McCauley, Theresa Gamble, Mina C. Hosseinipour, Nagalingeswaran Kumarasamy, James G. Hakim, Johnstone Kumwenda, Beatriz Grinsztejn, Jose H.S. Pilotto, Sheela V. Godbole, Sanjay Mehendale, Suwat Chariyalertsak Breno R. Santos, Kenneth H. Mayer, Irving F. Hoffman, Susan H. Eshleman, Estelle Piwowar-Manning, Lei Wang, Joseph Makhema Lisa A. Mills, Guy de Bruyn, Ian Sanne, Joseph Eron, Joel Gallant, Diane Havlir, Susan Swindells, Heather Ribaud, Vanessa Elharrar, David Burns, Taha E. Taha, Karin Nielsen-Saines, David Celentano, Max Essex, and Thomas R. Fleming
2011 Prevention of HIV-1 Infection with Early Antiretroviral Therapy. *New England Journal of Medicine* 365(6): 493-505.

Comaroff, Jean
2007 *Beyond Bare Life: AIDS, (Bio)Politics, and the Neoliberal Order*. *Public Culture* 19(1): 197-219.

Committee for the Evaluation of the President's Emergency Plan for AIDS Relief (PEPFAR) Implementation
2007 *PEPFAR Implementation: Progress and Promise*. Jaime Sepulveda, James Curran, William Holzemer, Helen Smits, Kimberly Scott, and Michele Orza, eds. Washington, D.C.: The National Academies Press.

Connell R.W.
1995 *Masculinities*. Cambridge: Polity Press.

Cooper, Barbara M.
1997 *Marriage in Maradi: Gender and Culture in a Hausa Society in Niger, 1900-89*. Oxford: James Currey.

Courtenay, Will H.
2000 Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine* 50:1385-1401.

Cox, M.
2002 The long-haul out of the closet: the journey from smalltown to boystown. In *Gay Tourism: Culture, Identity and Sex*. S. Clift, M. Luongo, and C. Callister, eds. Pp. 151-173. London ; New York: Continuum.

Coyne, Joseph S., and Peter Hilsenrath

2002 The World Health Report 2000: Can health care systems be compared using a single measure of performance? *American Journal of Public Health* 92(1): 30-33.

Das, Veena and Lori Leonard

2007 Kinship, Memory, and Time in the Lives of HIV/AIDS Patients in a North American City. In *Ghosts of Memory: Essays on Remembrance and Relatedness*. ed. Janet Carsten. New York: Blackwell.

Delaney, Carol

2001 Cutting the Ties that Bind: The Sacrifice of Abraham and Patriarchal Kinship. In *Relative Values: Reconfiguring Kinship Studies*. Ed. Susan McKinnon and Sarah Franklin. Durham, NC: Duke University Press, pp. 445-67.

Denny, Colleen C. and Ezekiel J. Emanuel

2008 US Health Aid Beyond PEPFAR: The Mother & Child Campaign. *JAMA* 300(17): 2048-2051.

de Walque, D. and Kline R.

2012 The association between remarriage and HIV infection in 13 Sub-Saharan African countries. *Studies in Family Planning* 43(1):1-10.

Dibia, Jude

2005 *Walking With Shadows*. Lagos: Lulu.

Donham, Donald

1998 Freeing South Africa: The "modernization" of male-male sexuality in Soweto. *Cultural Anthropology* 13(1):3-21.

Drucker, Peter

2000 Introduction: Remapping sexualities. In *Different Rainbows*. P. Drucker, ed. Pp. 9-41. London and Chicago: Gay Men's Press.

Durojaye, Ebenezer and Victoria Balogun

2010 Human rights implications of mandatory premarital HIV testing in Nigeria. *International Journal of Law, Policy, and the Family* 24(2): 245-265.

Elbe, Stefan

2004 The futility of protest? Biopower and biopolitics securitization of HIV/AIDS. Paper presented at the 45th Annual ISA Convention, Montreal, 17 March.

Ellison, C.G., and J.S. Levin

- 1998 The religion-health connection: Evidence, theory, and future directions. *Health Education and Behavior* 25(6): 700-720.
- Ellman, Tom, Health Culbert, and Victorio Torres-Feced.
Treatment of AIDS in conflict-affected settings: a failure of imagination. *Lancet* 365: 279-9.
- El-Sadir, Waffa M and David Hoos
2008 The President's Emergency Plan for AIDS Relief--Is the emergency over? *The New England Journal of Medicine* 359: 553-55.
- Epprecht, Marc
2008 *Heterosexual Africa?: The History of an Idea from the Age of Exploration to the Age of AIDS*. Athens: Ohio University Press.
- Epstein, Helen
2007 *The Invisible Cure: Africa, the West, and the Fight Against AIDS*. New York: Farrar, Straus, and Giroux.
- Epstein, Helen and David Stanton
2010 Is polygamy really benign? *AIDS* 24(11): 1791-92.
- Esiet, U. E.
2001 Nigeria—HIV/AIDS. In *The International Encyclopedia of Sexuality, Volume I-IV*. R. T. Francoeur, ed. New York: Continuum.
- Evans-Pritchard, E. E.
1936 [1976]. *Witchcraft, Oracles, and Magic Among the Azande*. Oxford: Clarendon Press.
- Falade, Dapo, Hassan Ibrahim, Kola Oyelere, and Christian Okeke
2013 Kano Bombing: Ploy to Break Nigeria – Senate, JNI. *Nigerian Tribune*, 21 March.
<http://tribune.com.ng/news2013/index.php/en/component/k2/item/7831-kano-bombing-ploy-to-break-up-nigeria-senate-jni-igbo-oppose-mass-burial> (Accessed 31 March 2013).
- Fallers, Lloyd A.
1974 Foreword to *The Sacred Meadow* by Abdul Hamid el-Zein, xv-xvii. Evanston, IL: Northwestern University Press.
- Falola, Toyin, and Matthew M. Heaton, eds.
2006 *Traditional and modern health systems in Nigeria*. Trenton, NJ: Africa World Press.

