"The World is a Pregnant Woman":
Marriage and Reproductive Decision-making among HIV-infected Women in Northern Nigeria

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> During my wedding, I was fourteen and my husband was thirty-two...I became pregnant after four months…We had a girl. We did not go to the hospital and I did not have any complications or tears. After two days she died without any fever or observed illness. Truly, I was sad but then I remembered that God giveth and he taketh whatsoever He wishes...I spent one year before getting pregnant [again] and had a boy… [Soon after his birth], my husband started with intensive diarrhea and cough, so we went to [the hospital] and tests were run and drugs administered while he was told he was HIV-positive. When he came back I accused him of infecting me and almost hated him for being on my own and him infecting me. This went on for days. Then later on, I thought: "God destined for this to happen to me, otherwise I would not have gotten it"…I only told my mother, who told my dad, and so I was taken to the hospital. My father went back for the result and later told me, preached, and advised me. Before my husband fell ill I had heard from people and on the radio about HIV and had heard people say, once you are infected then you die. So, when I learned of my status I said, "That's it. I am also going to die" and I spent the night crying and could not eat. At the time I never met an infected person before but just knew people called the disease "*kabari kusa*" ["grave site brought close"]…After some time I accepted my fate and believe that God has said that every affliction has a cure. Not long after my husband's test result, he became ill. And not long after, died. *Jummai*

How Jummai came to contract HIV, her reactions, and her experiences following infection are not unlike the experiences of many women who are infected with the human immunodeficiency virus [HIV] across Nigeria. These women are married, widowed, and divorced. They have had children and they have lost children. They care for their own illnesses, their husband's, and their children's. Many expect to die immediately after they learn of their status. Some have told their parents and their families. Many have not. Many Hausa women have accepted their infection as Islamic doctrine dictates—that God's authority and control extend over everything. They have faith in cures that will come from God. In addition, they take care to live healthily. Most, however, are poor and lack the health-sustaining anti-retroviral drugs that would suppress many of the opportunistic infections that are, at best, an irritating

burden, and, at worst, result in a complex set of symptoms. This latter condition marks the onset of AIDS [Acquired Immunodeficiency Syndrome], an illness that will ultimately lead to death. What is less understood by these women at the time of infection is that the onset of serious illnesses associated with HIV can take as many as ten years to appear. Jummai is an example of a woman who is coming to terms with the reality of a lifespan that could extend for many years.

As a consequence, Jummai faces a set of very difficult concerns: How will HIV affect her ability to remarry? *Can* she remarry? Who will marry her? How can she support herself and her child without a husband? If she desires to marry an HIV-positive husband, what will she tell the HIV-negative suitors who approach her? At age 18 with only one living child, her relatives and friends who are unaware of her HIV-status, all expect her to remarry. What will she tell them? Will she be able to have another child?

Although concerns like Jummai's are familiar to many infected women across the globe, unmarried Hausa women are unique in that their concerns are situated in a context of a country with one of the highest total fertility rates in the world. In the most populous country in Sub-Saharan Africa, with over 126 million people, Nigerian women will have an average of 5.7 children during the course of their lifetime (DHS 2004). In Hausa society, a fundamental component of a woman's social identity is the ability to give birth. The social and economic value of children, which sustains Nigeria's high levels of fertility are well accounted for by anthropologists and demographers. These values are embedded in lineage-based descent and extended kinship systems, polygyny, bridewealth, and child fostering (i.e. Caldwell and Caldwell 1987), as well as Hausa Islamic practice and tradition. Furthermore, Hausa society has no institutionalized role for single men or women (Goody 1976), and certainly no roles for single mothers. Women marry at young ages. Reluctance to marry or postponement of marriage by women is "perceived as a threat to organizational and economic value of the domestic unit" (Solivetti 1994:256). Marriage is thus the only route to achieving fertility, and subsequently domestic stability. Women must not only get married, but also stay married. Fertile widows and divorcees face intense social pressures to remarry. These Hausa marriage norms, therefore, leave no room for the majority of unmarried, HIV-infected women. Of the 3.3 to 3.6 percent of women from Kano State, located in the North central region of Nigeria, estimated to be infected with HIV (UNAIDS 2004), many are widowed or divorced. In order to understand the social dynamics of marriage and reproduction being confronted by unmarried, infected women, it is necessary to first contextualize this question within the broader HIV epidemic in Nigeria, as well as within the biomedical concerns surrounding sex and pregnancy following HIV infection.

Epidemiologists are becoming increasingly concerned with the trajectory of the AIDS epidemic in Nigeria. In December, 2003, there were an estimated 3.6 million adults and children living with HIV/AIDS in Nigeria (UNAIDS 2004), and approximately 1.9 million of these persons are women between the ages of 15 and 49. Overall, the HIV prevalence rate for adults is 5.4%. Infected children constitute 300,000 of the entire infected population. Statistics also demonstrate that in Nigeria today, there are currently 1.8 million orphans—children under the age of 17 who have lost one or both parents to AIDS. Reflecting these latter statistics, prevention of mother-to-child transmission of HIV [PMTCT] is one of the most emphasized

processes in health research, health literature, and in HIV program funding in developing countries. Research and programming devoted to prevention emphasize certain facets of the Nigerian woman's experience. Specifically, these highlight how her sexual relationships, marriage, and reproductive motivations and behaviors are situated within a context of adverse health consequences. Firstly, women risk transmitting HIV to uninfected sexual partners and to their unborn children. Secondly, pregnancy for HIV-infected women requires increased attention and care for their already weakened immune systems. Biomedical researchers, however, are quick to assert that the likelihood of transmitting HIV from mother to child is small when the mother receives antiretroviral therapy. Note that few Nigerian women have access to full antiretroviral therapy upon which these probability statistics are based. The likelihood of transmission varies considerably, depending on levels of treatment and the course of an individual's HIV progression. While the physiological consequences of HIV on a woman, her sexual partner, and unborn children are significant, the social consequences of a woman infected with HIV *not* being sexually active, *not* marrying, and *not* having children also demand serious scholarly attention.

