

Tending the HIV-Positive Body in Northern Nigeria

Over the past 15 years, my research has focused on how HIV-positive women in northern Nigeria protect themselves from the dangers they may confront if their diagnosis becomes publicly known. These women must work on different aspects of their selves—including their appearances, close relationships, and occupations—in order to preserve the moral and social resources that protect them from the virus’s stigma and allow them to pursue their aspirations for a virtuous and prosperous future. I use the concept of *care work* to refer to the labor HIV-positive women devote to the repair and enhancement of their bodies and the bodies of others, the cultivation of intimate experience, the generation of new and reliable modes of subsistence and exchange relations, and finally, the mending, and maintenance of their families' reputations, as well as their own. In this contribution to the IARI Inquiry, *Tending the Body*, I develop this argument through the story of Binta,¹ a beauty entrepreneur in the city of Kano, who sells the clothes off her back in order to generate an income, support her household, and mask the fact that her husband, who she loves dearly, cannot adequately provide for her.

In 2006, I sat in a counseling office at an HIV clinic with Patience, a close friend, who was then employed as a treatment support specialist at a local hospital in the northern Nigerian city of Kano. She complained to me about being called upon by the hospital management to offer advice about “living positively” to a patient based upon her own experience. Though some of the staff members knew that Patience was infected with the virus, many of her clients in the counseling center did not. She was not required to disclose her status and she resented being asked to do so. The young woman who Patience was asked to counsel was distraught over her positive test result and, like many other patients, believed that her life was over. Patience confronted the client and said to her, “Look at my face. Do you know if I am positive or negative?” The woman said she thought she was negative. She continued, “How do you know this?” The woman responded that it was because she was so fat. “In fact,” Patience countered, “I am positive... So you see you can live healthy just like everyone. So long as you take your medicines everyday.” The medical lesson was clear: If you adhere to your treatment regimen, you will remain healthy. However, Patience also imparted to her client a social lesson: Beauty—as exemplified by an HIV-positive woman’s curvy, well-dressed body and modest, yet self-assured, comportment—is deceptive.

Binta was among the first HIV-positive women I interviewed early in my research in 2006. At the time, she was widowed, poor, and both she and her baby were quite ill. However, when I came back a year and a half later to meet her again, I was surprised to find that Binta had remarried and she looked much healthier and happier. As I greeted her in her parlor, she was clearly proud of her new living environment and married life. That day, Binta wore a bright yellow blazer and long black skirt, with a small hijab covering

her hair. Although she was still petite, she had gained a considerable amount of weight since our last meeting. She smiled throughout our interview. Her social status as a new bride [*amarya*] was inscribed upon both her beautiful body and her neat, well-furnished home.

Binta was widely recognized within her HIV support group as a skilled saleswoman. She earned her money by participating in a category of labor defined broadly as *care work*; that is, work involving an array of routine caregiving activities centered on meeting or manipulating the embodied and sensual needs of other people. These kinds of needs may be medical, emotional, material, and financial, and they are usually distinctly gendered services. In northern Nigeria, where women have limited access to salaried occupations in the formal economy, these kinds of entrepreneurial jobs are common. Prior to her recent marriage, Binta's business centered on preparing herbal treatments for different kinds of illnesses and bodily ailments, including fertility problems, bleeding, pregnancy and delivery, sex, and sexually transmitted infections, among others. Binta would regularly go to a number of Kano's major hospitals and sell these herbs to patients and the hospital staff members, as a supplement to their biomedical treatments.

Binta's body was central to her success in her herb-selling business. She not only sold medicinal items, but she also provided valuable information about her own experiences in healing with these objects. If Binta were to fall sick—a particular concern given her HIV-positive status—she undoubtedly would have had difficulty selling these items. After all, if she could not take care of herself, how could she be entrusted to take care of others? Despite the fact that these same herbal treatments complemented the use of antiretroviral therapies and produced her beautiful, healthy appearance, she would never tell these clients her HIV status. Binta, however, stressed that she stopped this job because her new husband forbade it. For many conservative Muslims in northern Nigeria, occupations where a woman must travel frequently and engage in deeply intimate conversations about issues of sexual and reproductive health with strangers, including men—are considered dangerous, indecent, or inappropriate for married women.