Farmer, Paul

- 2001 *Infections and inequalities : the modern plagues*. Berkeley; London: University of California Press.
- 2003 *Pathologies of power: health, human rights, and the new war on the poor*. Berkeley: University of California Press.

Fassin, Didier

- 2007 *When Bodies Remember: Politics and Experiences of AIDS in South Africa*. Berkeley: University of California Press.

Federal Ministry of Health

- 2010 *Nigeria Integrated Biological and Behavioural Surveillance Survey*.
http://www.popcouncil.org/pdfs/2011HIV_IBBSS2010.pdf.

Federal Republic of Nigeria (National Agency for the Control of AIDS)

- 2012 *Global AIDS Response Country Progress Report [Nigeria]*. Abuja: Nigeria.

Ferdinando, Keith

- 1995 *Sickness and syncretism in the African context*. In *Mission and Meaning*. A. Billington, T. Lane, and M. Turner (eds.). Carlisle: Paternoster Press. Pp. 272-284.

Ferguson, James

- 2006 *Global shadows: Africa in the neoliberal world order*. Durham [N.C.]: Duke University Press.

Fluehr-Lobban, Carolyn

- 2004 *Islamic Societies in Practice*. Gainesville: University of Florida Press.

Forde, O. H.

- 1998 *Is imposing risk awareness cultural imperialism?* *Social Science & Medicine* 47(9): 1155-1159.

Foster, G. M.

- 1984 *Anthropological research perspectives on health problems in developing countries*. *Social Science & Medicine* 18(10): 847-854.

Foucault, Michel

- 1973 *The birth of the clinic: an archaeology of medical perception*. New York: Pantheon Books.
- 1976 *The History of Sexuality, Volume 1: The Will to Knowledge*. London: Penguin.
- 1980 *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*. Brighton: Harvester Press.

- Francesca, Ersilia
 2002 AIDS in contemporary Islamic ethical literature. *Med Law* 21(2):381-94.
- Fullwiley, Duana
 2004 Discriminate biopower and everyday politics: Views on Sickle Cell Testing in Dakar. *Medical Anthropology* 23: 157-94.
- Galdas P.M
 2009 Men, Masculinity and Help-Seeking. In *Men's Health: Body, Identity and Social Context* London, Broom A. and Tovey P. (eds). John Wiley and Sons Inc.
- Garba, Lubabatu I
 2013 Kano mass wedding: HIV positive, pregnant women discovered at screening. Daily Trust. 4 April.
<http://www.dailytrust.com.ng/index.php/news-news/53911-kano-mass-wedding-hiv-positive-pregnant-women-discovered-at-screening>. (Accessed 7 April 2013).
- Gaudio, Rudolf Pell
 2009 *Allah Made Us: Sexual Outlaws in an Islamic African City*. Malden, MA: Wiley-Blackwell.
- Geertz, Clifford
 1971 *Islam Observed*. Chicago: University of Chicago Press.
 1973 Thick description: Toward and interpretive theory of culture. In *The Interpretation of Cultures: Selected Essays*. Pp. 3-32. New York,: Basic Books.
 1976 Art as a cultural system. *MLN* 91(6): 1473-1499.
- Gibney, L., et al.
 1999 Behavioural risk factors for HIV/AIDS in a low-HIV prevalence Muslim nation: Bangladesh. *International Journal of STD and AIDS* 10(3): 186-194.
- Good, Charles
 1988 Traditional healers and AIDS management. In *AIDS in Africa: The Social And Policy Impact*. N. Miller and R. Rockwell (eds.). Lewiston NY: The Edwin Mellon Press.
- Gough, Kathleen
 1968 Anthropology and Imperialism. *Monthly Review* 19(11): 12-27.
- Gramsci, Antonio
 1992 *Prison Notebooks*. J.A. Buttigieg, transl. New York: Columbia University Press.

Gray, Peter

2004 HIV and Islam: is HIV prevalence lower among Muslims? *Social Science & Medicine* 58(9): 1751-1756.

Green, Edward

1994 *AIDS and STDs in Africa: Bridging the Gap Between Traditional Healers and Modern Medicine*. Boulder CO: Westview Press.

Green, Edward C. and Allison Herling Ruark

2011 *AIDS, Behavior, and Culture: Understanding Evidence-Based Prevention*. Walnut Creek, CA: Left Coast Press.

Gruenbaum, Ellen

2001 *The Female Circumcision Controversy: An Anthropological Perspective*. Philadelphia: University of Pennsylvania Press.

Guven, G. S.

2004 Can HIV-infected patients fast during the month of Ramadan? *Journal of Acquired Immune Deficiency Syndromes* 35(5):537-538.

Habib, A. G., et al.

2009 Adherence to Anti Retroviral Therapy (ART) During Muslim Ramadan Fasting. *Aids and Behavior* 13(1): 42-45.

Halperin, David M.

1990 *One Hundred Years of Homosexuality: And Other Essays on Greek Love*. New York: Routledge.

Halperin, Daniel and Helen Epstein.

2004 Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention. *Lancet* 364: 4-6.

Handler, Richard and Jocelyn Linnekin

1984 Tradition, genuine or spurious. *The Journal of American Folklore* 97(385): 273-290.

Hankins, C., S. Friedman, T. Zafar, and S. Strathdee

2000 Transmission and prevention of HIV and sexually transmitted infection in war settings: implications for current and future armed conflicts. *AIDS* 16(17): 2245-52.