This paper investigates the social position of unmarried, HIV-positive women in Hausa society. I will first show how HIV impacts and reinforces a woman's social position. Specifically, HIV drives the mechanisms that cause an infected woman to be unmarried in the first place. What makes the case for these Hausa women compelling, however, is that it is not being HIV-positive that drives their values, behaviors, and expected life trajectories, rather it is being unmarried. Unmarried Hausa women hold the same basic cultural values whether they are HIV-infected or not. Likewise, Hausa women also share the same social and economic consequences that result from being unmarried, regardless of their HIV status. After establishing the unique social position of unmarried, HIV-infected Hausa women, I then will examine the dual role of a support group for infected persons, as both a context for women to negotiate their social positions, and as a force in itself that that shapes their particular positions. On one hand, the support group is a window into which these women's values, aspirations, and life strategies are expressed and debated amongst one another. On the other hand, the support group itself is an influential force in purveying both resources and additional problems onto these women. Ultimately, however, the individual values and decisions made by women within the context of this group and the constraints placed upon women that are generated and reinforced by this group, must be interpreted through the lens of an unmarried Hausa identity. Ironically, examining the impact of HIV on women vis-à-vis a support group reveals most clearly the tensions and conflicts surrounding being unmarried, not that of HIV-related psychosocial or health concerns.

I will examine the interrelated concerns of gender and personhood, marriage, reproduction and well-being in Hausa society by emphasizing processes of social reproduction, as considered by Pierre Bourdieu in his theory of practice (1977). In addressing how values surrounding marriage are salient in Hausa women's lives, I will look to literature describing the implicit and explicit principles compelling Hausa women to marry and have children, and the institutions through which these values are outlined. These ideal pathways will be the basis upon which Bourdieu's theory will be applied. What will become evident in these descriptions is how Hausa gender ideals are culturally constructed through sexuality, marriage, fertility, and parenthood. I will consider how women give meaning to and derive meaning from these

practices. I will do so through using Elishe Renne's (2004) example of how Hausa women's conceptions of the term "women's status," are in fact imbued with culturally-specific meaning. Further, these are ideas that orient and inspire culturally-specific values, intentions, and actions. Following Bourdieu's explanation of *habitus*, however, I highlight the fact that women do not all share the same social positions, and it is these positions that will inform their values and behaviors. It will further shape what structures she attempts to reproduce and what structures she is able to reproduce when confronted with an unforeseen event, such as contracting HIV. Therefore, in this study, it is necessary to evaluate the factors that influence the social positions of Hausa women—namely those that surround being infected with HIV and being unmarried—in order to fully understand their marriage and fertility values, intentions, and behaviors.

What motivated this research are the increasingly concentrated public health efforts throughout Nigeria that have begun to confront HIV through voluntary testing centers and early interventions. These programs have allowed many individuals to learn of their status prior to the onset of serious infections associated with AIDS. Broadly, demographic and health researchers have sought to understand how sexual behaviors are changing in the context of HIV and how this will ultimately be reflected in population processes. In addressing these questions among infected populations, studies have begun to examine the impact of an HIV-positive diagnosis on fertility desires and behavior change. Researchers describe the persistence of reproductive desires and outcomes observed among infected populations who are aware of their status, and suggest that perceptions of health, maintenance of status, and cultural ideals of gender and personhood are tied to reproduction in many populations (Aka-Dago-Akribi et al 1999; Temmerman et al 1990; Lutalo et al 2000; Rutenberg et al 2000). Other studies, however, have suggested that reproductive trends in this population are curtailed on account of the fact that women are concerned that further pregnancies might exacerbate the disease, that HIV infection could spread to her child, and for the welfare of her children (Rutenberg et al 2000). Rutenberg and her colleagues suggest that researchers must question how men and women evaluate threats to their own health, that of their sexual partners, and that of their potential children. However, individual notions of risk hold weak explanatory power in reproductive intentions and behaviors, therefore mitigating family planning recommendations that call for understanding these factors to help individuals make better choices about contraception.

Theoretically, this paper endorses and seeks to expand upon Philip Setel's (1995) conclusion: "A decision by a healthy HIV-infected person to continue childbearing is likely to be influenced by the importance of fertility for men and women in tenuous socioeconomic contexts, and by how reproductive power is configured in culturally supported hierarchies of gender and generation" (180). This paper goes further in noting the gap in the demographic and health literature in considering centrally the role of marriage among HIV-infected persons. Even less is understood about marriage intentions and behaviors and how these are implicated in changing sexual practices in the context of HIV/AIDS, than is understood about reproduction. As will be revealed, marital intentions and behaviors are also simultaneously caught up in webs of social obligations and rewards with socio-economic underpinnings, are linked to ideals of gender and personhood, and mediate the sexual activity of individuals. This paper will ultimately contribute to an understanding of the significance of marriage and reproductive values and behaviors in an HIV-infected population. It will do so by emphasizing the roles of cultural ideals of gender and

personhood and socioeconomic contexts in informing the tension between individual choices and cultural constraints that engender women's marriage and reproductive ambitions and decisions.