Mindful about the need to protect her health and reputation, as well as obey her new husband, Binta changed occupations. She began to buy and sell used clothes to her friends, neighbors, and customers. As we sat on her couch that afternoon, Binta brought over a pile of carefully folded clothes for me to admire, and—she hoped—to purchase. I asked her how she gained a clientele for this business, as there seemed to me to be no shortage of markets or women who go door-to-door selling clothes in Kano. Binta explained that she wears the clothing that she purchases from these markets, and when women admire her dress, she tells them that she is willing to sell it. Or, she added, she could bring similar items if they are interested. For Binta, her beauty not only served to attract admirers, including her doting husband, it also attracted customers. To be successful in this business, Binta had to project an image of a professional, successful,

and attractive individual, one who women want to become, in order to create a demand for her goods; in other words, imaginatively rendering herself into an object to be bought and sold.

To describe this kind of labor in a different way, Binta generated more than just economic transactions; she profited off of women's needs to become desirable or alluring to others—namely, men—with a goal of securing respectable relationships, marriages, and families. As in her previous sales position, Binta relied upon her body—actually selling the clothes off her back—to generate income. From my perspective, Binta appeared to be doing very well in her business. She was only slightly disappointed when the clothes she brought to me did not fit.

Our conversation next moved on to her recent marriage. I asked her why she sought to marry another husband. Binta said:

I got married because I got tired of suffering and looking for food. Now, sometimes my husband brings, and sometimes I will bring [food]. If he has money, I will not do it. I married him, however, because of his piety, not because of his money... He is very patient and he has piety. When it is early morning and he gets up, he will not go out until he asked me, "Did you wake up well? I hope there is not a problem?" I will say yes. You see, my son is not his son. If he is sick, my husband will buy 20 naira pap [porridge] and I will prepare it for him to drink. If I come back and he sees that I am tired, he will prepare food for me. I even taught my husband how to cook!

Binta detailed the ways in which HIV-positive women feel powerless and humiliated when they are without husbands and left alone to meet their most basic needs. There is undoubtedly great shame in being poor. The indignities that accompany life in poverty are compounded by and sometimes even surpassed by the shame of being unmarried and HIV-positive. Despite the fact that Binta's current husband often lacked the money to provide for her economic needs, she appreciated his effort to care for her in other ways; specifically, his psychological and spiritual support. Care work, in other words, encompasses not merely the provision of material items, but also affective, or emotional, forms of care that are often, but not always, relegated to the domain of women. Binta's husband was one of these exceptions.

Binta's husband conspicuously displayed his concern for her wellbeing, as well as the wellbeing of her child—a child who he did not, in fact, father. By cooking Binta dinner, a responsibility that almost always falls on the wife in northern Nigeria, her husband accomplished two things that Binta greatly valued: first, he paid attention to her body, noting her fatigue or stress, and sought to relieve her of these sources of embodied suffering. The other women in the support group looked up to Binta and her husband as a model of a caring relationship that they too desired. And second, by taking on a distinctly

feminine domestic chore (on occasion), her husband established a relatively flexible space in their household for the expression of gendered identities; specifically, allowing Binta to continue to work—although only in a particular kind of occupation—and avail herself of the social and economic benefits that her autonomy and income provided her.

Though I never learned whether her new husband was also HIV-positive, such displays of intimacy were at the core of many women's aspirations and strategies for hiding their status and securing the respect of their families, friends, and neighbors. And undoubtedly, her attentive care of her body and conspicuous beauty was what attracted her husband to her in the first place.

Nevertheless, Binta was still left with a dilemma: How do you mask your husband's inability to fulfill these economic expectations and protect him (as well as yourself) from the shame of this shortcoming, while maintaining respectability in your work? This is a particularly important concern for Binta given the fact Hausa Muslim women's roles in the workforce are closely surveilled by families and communities for signs of impropriety. And from the perspective of northern Nigerian men, a man's inability to support his family exposes his own dishonorable character. Married women, therefore, often feel morally obliged to keep their husbands' flaws secret. These social stakes are even higher in economic concerns when a woman and her partner are attempting to prevent others from suspecting them of being infected with HIV. Vacillating between the value of work and her gendered moral principles, Binta elaborated:

Before, my problems were too many. Now I get food to eat with his money, even if I did not go out [to work]. It is just once in a while I will work, since his salary is not much... [But] sometimes if he does not have money, I go out to look for a hundred or fifty naira. He does not stop me because he does not want me to owe. If you see a man stopping his wife from going out, it is because he has taken away all her responsibilities. He satisfies her desires, so if he stops her from working, there is no problem.

If he cannot take away her needs and he trusts her, he can allow her to go out. My husband does not have the power to help me. If I make a profit, it is mine, and I can buy more with this capital. It is better than going to the street to beg for alms or pleading others to help me. I was humiliating myself before. God has not stopped me from looking for money, so long as the work is not sinful.