Hannerz, Ulf

1992 The global ecumene as a network of networks. In *Conceptualizing society*. A. Kuper, ed. Pp. 34-56. London: Routledge.

- Hasnain, M.
2005 Cultural approach to HIV/AIDS harm reduction in Muslim countries. *Harm Reduction Journal* 2. doi:10.1186/1477-7517-2-23.
- Held, Virginia
2007 *The Ethics of Care: Personal, Political, and Global*. Oxford: Oxford University Press.
- Herd, Gilbert and A. Boxer
1992 Introduction: Culture, history, and life course of gay men. In *Gay Culture in America: Essays From the Field*. G. Herdt, ed. Pp. 1-28. Boston: Beacon Press.
- Herskovits, Jean
2012 In Nigeria, Boko Haram Is Not the Problem. *New York Times*. 2 January.
<http://www.nytimes.com/2012/01/02/opinion/in-nigeria-boko-haram-is-not-the-problem.html?pagewanted=all> (accessed 6 April 2013)
- Hirsch, Jennifer, Holly Wardlow, Daniel Jordan Smith, Harriet M. Phinney, Shanti Parikh, and Constance A. Nathanson.
2009 *The Secret: Love, Marriage, and HIV*. Nashville: Vanderbilt University Press.
- Hirsch, Jennifer
2010 Lost in translation: Gender Theory and HIV/AIDS research. Paper presented at the Institute for Research on Women and Gender, University of Michigan, Ann Arbor. 2 February.
- Hoad, Neville
2000 Arrested development or the queerness of savages: resisting evolutionary narratives of difference. *Postcolonial Studies* 3(2): 133-158.
- Hobsbawn, Eric
1983 Introduction: Inventing traditions. In *The Invention of Tradition*. E. Hobsbawn and T. Ranger, eds. Cambridge: Cambridge University Press.
- Holmes C, Coggin W, Jamieson D, Mihm H, Granich R, Savio P, et al.
2010 Use of generic antiretroviral agents and cost savings in PEPFAR treatment programs. *JAMA*: 304(3): 313-20.
- Horton, Robin
1967a African traditional thought and Western science, Part 1: From tradition to science. *Africa* 37(1): 50-71.
1967b African Traditional thought and Western science, Part 2: Closed and open predicaments. *Africa* 37(2): 155-187.
- Hrdy, Daniel B.

- 1988 Cultural Practices Contributing to the Transmission of Human Immunodeficiency Virus in Africa. In *The Heterosexual Transmission of AIDS in Africa*. D. Koch-Weser and H. Vanderschmidt (eds.) Cambridge: Abt Books. Pp. 255-64.
- Huff, Toby
2003 *The Rise of Early Modern Science: Islam, China, and the West*. Cambridge: Cambridge University Press.
- Hunter, Mark
2010 *Love in the Time of AIDS: Inequality, Gender, and Rights in South Africa*. Bloomington: Indiana University Press.
- Ibrahim, J.
2004 *Sharia Penal and Family Laws in Nigeria and the Muslim World: Rights Based Approach*. Zaria: Ahmadu Bello University Press.
- Idoko, John
2012 A Clinician's Experience With The President's Emergency Plan For AIDS Relief In Nigeria: A Transformative Decade Of Hope. *Health Affairs* 21(7): 1422-1428.
- Igoe, Jim, and Tim Kelsall, eds.
2005 *Between a rock and a hard place: African NGOs, donors and the state*. Durham, N.C.: Carolina Academic Press.
- Inhorn, Marcia C.
2003 *Local babies, global science : gender, religion, and in vitro fertilization in Egypt*. New York: Routledge.
2004 Middle Eastern Masculinities in the Age of New Reproductive Technologies: Male Infertility and Stigma in Egypt and Lebanon. *Medical Anthropology Quarterly* 18(2):162-182.
- Isiugo-Abanihe, U.C.
1994 Extramarital relations and perceptions of HIV/AIDS in Nigeria. *Health Transition Review* 4(2): 111-125.
- Johnson, Mark
1998 Global desirings and translocal loves: Transgendering and same-sex sexualities in the southern Philippines. *American Ethnologist* 25(4): 695-711.
- Joint United Nations Programme on HIV/AIDS, World Health Organization.
2004 Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections: Nigeria [Internet]. Geneva: UNAIDS. Available from: http://data.unaids.org/Publications/Fact-Sheets01/nigeria_en.pdf

- 2007 AIDS Epidemic Update 2007. Accessed electronically 16 April 2008:
http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf
- 2010 Global Report: UNAIDS Report on the Global AIDS Epidemic 2010. ISBN
978-92-9173-871-7.

Justice, Judith

- 1986 Policies, plans, and people. Berkeley: University of California Press.
- 1987 The bureaucratic context of International Health: a social scientist's view.
Social Science & Medicine 25:1301-1306.

Kagimu, M., et al.

- 1998 Evaluation of the effectiveness of AIDS health education interventions in the
Muslim community in Uganda. Aids Education and Prevention 10(3):215-
228.

Kaminski, Marek M.

- 2004 Games Prisoners Play. Princeton, NJ: Princeton University Press.

Kane, Ousmane

- 2003 Muslim Modernity in Postcolonial Nigeria: A Study of the Society for the
Removal of Innovation and Reinstatement of Tradition. Leiden: Brill.

Katyal, Sonia

- 2002 Exporting identity. Yale Journal of Law and Feminism 14(1): 97-176.

Kirsch, Stuart

- 2006 Reverse Anthropology: Indigenous Analysis of Social and Environmental
Relations in New Guinea. Palo Alto: Stanford University Press.

Kleinman, Arthur

- 1978 Concepts and a model for the comparison of medical systems as cultural
systems. Social Science and Medicine 12(2B): 85-93.
- 1980 Patients and healers in the context of culture. Berkeley: University of
California Press.

Kopelman, Loretta M.

- 2005 If HIV/AIDS is punishment, who is bad? In *Ethics & AIDS in Africa*, ed.
Anton A. van Niekerk and Loretta M. Kopelman, 208-218. Walnut Creek, CA:
Left Coast Press.

Kugle, Scott Siraj al-Haqq

- 2003 Sexuality, diversity, and ethics in the agenda of progressive Muslims. In
Progressive Muslims: On Justice, Gender, and Pluralism. Omid Safi, ed.
Oxford: Oneworld.

Kuhn, Thomas

1962 *The Structure of Scientific Revolutions*. Chicago: The University of Chicago Press.

Kulick, Don and Margaret Wilson, eds.

1995 *Taboo: Sex, Identity, and Erotic Subjectivity in Anthropological Fieldwork*. London: Routledge.

Labous, Jane

2012 Nigeria Cuts Fuel Prices After Strike, Protests. *Voice of America News*, 15 January. <http://www.voanews.com/content/nigerian-unions-president-fail-to-resolve-subsidy-stalemate-137358213/150687.html> (Accessed 31 March 2013).

Ladan, M.T.

2005. *A Handbook on Sharia Implementation in Northern Nigeria: Women and Children's Rights Focus*. Kaduna: League of Democratic Women Nigeria.

LaGarde, E., Enel, C., Seck, K., Gueye-Ndiaye, A., Piau, J.-P., Pison, G.

2000 Religion and protective behaviours towards AIDS in rural Senegal. *AIDS* 14(13): 2027-33.

Laitin, David D

1986 *Hegemony and Culture: Politics and Religious Change among the Yoruba*. Chicago: The University of Chicago Press.

Lane, S.D., and R.A. Rubinstein

1996 International health: problems and programs in anthropological perspective. In *Medical anthropology: contemporary theory and method*. Rev. edition. C.F. Sargent and T.M. Johnson, eds. Pp. 396-423. Westport, CN: Praeger.

Langwick, Stacey

2006 Geographies of medicine: interrogating the boundary between "traditional" and "modern" medicine in colonial Tanganyika. In *Borders and healers: brokering therapeutic resources in southeast Africa*. T.J. Luedke and H.G. West, eds. Pp. 143-165. Bloomington: Indiana University Press.

2011 *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania*. Bloomington: Indiana University Press.

Last, Murray

1986 The professionalisation of African medicine: ambiguities and definitions. In *The Professionalisation of African medicine*. M. Last and G.L. Chavunduka, eds. Pp. 1-28, Vol. new ser, no 1. Manchester [England] ; Dover, NH: Manchester University Press in association with the International African

- Institute.
- 2004 Hausa. In: Ember, C.R. & Ember, M. (eds.) *Encyclopedia of Medical Anthropology: Health and Illness in the World's Cultures*. New York: Kluwer Academic/Plenum Publishers.
- 2005 Religion and healing in Hausaland. In: Falola, T. (ed.) *Christianity and Social Change in Africa: Essays in Honor of J.D.Y. Peel*. Durham, NC: Carolina Academic Press.
- 2007 The importance of knowing about not knowing. In: Littlewood, R. (ed.) *On Knowing and Not Knowing in the Anthropology of Medicine*. Walnut Creek, CA: Left Coast Press.
- 2008 The search for security in Muslim northern Nigeria. *Africa* 78 (1): 41-63.
- Latour, Bruno and Steve Woolgar
- 1979 *Laboratory Life: The Social Construction of Scientific Facts*. Beverly Hills: Sage Publications.
- Lenton, C.
- 1997 Will Egypt escape the AIDS epidemic? *Lancet* 349(9057): 1005.
- Lewin, Ellen and William Leap, eds.
- 1996 *Out in the Field: Reflections of Lesbian and Gay Anthropologists*. Urbana: University of Illinois Press.
- Lindsay, Lisa A., and Stephan Miescher, eds.
2003. *Men and Masculinities in Modern Africa*. Portsmouth, NH: Heinemann.
- Lobel, Mark
- 2012 Deadly attack on Nigeria's Bayero university in Kano. *BBC News*. 30 April. <http://www.bbc.co.uk/news/world-africa-17886143>. (Accessed 31 March 2013).
- Lock, Margaret, and Vinh-Kim Nguyen
- 2010 *An Anthropology of Biomedicine*. New York: Wiley-Blackwell.
- Lockhart, Jamie, and Paul Lovejoy, eds.
- 2005 *Hugh Clapperton into the Interior of Africa: Records of the Second Expedition, 1825-1827*. Leiden: Brill.
- Lubeck, Paul M.
- 2011 Nigeria: Mapping a Shari'a Restorationist Movement. In *Shari'a Politics: Islamic Law and Society in the Modern World*. Robert W. Hefner (ed). Bloomington: Indiana University Press. Pp. 244-79.
- Mahmud, A.A.M.B.
- 1981 *Marriage Under Islamic Law*. Zaria: Hudahuda Publishing.

Markowitz, Fran and Michael Askenazi, eds.

1999 *Sex, Sexuality, and the Anthropologist*. Urbana: University of Illinois Press.

Massad, Joseph A.

2008 *Desiring Arabs*. Chicago: University of Chicago Press.

Mattes, Dominik

2011 "We are just supposed to be quiet": the production of adherence to antiretroviral treatment in urban Tanzania. *Medical Anthropology* 30(2):158-82.

Mattingly, Cheryl, and Linda C. Garro

2000 *Narrative and the cultural construction of illness and healing*. Berkeley: University of California Press.

McLean, H., and L. Ngcobo

1995 Abangibhamayo bathi ngimnandi (those who fuck me say I'm tasty): gay sexuality in reef township. In *Defiant Desire*. M. Gevisser and E. Cameron, eds. Pp. 158-185. New York: Routledge.