On the one hand, Binta was grateful that her husband allows her to work, enabling her, in turn, to contribute to their household expenses and meet her personal economic obligations to others, including helping her brothers. On the other hand, if her husband had a good job, she would not need to work and her appearance would improve. Although not stated explicitly, if Binta's looks improved, her status would be further

concealed, she would be able to keep her husband's attention and prevent him for looking for extramarital relationships—or at least that is what she hoped. She would also be able to continue to rely upon her body to enhance her business, if she needed to return to work in the future.

Binta's narrative revealed two central themes critical to understanding the relationships between intimacy and the ordinary—as well as extraordinary—ethical dilemmas HIV-positive women encounter living healthy lives with a deeply stigmatizing virus. First, she gave me insight into the role women's bodies play in their efforts to earn money to support themselves and their families. Her case hinted at some of the hazards of these occupations, such as the very real threat a sickly, unattractive body would pose to one's business, or the reputation a woman might acquire if she becomes *too* familiar with a client's intimate needs. Given the very close associations between perceptions of immorality and accusations of HIV, women must tread lightly in this territory. Binta's profession as a kind of beauty entrepreneur was particularly illustrative in how it addressed gendered labor dynamics in the larger economy: Binta made a successful business out of buying and selling not only clothes and accessories, but also marketing and profiting off of women's goals to become desirable subjects—revealing a means through which women craft consumer-based identities as they seek to attract intimate partners and display their prosperous lifestyles. These hopes are particularly elevated among those seeking to conceal their status and search for partners, in order to garner greater stability, support, and respect in a larger economic context where some men can no longer be sole providers.

And second, Binta raised critical questions about the informal and uncompensated kinds of care men and women offer one another in the domestic sphere. Unquestionably, non-married women are deeply embarrassed by their poverty. Their lack of supportive husbands adds to this shame. Binta's second husband, however, offered spiritual, emotional, and embodied forms of support to her and her child, enacting a relationship in which their intimacy was forged through the mutual exchange of care for one another. Yet, he was not always able to fulfill his economic obligations to her. Binta thus contemplated what the virtuous thing to do in this situation was. On one hand, religious and cultural gendered norms surrounding economic responsibilities specify that men are supposed to earn the money and women are supposed to use this income take care of themselves, their partners, and their households. Work in the public sphere, many believe, poses risks to a married woman's reputation and character. It is not unusual for women to hide just how invested they are in these careers. On the other hand, Binta had to face the reality that her husband could not entirely meet these economic expectations—a common circumstance in northern Nigeria, where men also struggle to secure occupations with regular salaries. Binta's success in business enabled her to mask her husband's inability to support her, as well as prevent the possibility that visible displays of poverty and marital instability would expose her HIV status.

For the women in my research, an HIV-positive diagnosis exposed cracks in the tacit assumptions they possessed over how women are expected to live “positively”—or virtuously—as they confronted broader social forces that left them vulnerable to violence, inequality, and poor health, such as limited access to education and work in the formal economy, and limited legal protections from abusive husbands and families, to name a few. Most of the HIV-positive women I knew believed that HIV devalued their bodies, which was compounded by their poverty, neglectful husbands and families, and gendered norms that were constraining, disabling, and seemingly impossible to fully realize. This virus produced a new set of needs related to maintaining one’s health and hiding one’s status. However, these commitments were difficult to secure, as women felt too ashamed to disclose their status, as well as too embarrassed to beg for help from others. At the same time, their precarious relationships with husbands and family members led to the additional pressure of giving more of themselves—their money, time, and labor—than they perhaps intended to give. HIV-positive women routinely take major risks—in their occupations and their relationships, in addition to their health—in order to salvage their dignity.

And yet, this same diagnosis also allows us to understand how women persevere, assert their agency, and reimagine their futures. Binta found fulfillment in a marriage in which her husband was able to make up for his shortcomings through his efforts to care for *her* intimate needs. These acts of care work included providing her emotional and spiritual support, as well as expressing concern for her body, children, and overall wellbeing. Binta’s satisfaction was so strong that, in our conversation, she recast her husband’s inability to support them and her need to work into a moral narrative over his desire to not allow her to fall into debt, thus justifying both of their actions as ethical. Such profound displays of hope in the face of uncertainty, hypocrisy, and injustice offer a window onto the possibility that these women can—and *do*—in fact transcend the physiological and social “death sentences” that too commonly haunt this diagnosis.

¹ Pseudonym