McNeil, Donald

2006 Circumcision Halves H.I.V. Risk, U.S. Agency Finds. *The New York Times*, 14 December.

2013 Gunmen Kill Nigerian Polio Vaccine Workers in Echo of Pakistan Attacks. *New York Times*. http://www.nytimes.com/2013/02/09/world/africa/in-nigeria-polio-vaccine-workers-are-killed-by-gunmen.html?_r=0. Accessed online 6 March 2013.

Michel, Nader

2005 Fighting AIDS in a Society Where We Egyptians Don't Talk about It. In *Ethics & AIDS in Africa*, ed. Anton A. van Niekerk and Loretta M. Kopelman, 155-160. Walnut Creek, CA: Left Coast Press.

Miles, William F. S.

1994 *Hausaland divided :Colonialism and Independence in Nigeria and Niger*. Ithaca: Cornell University Press.

Mills, Edward J, Sonal Singh, Brett D Nelson, and Jean B Nachega

2006 The impact of conflict on HIV/AIDS in sub-Saharan Africa. *International Journal of STD & AIDS* 17(11): 713-17.

Morgan, Henry Lewis

1871 *Systems of Consanguinity and Affinity of the Human Family*. Washington, D.C.: Smithsonian Institution Press.

- 1877 Ancient Society. New York: Henry Holt and Company.
- Morgan, Lynn M.
 1987 Dependency Theory in the Political Economy of Health: An Anthropological Critique. *Medical Anthropology Quarterly* 1(2): 131-154.
- Morrell, Robert and Sandra Swart
 2005 Men in the Third World: Postcolonial Perspectives on Masculinity. In *Handbook of Studies on Men and Masculinities*, ed. Michael S. Kimmel, Jeff Hearn, and R.W. Connell. 90-113. Thousand Oaks: Sage Publications.
- Morsy, S.
 1996 Political economy in medical anthropology. In *Medical Anthropology: Contemporary Theory and Method*.
- Mullings, L.
 1987 *Cities of the United States in Urban Anthropology*. New York: Columbia University Press.
- Murchison, Julian
 2006 From HIV/AIDS to ukimwi: Narrating local accounts of a cure. In *Borders and Healers: Brokering Therapeutic Resources in Southeast Africa*. T.J. Luedke and H.G. West (eds.) Bloomington: Indiana University Press.
- Murray, Stephen D. and Will Roscoe
 1998 *Boy-Wives and Female Husbands: Studies in African Homosexualities*. New York: Palgrave Macmillan.
- National Population Commission
 2003 *Nigeria Demographic and Health Survey*. Calverton, Maryland, ORC Macro.
 2009 *Nigeria Demographic and Health Survey 2008*. Calverton, MD: ICF Macro.
- Nguyen, Vinh-Kim
 2003 Epidemics, interzones and biosocial change: retroviruses and biologies of globalisation in West Africa. In *Entangled histories and negotiated universals : centers and peripheries in a changing world*. W. Lepeyres, ed. Pp. 183-210. Frankfurt ; New York: Campus.
 2005a Antiretroviral globalism, biopolitics, and therapeutic citizenship. In *Global assemblages: technology, politics, and ethics as anthropological problems*. A. Ong and S.J. Collier, eds. Pp. 124-144. Malden, MA: Blackwell Publishing.
 2005b Uses and pleasures: sexual modernity, HIV/AIDS, and confessional technologies in a West African metropolis. In *Sex in development: science, sexuality, and morality in global perspective*. V. Adams and S.L. Pigg, eds. Pp. 245-268. Durham: Duke University Press.
 2010 *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of*

AIDS. Durham: Duke University Press.

Nichter, Mark

2008 *Global health: why cultural perceptions, social representations, and biopolitics matter*. Tucson: University of Arizona Press.

Nigerian Supreme Council for Islamic Affairs

2009 *National Islamic Policy on HIV/AIDS*. Abuja: NSCIA.

Nossiter, Adam

2013 *Islamists Kill 7 Captives in Nigeria*. *New York Times*. 10 March.
http://www.nytimes.com/2013/03/11/world/africa/islamists-kill-7-captives-in-nigeria-a-shift-in-tactics.html?_r=0 (Accessed 11 March 2013).

Obadare, Ebenezer

2012 *Paper Truths and Ersatz Lives: Authenticity and Fakery in an African Transnational Visa Economy*. Paper presented at Department of Afroamerican and African Studies Africa Workshop, University of Michigan, Ann Arbor, 30 October.

Oboh, Mike

2012 *Islamist insurgents kill over 178 in Nigeria's Kano*. Reuters, 22 January.
<http://www.trust.org/alertnet/news/islamist-insurgents-kill-over-178-in-nigerias-kano/> (Accessed 31 March 2013).

O'Brien, Susan.

2001 *Spirit discipline: gender, Islam, and hierarchies of treatment in postcolonial northern Nigeria*. *Interventions* 3(2): 222–241.
2007 *La Charia contestée: démocratie, débat et diversité musulmane dans les 'états charia' du Nigeria*. *Politique Africaine* 106: 46–68.

O'Manique, Colleen

2004 *Neoliberalism and AIDS Crisis in Sub-Saharan Africa: Globalization's Pandemic*. Basingstoke: Palgrave-Macmillan.

Ortner, Sherry B., and Harriet Whitehead

1981 *Introduction: accounting for sexual meanings*. In *Sexual Meanings: The Cultural Construction of Gender and Sexuality*. S.B. Ortner and H. Whitehead, eds. Cambridge: Cambridge University Press.

Osoimehin, B.

2004 *HIV/AIDS in Nigeria today*. Paper presented at the 4th National Conference on HIV/AIDS, Abuja, Nigeria, 2–5 May.

Ostien, Philip

2007 Sharia Implementation in Northern Nigeria 1999–2006: A Sourcebook. Ibadan, Nigeria, Spectrum Books.

Ouzgane, Lahoucine, and Robert Morrell, eds.

2005 African Masculinities: Men in Africa From The Late Nineteenth Century To The Present. New York: Palgrave Macmillan.

Oyebola, D.D.O.

1986 National medical policies in Nigeria. In: Last, M. & Chavunduka, G. (eds.) The Professionalisation of African Medicine. Manchester: Manchester University Press.

Paden, John N.

1973 Religion and Political Culture in Kano. Berkeley: University of California Press.

2005 Muslim Civic Cultures and Conflict Resolution: The Challenge of Democratic Federalism in Nigeria. Washington, D.C.: Brookings Institution Press.

2008 Faith and Politics in Nigeria: Nigeria as a Pivotal State in the Muslim World. Washington, D.C.: United States Institute of Peace Press.

Padilla, Mark

2007a Caribbean Pleasure Industry: Tourism, Sexuality, and AIDS in the Dominican Republic. Chicago: University of Chicago Press.

2007b Globalization, structural violence, and LGBT health: a cross-cultural perspective. In *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*. I.H. Meyer and M.E. Northridge, eds. New York: Springer.

Pearce, Tola Olu

1986 Professional interests and the creation of medical knowledge in Nigeria. In *The Professionalisation of African medicine*. M. Last and G.L. Chavunduka, eds. Pp. 237-258, Manchester [England] ; Dover, NH, U.S.A.: Manchester University Press in association with the International African Institute.

1993 Lay medical knowledge in an African context. In *Knowledge, power, and practice : the anthropology of medicine and everyday life*. S. Lindenbaum and M.M. Lock, eds. Pp. xv, 428 p. Comparative studies of health systems and medical care, Vol. no 36. Berkeley: University of California Press.

Peterson, Kristen

2004 HIV/AIDS and Democracy in Nigeria: Policy, Rights, and Therapeutic Economies. PhD dissertation, Rice University.

2012 AIDS Policies for Markets and Warriors: Dispossession, Capital, and Pharmaceuticals in Nigeria. In *Medicine, Mobility, and Power in Global Africa: Transnational Health and Healing*. Hansjorg Dilger, Abdoulaye Kane, and Stacey A. Langwick (eds). Bloomington: Indiana University Press.

Pp.138-162.

Pincheon, Bill Stanford

- 2000 An ethnography of silences: Race, (homo)sexualities, and a discourse of Africa. *African Studies Review* 43(3): 39-58.

Pittin, Renee

- 1979 Marriage and alternative strategies: career patterns of Hausa women in Katsina city. PhD dissertation: University of London.
1983 Houses of women: a focus on alternative life-styles in Katsina City. In *Female and Male in West Africa*. C. Oppong, ed. Pp. 291-302. London: Allen & Unwin.

Porter L, Hao L, Bishai D, Serwadda D, Wawer MJ, Lutalo T, Gray R.

- 2004 HIV status and union dissolution in sub-Saharan Africa: the case of Rakai, Uganda. *Demography* 41(3): 465-82.

Pulerwitz, J., S.L. Gortmaker & W. DeJong

- 2000 Measuring sexual relationship power in HIV/STD research. *Sex Roles* 42 (7/8), pp. 637-660.

Reid, Elizabeth

- 1997 Placing women at the center of analysis. In *AIDS in Africa and the Caribbean*, ed. George C. Bond, John Kreniske, Ida Susser, and Joan Vincent. 159-164. Boulder: Westview Press.

Rabinow, Paul

- 1996 Artificiality and enlightenment: from sociobiology to biosociality. In *Essays on the anthropology of reason*. Pp. 91-111. Princeton, N.J.: Princeton University Press.

Rapp, Rayna and Faye Ginsburg

- 2001 Enabling disability: Rewriting kinship, reimagining citizenship. *Public Culture* 13(3): 533-556.

Reniers, Georges

- 2008 Martial strategies for regulating exposure to HIV. *Demography* 45(2): 417-38.

Renne, Elisha P.

- 1996 Perceptions of Population Policy, Development, and Family Planning Programs in Northern Nigeria. *Studies in Family Planning* 27(3): 127-136.
2009 Anthropological and public health perspectives on the global polio eradication initiative in northern Nigeria. In: Hahn, R. & Inhorn, M. (eds.) *Anthropology and Public Health: Bridging Differences in Culture and*

- Society. Oxford: Oxford University Press.
- 2010 *The Politics of Polio In Northern Nigeria*. Bloomington: Indiana University Press.
- Resch, Stephen; Hong Wang; Michael Kayode Ogungbemi; Gilbert Kombe
 2009 *Sustainability Analysis of HIV/AIDS Services in Nigeria*. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.
- Rhine, Kathryn
 2009 Support Groups, Marriage, and the Management of Ambiguity among HIV-Positive Women in Northern Nigeria. *Anthropological Quarterly* 82(2): 369-400.
- Rhodes, Lorna A.
 1996 Studying biomedicine as a cultural system. In *Medical Anthropology: Contemporary Theory and Method*. (Revised edition.) C.F. Sargent and T.M. Johnson, eds. Pp. 165-180. Westport, CT: Praeger.
- Ridanovic, Z.
 1997 AIDS and Islam. *Medicinski Archiv* 51: 45-46.
- Robertson, Jennifer
 2002 Reflexivity Redux: A Pithy Polemic on "Positionality". *Anthropological Quarterly* 75(4): 785-792.
- Robins, S.
 2006 From "Rights" to "Ritual": AIDS Activism in South Africa. *American Anthropologist* 108(2): 312-323.
- Ross, Will
 2013 Nigeria: Kano reels after emir attack. BBC News. 7 February. <http://www.bbc.co.uk/news/world-africa-21340480> (accessed 31 March 2013).
- Rubin, Gayle
 2011 [1975] The traffic in women: Notes on the "political economy" of sex. In *Deviations: A Gayle Rubin Reader*. Durham, NC: Duke University Press. Pp. 33-65.
 2011 [1984] Thinking sex: Notes for a radical theory of the politics of sexuality. In *Deviations: A Gayle Rubin Reader*. Durham, NC: Duke University Press. Pp. 137-181.
- Salamone, Frank A. and Virginia A. Salamone
 1993 Kirki: A Core Value of Hausa Culture. *Africa: Rivista trimestrale di studi e documentazione dell'Istituto italiano per l'Africa e l'Oriente* 48(3): 359-81.

Salihi, Abubakar

- 2013 Achaba Ban: Riders Could Lose N500m Daily in Kano. *Leadership*. 24 January.
http://www.leadership.ng/nga/articles/45876/2013/01/24/achaba_ban_riders_could_lose_n500m_daily_kano.html (Accessed 2 April 2013).

Santelli, John S., Irene S. Speizer, and Zoe R. Edelstein

- 2013 Abstinence promotion under PEPFAR: The shifting focus on HIV prevention for youth. *Global Public Health* 8(1): 1-12.

Sastry, Shaunak and Mohan Jyoti Dutta

- 2013 Global health interventions and the "common sense" of neoliberalism: A dialectical analysis of PEPFAR. *Journal of International and Intercultural Communication* 6(1): 21-39.

Scheper-Hughes, N. and Lock, M

- 1987 The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly* 1: 6-41.

Schoepf, Brooke

- 1992 AIDS, sex and condoms: African healers and the reinvention of tradition in Zaire. *Medical Anthropology* 14: 225-42.

Schram, Ralph

- 1971 *A History of the Nigerian Health Services*. Ibadan: Ibadan University Press.

Shildkrou, E.

- 1982 Dependence and autonomy: the economic activities of secluded Hausa women in Kano, Nigeria. In *Women and Work in Africa*. E. Bay (ed.) Boulder, CO: Westview. Pages 55-81.

Simpson, Anthony

- 2009 *Boys to Men in the Shadow of AIDS: Masculinities and HIV Risk in Zambia*. New York: Palgrave Macmillan.

Singer, Merrill

- 1995 Beyond the Ivory Tower: Critical Praxis in Medical Anthropology. *Medical Anthropology Quarterly* 9(1):80-106.
2004 Critical Medical Anthropology. In *Encyclopedia of Medical Anthropology: Health and Illness in the World's Cultures, Volume 1: Topics*. Carol R. Ember and Melvin Ember (eds.): Springer. Pp. 23-30.

Singer, Merrill, and Hans Baer

- 1995 *Critical Medical anthropology*. Amityville, NY: Baywood Publishing. Co.

Smith, Adrian D, et al.

2009 Men who have sex with men and HIV/AIDS in sub-Saharan Africa. *Lancet* 374: 416-422.

Smith, Daniel J.

2003 Imagining HIV/AIDS: Morality and Perceptions of Personal Risk in Nigeria. *Medical Anthropology* 22(4): 343-72.

2007 A culture of corruption: everyday deception and popular discontent in Nigeria. Princeton: Princeton University Press.

2009 Gender Inequality, Infidelity, and the Social Risks of Modern Marriage in Nigeria. In *The Secret: Love, Marriage, and HIV*. Jennifer Hirsch et al (eds). Pages 84-135.

Smith, David

2013 Polio workers in Nigeria shot dead. *The Guardian*, 8 February.
<http://www.guardian.co.uk/world/2013/feb/08/polio-workers-nigeria-shot-dead> (Accessed 31 March 2013).

Solivetti, LM.

1994 Family, marriage and divorce in a Hausa community: a sociological model. *Africa* 64(2): 252-71.

Soyinka, Wole

1965 *The Interpreters*. London: Trafalgar Square Press.

Stewart, Charles and Rosalind Shaw

1994 *Syncretism/Anti-Syncretism: The Politics of Religious Synthesis*. London: Routledge.

Stoler, Ann Laura

1995 *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things*. Durham: Duke University Press.

Suganuma, K.

2007 Associative identity politics: unmasking the multi-layered formation of queer male selves in 1990s Japan. *Inter-Asia Cultural Studies* 8(4): 485-502.

Svensson, Jonas

2009 'Muslims have instructions': HIV/AIDS, modernity, and Islamic religious education in Kisumu, Kenya. In: Becker, F. & Geissler, P.W. (eds.) *AIDS and Religious Practice in Africa*. Leiden: Brill.

Swarns, Rachel

1999 Mozambique Enlists Healers in AIDS Prevention." *New York Times*. 6

December.

Taussig, Michael

1999 *Defacement: Public Secrecy and the Labor of the Negative*. Palo Alto: Stanford University Press.

Thornton, Robert J.

2008 *Unimagined Communities: Sex, Networks, and AIDS in Uganda and South Africa*. Berkeley: University of California Press.

Ticktin, Mariam

2006 *Where Ethics and Politics Meet: The Violence of Humanitarianism in France*. *American Ethnologist* 33(1): 33-49.

Tocco, Jack, Andrew Karlyn, Sylvia Adebajo, Babatunde Ahonsi, and Dennis Akpona.

2012 *Research Report: The Experiences of Men Engaged in Transactional Sex with Other Men in Urban Nigeria - A Size Estimation and Qualitative Study*. Abuja: Population Council Nigeria.

Todd, Catherine S., et al.

2007 *Emerging HIV epidemics in Muslim countries: assessment of different cultural responses to harm reduction and implications for HIV control*. *Current HIV/AIDS Report* 4(4):151-7.

Turner, Victor W.

1995 [1969] *The Ritual Process: Structure and Anti-Structure*. Piscataway, NJ: Aldine Transaction.

Turshen, Meredith

1999 *Privatizing health services in Africa*. New Brunswick, N.J.: Rutgers University Press.

Tylor, Edward B.

1920 [1871]. *Primitive Culture*. New York: J.P. Putnam's Sons.

Umar, Muhammad Sani

1993 *Changing Islamic identity in Nigeria from the 1960s to the 1980s: From Sufism to anti-Sufism*. In *Muslim Identity and Social Change in Sub-Saharan Africa*. L. Brenner (ed). London: Hur.st. Pp. 116-134.

Umar, Sambo Adamu and Oche Mansur Oche

2012 *Knowledge of HIV/AIDS and use of mandatory premarital HIV testing as a prerequisite for marriages among religious leaders in Sokoto, North Western Nigeria*. *Pan African Medical Journal*.
11.<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3325065/> (Accessed 7

April 2013)

UNAIDS

- 2012a World AIDS Day Report. Geneva.
http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/JC2434_WorldAIDSday_results_en.pdf (Accessed 19 March 2013)
- 2012b UNAIDS Report on the Global AIDS Epidemic.
http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf (Accessed 19 March 2013)

United Nations General Assembly

- 2001 Declaration of Commitment on HIV/AIDS.
http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub03/aidsdeclaration_en.pdf (Accessed 31 March 2013)

United States President's Emergency Plan for AIDS Relief

- 2010 Partnership Framework on HIV/AIDS, 2010-2015: A Memorandum of Understanding between the Government of Nigeria and the United States Government to Fight HIV/AIDS.
<http://www.pepfar.gov/documents/organization/148812.pdf>. Accessed 31 January 2013.

Urban, Greg

- 2001 *Metaculture: How Culture Moves Through the World*. Minneapolis: University of Minnesota Press.

Valentine, David

- 2007 *Imagining Transgender: An Ethnography of a Category*. Durham, NC: Duke University Press.

Van deer Geest, Sjaak and Anita Hardon

- 2006 Social and cultural efficacies of medicines: Complications for antiretroviral therapy. *Journal of Ethnobiology and Ethnomedicine* 2 (48) Accessed online at: <http://www.ethnobiomed.com/content/2/1/48>.

Varisco, Daniel M.

- 2005 *Islam Obscured: The Rhetoric of Anthropological Representation*. New York: Palgrave Macmillan.

Vaughan, Megan

- 1991 *Curing Their Ills: Colonial Power and African Illness*. Cambridge, UK: Polity Press.

Velayati AA, Bakayev V, Bahadori M, Tabatabaei SJ, Alaei A, Farahboud A, Masjedi MR.

2007 Religious and cultural traits in HIV/AIDS epidemics in sub-Saharan Africa. *Archives of Iranian Medicine* 10(4): 486-97.

Venkatesh, Kartik K., Kenneth H. Mayer, and Charles C.J. Carpenter

2012 Low-Cost Generic Drugs Under The President's Emergency Plan For AIDS Relief Drove Down Treatment Cost; More Are Needed. *Health Affairs* 31(7): 1429-38.

Wall, Lewis

1988 *Hausa Medicine: Illness and Well-Being in a West African Culture*. Durham, NC: Duke University Press.

Watts, Michael

1994 Oil as money: the devil's excrement and the spectacle of black gold. In *Money, power, and space*. S. Corbridge, R. Martin, and N.J. Thrift, eds. Oxford, England; Cambridge, Mass.: Blackwell.

Waxler, Nancy

1998 Learning to be a leper: a case study in the social construction of illness. In *Understanding and applying medical anthropology*. P.J. Brown, ed. Pp. xii, 451 p. Mountain View, Calif.: Mayfield Pub. Co.

West, Harry G.

2006 Working the borders to beneficial effect: The not-so-indigenous knowledge of not-so-traditional healers in northern Mozambique. In *Borders and Healers: Brokering Therapeutic Resources in Southeast Africa*. T.J. Luedke and H.G. West, eds. Pp. 21-42. Bloomington: Indiana University Press.

Whiteside, Alan

2002 Poverty and HIV/AIDS in Africa. *Third World Quarterly* 23(2):313-32.

Whyte, Susan Reynolds, Sjaak van der Geest, and Anita Hardon

2002 *Social lives of medicines*. Cambridge, UK ; New York: Cambridge University Press.

Wolf, Erik

1992 *Europe and the People Without History*. Berkeley: University of California Press.

World Health Organization

2000 *The World Health Report 2000: Health Systems : Improving Performance*. Geneva: WHO Office of Publications.

2012a *Data on the HIV/AIDS response: Antiretroviral therapy coverage*.

<http://apps.who.int/gho/data/?vid=23300>. Accessed 31 January 2013.
2012b Weekly epidemiological report [polio] 12(87): 109-16.
<http://who.int/wer/2012/wer8712.pdf>. Accessed 1 March 2013.

Wright, Timothy

2005 Gay organizations, NGOs, and the globalization of sexual identity: the case of Bolivia. In *Same-sex Cultures and Sexualities: An Anthropological Reader*. J.E. Robertson, ed. Pp. 279-294. Malden, MA: Blackwell Publishing.

Wyrod, Robert

2011 Masculinity and the persistence of AIDS stigma. *Culture, Health & Sexuality* 13(4): 443-56.

Young, Rebecca M., and Ilan H. Meyer

2005 The trouble with "MSM" and "WSW": Erasure of the sexual minority person in public health discourse. *American Journal of Public Health* 95(7): 1144-1149.